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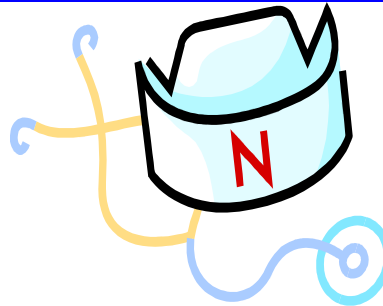
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## DEVELOPMENTAL DISABILITIES NURSING:

### Not the Nursing They Tell You About in Nursing School

True? You can talk to just about any DD Nurse and get the same answers. DD Nursing is in a class of its own. And most DD Nurses became DD Nurses by happenstance. They were looking for a job, wanted something different than the hospital or doctor's office gig...so they applied for this innocuously-described nursing position in the newspaper ad. Many have taken their turn at DD nursing and quickly come and gone. For many who choose nursing as their career and profession, DD nursing just does not fit the mold. Nurses generally like to see results. They went into nursing to make a difference in people's lives. They like to have things a certain way...neat and orderly. This isn't the nursing you learned about in nursing school. It isn't all technological and precise and supported by a myriad of other medical personnel doing various tasks. You don't work 8 hours and go home while some other nurse takes care of your patients while you're gone...and then another...until they are handed back to you again tomorrow. DD nursing isn't that pretty.

Many of the nurses who find DD nursing as their professional home are tough. They can deal with just about any situation and bounce back. They keep going like the Energizer™ bunny...and not just for 1 shift. They are On Call all hours of the day and



night, show up at hospitals when they should be in bed, and arrive for the team meeting bright and early the next day. So why do they do it? Because they love it, that's why.....

DD nurses have some elements of their jobs that are very different than the usual nurse you will see in a hospital or doctor's office. Some of these differences are that DD nurses:

- Work in a field in which the tools to do their jobs are limited (technology, communication, etc.)
- Often report to non-medical supervisors who may not understand the practice of nursing and how this should apply in that particular setting
- Must constantly stretch the boundaries of sensible delegation and often delegate to those that they do not directly supervise and have limited ability to insure for appropriate follow through
- Work with other professionals such as physicians, psychiatrists,

and dentists who *do not understand* the DD population and their needs

- Work in a field that is not equipped to support people that are often quite medically-fragile and have multiple comorbidities
- Spend more than the usual time training and retraining staff due to high turnover of positions which can cause potential health and safety risks
- Are sometimes limited in their professional autonomy to use nursing judgment as is provided for in ANA Standards of Practice and in individual states' Nurse Practice Acts

Every DD Nurse knows these things....and yet, they practice in their beloved field of developmental disabilities. Nursing school never prepared anyone to work in DD. And yet...they do it. DD nursing requires a special type of nurse...one that can do a lot with a little...who revels in the seemingly insignificant gains in their clients...who can't sleep at night because they have to figure out what's going on with so-and-so's sore tummy before it gets worse....*that's* a DD Nurse.

# THE POLYPHARMACY TRAP



Polypharmacy has gained attention within the past few years as a negative side effect of the prolific number of medications available for everything that ails you....and for some things that aren't even really ailments (like medication to promote hair growth).

The basic definition of polypharmacy is that more drugs are prescribed for a person than is clinically warranted. In the DD population, the average number of medications per person per day is 8-15 different medications. This is a lot! There is a higher prevalence of polypharmacy in groups like the elderly and individuals with DD due to the multiple comorbidities seen (diabetes, seizures, heart disease, pneumonia, psych issues).

Interactions between drugs are certainly occurring for many of our consumers who take this many medications in a day. Polypharmacy also includes vitamins, minerals, and herbal supplements as well. These can all be a component of drug interactions and negative side effects of the medications one takes. In addition, some of our consumers have kidney and liver function irregularities. These 2 organs primarily deal with metabolites of the drugs taken. Poorly functioning kidneys could mean a build up of medication in the system. For someone on 15 medications a day, the long term effects of this daily can stress the kidneys and the body, leading to more medical issues in the future.

