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Ashley M. Cooper

Children's Mercy Hospital, amcooper@cmh.edu

Julia G. Harris

Children's Mercy Hospital, jgharris@cmh.edu

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Medication Education in the Pediatric Rheumatology Clinic

Ashley M. Cooper, MD; Julia G. Harris, MD

Children's Mercy Kansas City, Kansas City, Missouri

Introduction

The Children's Mercy rheumatology division previously conducted a successful initiative to standardize patient education about the teratogenic risks of immunosuppressive medications. After joining the Pediatric Rheumatology Care and Outcomes Improvement Network (PR-COIN), a multi-center learning network focused on improving care for children with juvenile arthritis, we sought to spread the successful interventions from our teratogen project to all immunomodulators prescribed in our clinic and to increase provision to annual medication education to 85% by January 2019.

Methods

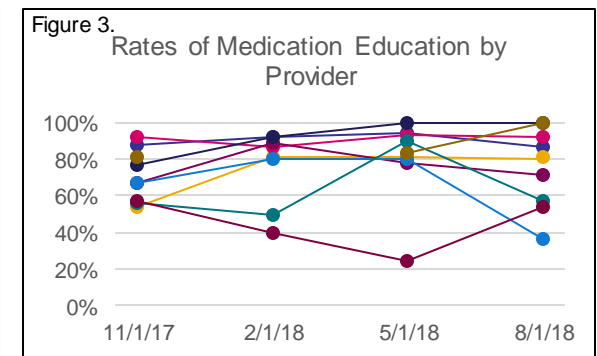
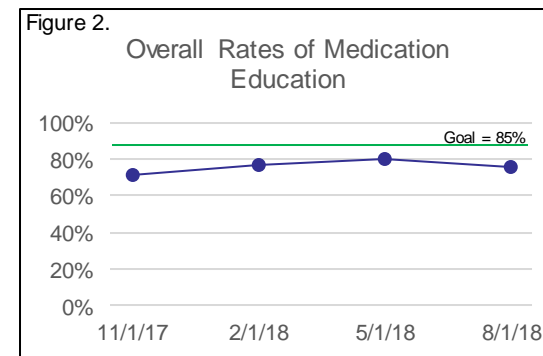
- Created medication education documentation template in the electronic medical record (Figure 1).
- Standardized pre-visit planning process.
- Spread process to all target medications in March 2017.
- Initial medication education done by providers.
- Annual medication education done typically by nurses.
- Quarterly chart audits with data displayed on run charts.

The screenshot shows an EMR form titled "Leflunomide (Arava) Education". It includes a "Reviewed with:" field, a "What are some possible side effects of this medicine?" section with checkboxes for "Risk of infection", "Nausea and vomiting", "Diarrhea", and "Liver damage can rarely occur.", a "How can this medication affect reproductive health?" section with checkboxes for "Risk of causing birth defects", "Two forms of birth control", "Females should wait 2 years after stopping Arava", and "The risk of birth defects in a baby whose father is taking Arava is unclear". There are also checkboxes for "More information requested?" and "Education handout given?".

Figure 1. Screenshot of EMR education documentation template.

Results

Our initial chart review in November 2017 demonstrated an average rate of education documentation among all rheumatology providers of 71%. Subsequent quarterly chart reviews have demonstrated rates above the baseline (ranging from 73.8 to 84.4%), but not a consistent trend towards improvement (Figure 2). Considerable variation remains between the lowest and highest performing providers (Figure 3).



Conclusion

We have implemented a standardized process for providing initial and annual education to patients receiving immunosuppressive medications in the rheumatology clinic by utilizing pre-visit planning, consistent verbiage and uniform documentation. Despite these interventions, we have not yet achieved our goal of providing ongoing medication education to at least 85% of patients prescribed immunosuppressive medications. Next steps include sharing these results with the rheumatology team and re-assessing clinic processes to determine factors contributing to variation in medication education rates.