The Adherence Encounter Structure: Putting it All Together

Making the Most of My Medications

Screening form for patients to complete while waiting for prescriptions to be filled or before Comprehensive Medication Review (CMR); to help identify patients with adherence barriers.

Assess & Address in 5 Minutes or Less

Trigger form to be placed by the verifying pharmacist into bins/bags with late prescription refills. The pharmacist conducting the brief adherence consult can use this to identify the patient's adherence barriers.

Solve & Involve

Use this sheet to help the patient develop a Medication Plan (a strategy to address the adherence barrier) and a plan for follow up.

Resources to Help with My Medication Plan

Use this sheet to provide resources that could be helpful for the patient's specific adherence barriers.

My Medication Plan

Use this sheet to help the patient develop a Medication Plan (a strategy to address the adherence barrier) and a plan for follow up.

May go directly to follow up for brief adherence encounters.

Adherence Follow Up Documentation Form

After completing "ASSESS & ADDRESS" for brief adherence encounters, or if additionally using "SOLVE & INVOLVE" to develop a Medication Plan with the patient, fill out this form and file in the pharmacy by scheduled follow-up date for future use.

Adherence Follow Up Guide

During the follow up call/visit, use this sheet to assess patient success/satisfaction with their chosen adherence solution(s).

MAKING THE MOST OF MY MEDICATIONS

1. What are you taking your medication(s) for?

- ❒ Blood Pressure
- ❒ Heart Disease
- ❒ Asthma
- ❒ COPD
- ❒ Kidney Disease
- ❒ High Cholesterol
- ❒ Depression
- ❒ Anxiety
- ❒ Diabetes
- ❒ Supplement
- ❒ Infection
- ❒ I don't know
- ❒ Other_____

2. How often do you forget to take your medication or forget if you took your dose?

- ❒ 5 or more doses in a week
- ❒ 3-4 doses in a week
- ❒ 1-2 doses in a week
- ❒ I never forget to take my medication

3. How well do you feel your medications are working for you?

- ❒ Very well
- ❒ Somewhat well, but not as much as I would like
- ❒ Not well
- ❒ I don't know

4. I have these concerns about my medication(s):

- ❒ Getting refills
- ❒ I don't think I need it
- ❒ Side effects
- ❒ How to take it
- ❒ Reading medication bottles
- ❒ Remembering if I took my medication
- ❒ Remembering to take all my doses
- ❒ Cost
- ❒ Other: _____

5. What changes would make it easier for you to take your medications?

_____

_____

ASSESS & ADDRESS IN 5 MINUTES OR LESS

PURPOSE: Place this trigger form into bins/bags with late prescription refills. The pharmacist conducting the consult can use this to identify the patient's adherence barriers.

1. I saw that some of your medications could have been filled around _____ (Date).
   a. Do you still have some **left at home?**
   b. Have you **received samples** of this medication or had it filled at another pharmacy?
   c. **How are you taking** this medication? What time of day do you take this medication?
   d. How is taking this medication **fitting into your schedule**?
2. Remembering to take medications can be difficult for a lot of people. Thinking about the past week/month, how many times would you say you **missed a dose** of your medications?
   a. What **times of day** are you most likely to miss a dose?
   b. What have you **tried in the past** to help you remember to take your medications? What works well for you?
   c. What are your **biggest challenges** with taking your medications?
3. How do you feel your medications are working for you?
   a. Do you do any **home monitoring** of your (blood pressure/blood sugar)?
      • Having concrete numbers can help a lot of people track how well their medications are working. Has your doctor discussed home monitoring with you?

SOLVE & INVOLVE

PURPOSE: Use this sheet to help the patient develop a Medication Plan (a strategy to address the adherence barrier) and a plan to follow up.

1. Summarize specific target behavior/goal:
    a. "So, just to be sure I understand, it sounds like controlling your blood pressure is important to you, for _____ (reasons). Due to _____ (barriers), it's been hard taking your medications every day as prescribed."

2. Help the patient make a S.M.A.R.T. plan (Specific, Measurable, Achievable, Relevant and Timed)
    a. "What is something that you'd like to do to help you remember to take your medications in the next week or two?"
        • Include medications/regimen/resources in the plan.
    b. "That sounds like an important goal. Many people find it useful to have a specific plan."
    c. "When do you see yourself doing this? (How do you see this fitting into your schedule?)"
    d. "When would be a realistic start date?"
    e. "Who might you see helping and supporting you with this?"

3. Elicit a commitment statement:
    a. "Just to make sure we both understand the details of your plan, would you mind sharing it in your own words?"

4. "I wonder how sure you're feeling about this. How confident are you about completing your plan?"

5. Identify potential barriers to the plan:
    a. "What things do you think could get in the way of your plan?"
    b. "What could you do to prepare for these problems?"

