Clinical Practice Initiatives

Medication Management

NaviCare® HMO SNP, a Medicare Advantage Special Needs Plan and NaviCare® SCO, a Senior Care Options program, are both from Fallon Health (Fallon).

Preventive patient education

NaviCare may provide the following educational information to your patients and their

- Reinforcement of healthy lifestyle changes including the importance of having routine follow-up visits, taking medication(s) as prescribed, maintaining a healthy diet for weight management, following exercise recommendations, smoking cessation, and avoidance of secondhand smoke
- Importance of regular follow-up visits to include medication review and monitoring, especially at care transitions
- Importance of reporting to care providers all non-prescription medications being taken
- Review of medication list with your care provider after an inpatient hospitalization
- The use of high-risk medications with potentially harmful drug-disease and drug-drug interactions inclusive of the American Geriatric Society 2018 updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

Clinical indicators

When evaluating your performance, Fallon will look at the percentage of your patients:

- Taking the following medications for at least six months and receiving **annual** monitoring:
  - ACE Inhibitors/ARBs: Serum K+ **and** Serum creatinine
  - Digoxin: Serum K+, Serum creatinine **and** Digoxin level
  - Diuretics: Serum K+ **and** Serum creatinine
- For whom the inpatient (acute or non-acute) discharge medication list is reconciled with the current outpatient medication list on or within 30 days of the inpatient discharge

Dated documentation in the outpatient medical record must include one of the following:

- Documentation that the provider reconciled current and discharge medications
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications)
- Documentation of the current medications with a notation that the discharge medications were reviewed
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service
- Notation that no medications were prescribed or ordered upon discharge
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).

1-866-275-3247

Monday through Friday from 8:30 a.m. to 5:00 p.m.

fallonhealth.org