HOME HEALTH NURSES' VIEWS OF PROMOTING MEDICATION ADHERENCE AMONG COMMUNITY-DWELLING ELDERLY PATIENTS

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OLUSOLA OMIDIRAN B.S., M.S.

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DEDICATION

To God Almighty, for Your mercy and love.
I could not have done this without You. It is in You that I live, move, and have my being.

To my husband, Goke, thank you for your encouragement all the way.

To my son Dr. Dapo Omidiran, you walked and completed your PhD journey long before me. Thank you for believing in me and cheering me onto the finish line.

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ABSTRACT

OLUSOLA OMIDIRAN

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Home health nurses are key healthcare providers in all communities, and they have valuable insights on issues such as promoting medication-adherence among community-dwelling elderly patients. Evidence shows that poor adherence to prescribed medication(s) leads to negative health outcomes among community-dwelling elderly patients. Although home health nurses are recognized stakeholders in healthcare delivery, their perspectives on promoting medication adherence among their elderly patients is sparse in existing literature. The purpose of this study was to describe the views of home health nurses on promoting medication adherence among community-dwelling elderly patients, and to explore the sociocultural contexts for the formation of these home health nurses' views. The study utilized Fairclough's (2003) critical discourse analysis (CDA) methodology. Data analyzed included 13 in-depth interviews with home health nurses, and analysis of four official documents relevant to medication adherence promotion among community-dwelling elderly patients. The five categories identified from the interview analysis include: (a) medication adherence promotion as providing nursing care, (b) medication adherence promotion as engaging patients/caregivers, (c) medication

adherence promotion as requiring multiple reinforcements, (d) medication adherence promotion as preventing adverse outcomes, and (e) medication adherence as requiring team effort. The four categories that emerged from analysis of the documents were: (a) monitoring medication compliance, (b) monitoring medication safety, (c) notifying the physician, and (d) communicating with patient/caregiver. Four out of the five categories representing home health nurses' views on promoting medication adherence among their elderly patients converged with the language of the official documents examined in this study. Only the category of medication adherence promotion as requiring multiple reinforcements did not converge with the language used in these official documents. Nurse educators may use the findings from this study to enhance the behavioral health component of the nursing education curriculum. The findings from this study can also spur research that evaluates the influence of co-pays on patients' adherence to prescribed brand-name medications. Policy makers may use the findings from this study to develop and enact policies that promote efficiency among healthcare providers as they manage elderly patients' medication regimen.

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CHAPTER I

INTRODUCTION

In the United States (US), about 40 million elderly, defined as persons aged 65 years and older, are community-dwelling (U.S. Census Bureau, 2016). A community-dwelling person is anyone who lives outside of an institutionalized setting. The community-dwelling population include persons who live in independent living housing arrangements or community-based group homes, but it does not include those who live in skilled nursing facilities (French, 2004). Community-dwelling elderly individuals tend to have challenges with medication adherence. Estimates show that more than one out of every three persons among this population does not take their medications as prescribed (Sirey, Greenfield, Weinberger, & Bruce, 2013). Medication non-adherence occurs when a person either purposefully or inadvertently does not follow a prescribed medication regimen (Johnson, Williams, & Marshall, 1999). Adherent medication-taking behaviors involve procuring the medication; administering the correct drug, dose, time, and route; and continuing to take the medication for the prescribed length of time (Ruppar, Conn, & Russell, 2008).

Medication adherence is a complex behavioral process related to patients' knowledge and beliefs regarding their illnesses, motivation and confidence in their ability to engage in management behaviors, expectations regarding treatment outcomes, and understanding of the consequences of poor adherence. Medication non-adherence results

in decreased therapeutic benefits for the patient, frequent hospital and physician office visits due to a decline in the patient's condition, and increased healthcare expenditure (Boswell, Cook, Burch, Eaddy, & Cantrell, 2012; Chisholm-Burns & Spivey, 2012; Mahoney, Ansell, Fleming, & Butterworth, 2008). In the US, about 1 million elderly persons receive home health services each year, with 84% of these elderly individuals requiring skilled nursing services (Jones, Harris-Kojetin, & Valverde, 2012). As key stakeholders in the health services delivered in communities, home health nurses may be capable of promoting medication adherence among their elderly patients. Furthermore, Setter, Corbett, and Neumiller (2012) highlight that that the medication-related services home health nurses provide—such as reviewing medication history, resolving medication discrepancies, providing medication teaching, and monitoring side effects—place these nurses in a prime position to promote medication adherence among community-dwelling elderly patients.

While home health nurses' medication management activity is likely to influence medication adherence among community-dwelling elderly patients, available evidence about the influence of home health nurses on promoting medication adherence among their community-dwelling elderly patients is ambiguous. As an example, Owens (2006) found that the caring behavior by home health nurses positively influenced elderly patients' medication adherence. In contrast, Mager and Madigan (2010) observed that up to 64% of elderly patients who were actively receiving nursing services from home health agencies were not adherent to their medications. Hence, while the evidence suggests that

home health nurses' interaction with their elderly patients is an important factor, it appears that other contextual elements are also present within the home health practice, limiting these nurses' influence on promoting medication adherence among their community-dwelling elderly patients. Thus, there is a need to investigate the perspectives of home health nurses regarding medication adherence promotion, and to examine the sociocultural and regulatory contexts that influence these nurses' views regarding medication adherence promotion among their community-dwelling elderly patients.