6. Restate summary of plan, including start date.

7. Establish Follow-Up:
    a. "Would it be helpful to set up a time to check in and see how things are going with your plan?"
        • Make the follow-up plan specific as to day, time and method.

8. Fill out the "My Medication Plan" sheet with the patient, using the reverse side to decide together what resources may be helpful.

(Adapted from CCMI Brief Action Planning: A White Paper[9])

RESOURCES TO HELP WITH MY MEDICATION PLAN

- ❒ Bus Pass
- ❒ Call 2-1-1
- ❒ Contact local senior center or ADRC
- ❒ Align medication refill dates
- ❒ Delivery or mail-out services
- ❒ Community cab/ shuttle info:

_____

_____

- ❒ Family members/ friends who could help pick up prescriptions:

_____

_____

- ❒ Goal to improve health (i.e. blood pressure goal):

_____

_____

- ❒ Home testing plan:

_____

_____

- ❒ OTC products/ strategies to manage side effects
- ❒ Helpful tools or smart phone apps:

_____

_____

_____

_____

_____

_____

- ❒ Medication information, instructions, and visual aids that fit my needs
- ❒ Large font size
- ❒ Translation

Pharmacy phone #:

_____

- ❒ Single dosage form
- ❒ Different shapes or colors of prescription bottles
- ❒ Phone alarm
- ❒ Family members or friends to help remind me to take my medications
- ❒ Helpful websites and apps
  - MyMedSchedule.com
  - NexDose.com
  - Epill.com
  - Forgettingthepill.com
  - Thedidit.com
  - Mango Health App
  - MediSafe App

- ❒ Change Medication
- ❒ Tablet splitting
- ❒ Combination product
- ❒ Manufacturer coupons
- ❒ Savings cards
- ❒ Free or low cost clinics
- ❒ ForwardHealth WI (Medicaid) (1-800-362-3002)
- ❒ Federally Qualified Health Centers (FQHC)
- ❒ Community Support
  - www.211wisconsin.org
  - Dial 2-1-1 on phone
  - Local United Way
- ❒ Prescription discount and assistance websites
  - pparx.org
  - needymeds.org

MY MEDICATION PLAN

In the next _____ (one week; 2 weeks; month) I will:

Start date for my plan: _____

Things that could get in the way of my plan:

1.

2.

3.

Ways I will prepare for these problems:

1.

2.

3.

My pharmacist_____ will:
(name)

- ❒ Contact my doctor about: _____
- ❒ Other: _____

Plan to FOLLOW UP with my pharmacist:

_____ will check in with me on _____ via (phone call, visit) to
(pharmacist name) (date)

discuss today's plan.

ADHERENCE FOLLOW UP DOCUMENTATION

Date of **service**: _____ Date of **follow up**:_____

Patient name:

❒ Telephone
❒ In person

DOB:

Phone number: (___)_____

RX #: _____

Medication (name, dose, strength):

_____

Provider name: _____

❒ Documented encounter to provider

Notes from Medication Plan:

_____
_____
_____

Recommended Resources:

_____
_____
_____
_____

Notes from follow up call:

_____
_____
_____

ADHERENCE FOLLOW UP DOCUMENTATION

Date of **service**: _____ Date of **follow up**:_____

Patient name:

❒ Telephone
❒ In person

DOB:

Phone number: (___)_____

RX #: _____

Medication (name, dose, strength):

_____

Provider name: _____

❒ Documented encounter to provider

Notes from Medication Plan:

_____
_____
_____

Recommended Resources:

_____
_____
_____
_____

Notes from follow up call:

_____
_____
_____

ADHERENCE FOLLOW UP GUIDE

1. "How has taking this medication been **fitting into your daily schedule** since your last visit?"

2. "Last time I saw you we discussed (setting a reminder alarm on your phone; using a pill box, other), **how has this been working for you?"**

3. "Since the last time I saw you, how many times would you say you've **missed doses** of your medications?"

    a. If they had positive adherence outcomes, **recognize (affirm) success.**
        - **"Congratulations!"**
        - "What changes worked well for you?"

    b. If they had some improvement with adherence, **recognize (affirm) partial completion.**
        - For example, if the patient had success on 2 days following the brief adherence encounter, **validate the positive.**
        - "You had success on those two days. Tell me more about that."

    c. If they had no improvement with adherence, **acknowledge their effort** and work with them toward developing a new, more attainable plan.
        - "That is common for people making new changes."

4. "What **changes would make it easier** for you to take your medications?"

5. **"What would you like to do next?"**

    a. If they want to make a new plan, follow the steps on the Solve and Involve document.
    b. If they would like to talk about what they learned from their Medication Plan, discuss ways of adapting the plan to be more successful in the future.
    c. If they would not like to make another Medication Plan at this time, offer to return to action planning in the future.

(Adapted from CCMI Brief Action Planning: A White Paper[9])