3.5.41 Medication Adherence

(a) Procedure Overview

This procedure provides guidelines for the monitoring and reporting of patient medication adherence issues. Parameters vary by administration type (keep-on-person [KOP], nurse administered [NA], and directly observed therapy [DOT]) and by its reporting status (immediate or over time).

(b) Responsibility

(1) Statewide

California Correctional Health Care Services (CCHCS) and California Department of Corrections and Rehabilitation (CDCR) departmental leadership at all levels of the organization, within the scope of their authority, shall ensure administrative and clinical systems are in place and appropriate tools, training, technical assistance, and levels of resources are available so that licensed health care staff can successfully implement this procedure.

(2) Regional

Regional Health Care Executives are responsible for implementation of this procedure at the subset of institutions within an assigned region.

(3) Institutional

The Chief Executive Officer, or designee, is responsible for the administration, monitoring, and evaluation of the compliance with this procedure at the institution level.

(c) Procedure

(1) Auto-refill Process

(A) When feasible and clinically appropriate, regularly scheduled doses of KOP medications shall be automatically refilled to encourage patient adherence and to maintain continuity of care.

(B) At any time, a patient may request the discontinuation of the auto-refill process for one or more medications by submitting a CDCR 7362, Health Care Services Request Form, or by discussing with their provider.

(2) Critical Adherence Medication List

(A) Each year, the Systemwide Pharmacy and Therapeutics Committee, in collaboration with the Statewide Patient Safety Committee, shall release a Critical Adherence Medication List with corresponding interventions. While adherence is important for all medications, missing a single dose for one of the selected critical medications carries a higher risk.

(B) Medications that are part of involuntary treatment court orders (i.e., Penal Code [PC] 2602 and PC 2604) shall be included in the Critical Adherence Medication List.

(C) Medications on the Critical Adherence Medication List shall be programmed in the Electronic Health Record System (EHRS) to alert the prescriber and the patient's Primary Care Team (PCT) for timely intervention.

(D) The Critical Adherence Medication List is available on Lifeline and the CCHCS/CDCR publically accessible website.

(3) Medication Administration Record

(A) An automated flag to the Huddle Report and/or an automated alert to the EHRS Message Pool shall notify all members of the patient's PCT if the patient misses:

1. Three consecutive days of a scheduled NA or DOT medication;
2. 50 percent or more of scheduled doses over seven consecutive days of an NA or DOT order; or
3. A single dose of a medication on the Critical Adherence Medication List.

(B) In addition, an automated alert in the EHRS Message Center shall notify the mental health prescriber (defined as a psychiatrist or psychiatric nurse practitioner acting under the supervision of a psychiatrist) if the patient misses:

1. Three consecutive days of a non-critical psychiatric medication;
2. 50 percent or more of scheduled doses of a psychiatric medication over seven consecutive days; or
3. A single dose of a medication on the Critical Adherence Medication List.

(C) A designated nursing supervisor shall review the compliance of medication administration utilizing dashboards, master registries, patient summaries, and decision support tools to address or elevate issues concerning medication adherence as necessary.

(4) Medication No-Shows for Medication Lines (Medication Administration)

(A) At the conclusion of each medication line, licensed nursing staff shall access the Post Medline Report located in PowerChart to identify patients who did not present to the medication line to receive their scheduled

medications (no-shows) and/or other medication administration problems. The only exception to this will be those patients with PRN (as needed) medications.

(B) If the patient is a no-show for an NA or DOT medication, licensed nursing staff shall coordinate with the nursing supervisor, Facility Captain, Lieutenant, Sergeant, or Associate Warden, Health Care Services, to locate the patient and to assist with resolving any identified barriers to medication administration as appropriate, and make every effort to bring the patient to the medication line for:

a. Medication administration; and
b. Documentation of barriers that prevented the patient from presenting to the medication line (e.g., lockdowns or transfers to another area or institution); or
c. Documentation of their refusal and reason for refusal of the medication.

(5) Medication Refusals

(A) Licensed nursing staff shall document each refusal of an NA or DOT medication in the EHRS Medication Administration Wizard or electronic Medication Administration Record and document the reason for each medication refused, as stated by the patient.

1. If a patient refuses methadone administration by the Narcotic Treatment Program, licensed nursing staff shall have the patient sign a CDCR 7225, Refusal of Examination and/or Treatment. The Addiction Medicine Central Team and the patient's PCT shall be notified via the EHRS Message Pool.

(B) Licensed nursing staff shall notify the prescriber when the patient refuses to pick up KOP medication, provide medication adherence counseling as determined by the prescriber, and document in the health record.

(C) Prescribers shall consider changing prescriptions, discontinuing medications, or discontinuing auto-refill for medication refusals and document the rationale for the action in the health record.