Do you have individuals who you feel fall into the category of The Polypharmacy Trap? Do you have 2 or more physicians prescribing for an individual...in isolation of what the other physicians are doing? Who reviews the entire medication regimen as a whole and considers diagnoses, current health, medications, side effects, drug interactions, unnecessary drugs, etc.? Is this review only done if it is required by regulation? Or, is the best interest of the consumer the guiding force for whether this is needed.

### Consequences of Polypharmacy:

- Adverse drug events
- Drug interactions
- Duplication of therapy

- Unnecessary cost (medication & time in administering the med)
- Greater potential for med errors when giving more medications in a day
- Decreased quality of life
- Increased noncompliance with meds due to taking so many in a day

Is taking 8-15 medications ALWAYS a bad thing? No. Thoughtful, intentional polypharmacy is the other aspect of this picture. A particular individual with multiple medical issues who is highly functional and in general good health on a med regimen of 12 meds...may be on exactly what he needs to be. It still needs periodic evaluation as things DO change....like kidney function, circulation, metabolism, and overall clinical picture.

### To LIMIT POLYPHARMACY, look at:

- Justification for each med on the list.
- Remember that not every complaint requires a pill.
- Do not add and discontinue medications frequently. Reach maximally tolerated dose before adding another pill.
- Avoid starting 2 medications at the same time. It is impossible to tell which one may be working and side effects between the 2 are probable, creating new issues to deal with.
- Regular review of all meds by primary practitioner regardless of who prescribed—encourage physicians to really LOOK AT the medications as a whole and to talk to each other about optimal prescribing habits for a given individual. It is a part of 'the code' for a physician to not question the practices of another physician, so this can be a challenge.
- Having a regular Medication Regimen Review (MRR) by a consultant pharmacist especially of any client who has multiple diagnoses and/or multiple medications.

Don't fall for the Polypharmacy Trap!

# The Food and Drug Administration: Our Watchdog for Quality

The Food and Drug Administration (FDA) is a division of the U.S. Department of Health and Human Services. It has the responsibility of protecting and promoting the health of the American people. The FDA regulates food, drugs, dietary supplements, cosmetics, medical devices, radiation-emitting devices, biologics, and blood products in the U.S. It is the watchdog for these items used by humans and in animals (like the medicines your vet uses for your dog or cat).

The FDA is ascribed its authority through the Congressional Act known as the Food, Drug, and Cosmetic Act. It is in place to ensure the safety and effectiveness of many of the products that we use in our everyday lives.

Drugs must go through a pre-approval process before these can be marketed and prescribed to the public. However, there is no pre-approval process for dietary supplements for the same proof of safety and effectiveness. The FDA can only remove these products from the market AFTER they have been shown to cause harm. Certain dietary supplements such as baby formulas are more closely regulated since these are distributed to a more vulnerable population (infants) who can

be more easily harmed if problems exist. The FDA is divided into 5 major Centers, each with its own specific area of expertise and regulation:

- The Center for Drug Evaluation and Research (CDER)
- The Center for Biologics Evaluation and Research (CBER)
- The Center for Devices and Radiologic Health (CDRH)
- The Center for Food Safety and Applied Nutrition (CFSAN)
- The Center for Veterinary Medicine (CVM)

In pharmacy, we deal mostly with CDER who is responsible for the evaluation, safety, and labeling of drugs. They even monitor drugs after approval to insure that no unknown features of a drug become known after administration in the general population. They can recall a drug from the market if additional side effects or anomalies occur that were not within the parameters of the medication's original profile. This is a very interesting website with access to a multitude of scientific and medical research topics, drug information, podcasts and more. Go to [www.fda.gov](http://www.fda.gov) to check it out!



You're all most likely fairly familiar with HIPAA (that's the Health Information Portability and Accountability Act)...but only because you are required to sit through some mandatory mind-numbing training that attempts to make boring information a little less boring. We know that following HIPAA guidelines means that we should consider each individual's private health information as protected and only provide minimally-necessary information on a need-to-know basis to the appropriate person or entity. We all handle a LOT of health information pertaining to the individuals we support. As a matter of fact, *almost everything* we come in contact with on paper has to do with the individuals we support, whether we work in a residential setting, Home Health, Job Corps, Day Program, or in an office setting related to any one of these. The Pharmacy would be hard pressed to find a piece of paper that *wasn't* a

HIPAA protected document....that is 99% of what we deal with.

There are other aspects of HIPAA that you may not think about however. And these are not related to what's on a computer screen or in a consumer's chart.

Consider these situations in your HIPAA program:

- Fax machines that are sitting in the open or in public traffic areas in which private consumer information is faxed to you...and may sit for a period of time. This information could be picked up or read by anyone walking by. What are your processes for protecting it?
- Direct Support Staff, Nurses, and others who work for your organization who may chit-chat about consumers within

earshot of others (including other consumers) who do not have the right to know this information.

- Disposing of empty bubblepacks, vials, bottles, and other packaging from the pharmacy, that has a consumer's identifying information and medication listed together on the label. This information should be obliterated so that it is not visible prior to discarding in the trash.
- Carrying consumer information in folders and charts to go to physician appointments, and leaving this information unattended for periods of time as you talk to the receptionist, go to the bathroom, etc.

Examine your opportunities to HIPAA—FY and keep your consumers' information under wraps. It's the right thing to do...and it's the LAW!

# Pharmacy Alternatives™

Exceptional service - Exceptional people

## THE POST SCRIPT

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**All articles to be considered for submission to this newsletter should go to Georgia Swank at the above email address. We welcome your comments and ideas!**



*Medications refilled too soon could cost consumers money!*

*Insurance for medications will only cover a certain amount in a certain time frame.*

## “REFILL TOO SOON”

You've faxed in the stickers to get several of your consumers' meds refilled and you are anxiously awaiting these meds to show up the next day. But, of the 10 meds you faxed refill orders for, only 8 show up in the delivery! What's going on? That DARN PHARMACY!

Those of us nurses who've been around a few years know that things have really changed in recent years in the medical field in general. With the advent of DRGs (drug-related groups) guiding what the reimbursement will be for all types of medical services, it is no wonder that the world of pharmacy has been enveloped into this web of cost containment. It used to be that if you ordered a drug from the pharmacy, it came...regardless of whether the insurance company might pay...or not. There didn't used to be nearly as many medications as there are now. And nearly everything seemed to be covered. The concept of Medicare Part D was not even a firing neuron in someone's brain yet. There weren't, however, all of these highly expensive, specialized medications that exist nowadays. People take lots more medicine than they used to when our parents were young. Why? Because it's there!

Different Medicare Part D prescription drug plans (PDPs) cover different lists of meds, called formularies. Each formulary will basically have some drugs from each class of medications, to provide a fairly broad choice of prescriptive liberty to physicians. However, these formularies are also created with the intention of saving money for the government...so lesser expensive medications are a large part of the mix. If you belong to PDP #1, you may or may not have a drug covered that your physician writes for you. Your physician and you can choose to go with a different drug that is covered or stick with what is written and you end up getting stuck with the extra expense.

Another phenomena with Medicare Part D PDPs is that the formularies can change without you knowing it. This means you can be taking a drug one month and it is covered and when you reorder the drug, it is NOT covered. Again...as we bill your medications, we offer YOU (and your physician) the option of what you want to do at this point. It is your money. We aren't going to spend it for you without your permission.

Along with the specific drugs a PDP will cover, is the amount and frequency of refilling that will be approved. A 30-day supply is the usual amount, but this can vary. If you try to REFILL TOO SOON, the insurance will not reimburse for that order. This is why 8 reordered meds show up the next day after you reordered, and the other 2 don't show up until 2 days later. They were ordered too soon and the insurance kicked it out. The PAL billing department will wait that 2 days and submit for payment again, making sure all of your meds are covered before they are shipped to you. Doing it this way means that your consumers and your operations do not get stuck with unexpected costs if insurance should deny the medication. We want to provide you with all of the options for minimizing your liability cost-wise. It is important to PAL to make sure the consumers' personal funds are utilized optimally and not spent unnecessarily.

If you are perplexed about why a reorder did not show up, you are always welcome to call your pharmacy and ask. We will tell you if the reason is that the med was “REFILLED TOO SOON”.