(6) Medication Non-Adherence Counseling

(A) Any prescribers and other licensed health care staff conducting patient interviews and/or education shall ensure that effective communication is provided and documented in the health record.

(B) Medication adherence issues shall also be documented on the problem list.

(C) Clinical health care staff shall review medication adherence by way of the Automated Huddle Report or EHRS Message Pool for licensed health care staff to perform medication counseling.

(D) Patients prescribed medications by a medical prescriber:

1. For critical medications on the Critical Adherence Medications List, the PCT shall be notified verbally and in writing when a patient misses a critical medication by the end of the medication pass. Patients shall be seen by licensed health care staff within 24 hours when referred for missing or refusing a dose of a critical medication.
2. For non-critical medications, licensed health care staff shall provide medication adherence counseling as determined by the PCT and document in the health record. When indicated, licensed health care staff shall contact the prescriber for guidance.

(E) Patients prescribed psychiatric medications by a mental health prescriber:

1. For medications on the Critical Adherence Medication List, the patient shall be seen by a mental health prescriber for an urgent mental health referral within 24 hours from receipt of the notification of medication non-adherence.
2. For non-critical medications, a mental health prescriber shall review the health record and document in the health record the plan of action within seven calendar days from receipt of the notification of medication non-adherence.
   a. The documented plan of action should take into account anticipated future medication non-adherence.
   b. A mental health prescriber shall follow up with a face-to-face session addressing the medication non-adherence as soon as clinically indicated, but no longer than 30 calendar days from the first day the mental health prescriber is notified of non-adherence.
3. Any medication adherence counseling session with a mental health prescriber shall be documented in a detailed note, and shall take place in a confidential setting, unless the patient refuses to attend.

(F) If the patient refuses life-sustaining medications, the prescriber shall assess the patient's decision-making capacity and document in the health record.

1. If the patient has significant mental illness, it may be necessary to seek assistance from a psychiatric physician regarding the patient's decision-making capacity.

2. If a mental health referral is needed, the Primary Care Provider shall make a referral to the psychiatric physician for a determination of capacity to refuse treatment and inform the patient of the reason for the referral.

(G) The prescriber may discontinue the medication and have the patient sign a CDCR 7225 when a patient who has decision-making capacity continues to refuse medication.

1. For adherence issues with Medication Assisted Treatment medications, prior to discontinuing the medication licensed health care staff shall:
    a. Meet with the patient to discuss the concerns;
    b. Seek case consultation from the CCHCS Complex Care Team at CCHCSComplexCare@cdcr.ca.gov;
    c. Consider alternative medication types (including injectable medications) via existing procedures; and
    d. Document the outcome of the above steps in a progress note in EHRS.

(H) All refusals shall be signed by the patient and co-signed by licensed health care staff. If the patient refuses to sign the CDCR 7225, two licensed health care staff shall sign. In unusual circumstances (e.g., Administrative Segregation Unit, Mental Health Crisis Bed), the CDCR 7225 may be signed by two staff members, one of whom shall be a licensed health care staff.

(I) When a refusal is signed, the original refusal form shall be forwarded to Health Information Management to be scanned to the health record.

(7) Hoarding/Cheeking/Medication Misuse

(A) Medication issues that involve a security or safety issue (e.g., hoarding or diverting of medications) shall be referred to the prescriber via the EHRS Message Center and the appropriate Facility Lieutenant, or designee, shall be notified.

(B) Upon notification, the prescriber shall evaluate the need for a modification to the medication regimen (such as discontinuing medication, requiring "crush and float," changing to NA or DOT) and schedule an appointment with the patient as clinically appropriate.

1. For suspected misuse of medications, prior to modifying or discontinuing the medication, licensed health care staff shall:
    a. Conduct an assessment to understand the facts;
    b. Meet with the patient to discuss the importance of taking medications as prescribed;
    c. Seek case consultation, as needed, based on patient need and circumstances;
    d. Consider alternative medication types (e.g., injectable medications) via existing procedures; and
    e. Document the outcome of the above steps in a progress note in EHRS.

(C) Prescribers shall take necessary action regarding the patient's prescribed medication based on information provided and subsequent patient evaluation.

(D) Prescribers shall notify the Pharmacist-In-Charge of medication misuse.

References

- California Business and Professions Code, Division 2, Chapter 9, Article 2, Section 4016
- California Penal Code, Part 3, Title 1, Chapter 3, Article 1, Section 2602
- Health Care Department Operations Manual, Chapter 2, Article 1, Section 2.1.2, Effective Communication
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.3, Care Teams and Patient Panels

Revision History

Effective: 10/2008
Revision: 08/2021