Statement of Purpose

Promoting medication adherence remains a health care priority in the US. As former U.S. Surgeon General Charles Everett Koop reminded us, "drugs don't work in patients who don't take them" (quoted in Osterberg & Blaschke, 2005, p. 487). Among elderly individuals, medication non-adherence is responsible for as much as 10% of unplanned inpatient admissions (Banning, 2008). Furthermore, medication non-adherence is a multifaceted problem; failure at the level of the healthcare system, the individual patient, or the healthcare provider, can ultimately influence a patient's medication adherence (Ruppar et al., 2008; Sirey et al., 2013).

Within the context of the U.S. healthcare system, home health nurses are key healthcare providers in communities, and they may have insights about solutions that will result in better medication adherence among community-dwelling elderly patients. Earlier research by Owens (2006) indicates that home health nurses have an influence on medication adherence among their elderly patients. However, recent work by Mager and

Madigan (2010) found that a high percentage of community-dwelling elderly patients receiving home health services were not adherent to their medications. These divergent findings suggest that other factors may be competing against home health nurses' efforts to promote medication adherence. Furthermore, the voice of home health nurses is not sufficiently audible on the issue of promoting medication adherence among their elderly patients.

The literature does not provide substantive information about home health nurses' views on this issue; nor does it describe the contextual factors that may influence home health nurses' medication promotion activity. By gaining clarity about the views of home health nurses relative to these two issues, researchers can identify better ways to tap into these nurses' potential to promote medication adherence. The knowledge gained from this study will also be a springboard for policies that support promoting medication adherence among community-dwelling elderly patients. The purpose of the study was to describe the views of home health nurses on promoting medication adherence among community-dwelling elderly patients. Additionally, this study explored the sociocultural and regulatory contexts for the formation of home health nurses' views.

Research Questions

The researcher sought to answer the following three questions:

(1) What are home health nurses' views about medication adherence promotion among community-dwelling elderly patients?

(2) How are home health nurses' views about medication adherence promotion among community-dwelling elderly patients created within and informed by their sociocultural context?

(3) How are home health nurses' views about medication adherence promotion among community-dwelling elderly patients influenced by healthcare regulations?

Researcher's Relationship to the Topic and Assumptions

The researcher's interest in the area of promoting medication adherence started in the late 1990s, when she worked as a home health nurse in the District of Columbia and saw that many of her elderly patients were not taking their medications as prescribed. Upon relocating to Houston, the researcher worked in the home health industry between the years 2004 to 2008. There, she noticed a similar trend of suboptimal medication adherence among the elderly patients that she provided services to as a home health nurse. Recently, in her employment as a health maintenance organization (HMO) nurse, the researcher has collaborated with several home health agencies to identify strategies for improving medication adherence among HMO elderly members who demonstrate patterns of suboptimal adherence.

The researcher conducted this study with the purpose of learning how home health nurses view the promotion of medication adherence among their community-dwelling elderly patients, and understanding the sociocultural and regulatory contexts for these home health nurses' views. The overarching purpose for conducting this study was to provide healthcare professionals and other stakeholders with a greater sense of clarity

about medication adherence promotion among community-dwelling elderly patients. This study proceeded from the following assumptions:

1. Home health nurses have a viewpoint about the topic of interest.
2. The participants responded to questions honestly and without duress.
3. Each participant's responses accurately reflected his/her thoughts, feelings, and perceptions.
4. The participants understood the terms, concepts, and vocabulary used during the research study.

The researcher recognized that her previous experience, knowledge and expectations as a home health nurse were likely to influence how she received and interpreted the data relative to this study. Hence, the researcher maintained a reflective journal, in which she logged the details of how she may have influenced the results of each interview.

Theoretical Framework

The Habermas critical social theory (Habermas CST) and the discourse theory (DT) guided this study. The Habermas CST theory evolved from ideas that started in the 1920s and 1930s at the University of Frankfurt's Institute of Social Research, where an interdisciplinary group of scholars proposed that a theory that unified the empirical science and the philosophical constructs was essential for understanding the complex issues facing that era (Mosqueda-Diaz, Vilchez-Barboza, Valenzueala-Suazo, & Sanhueza-Alvarado, 2014). Critical theorists believe in the importance of combining experiential with factual knowledge in order to have complete understanding of an issue

(Crotty, 1998). Critical theorists are action-oriented, and they believe that motivations to change occur as people become aware of the contradictions and disparities in their beliefs and social practices (Crotty, 1998).

Taking the views of the first-generation critical theorists regarding knowledge development further, Habermas (1984) proposed that language plays a key role in apprehending knowledge, asserting that "what raises us out of nature is the only thing whose nature we know: language" (p. 314). Habermas posited that people use communication, specifically language, to self-identify and understand the world around them. According to Habermas (1984), the systems in our modern society - educational institutions, workplaces, and political institutions - have a dominating effect on people, limiting utterances, imaginations, and activities. To Habermas (1984), as people become engaged in an *ideal speech* situation where communication is freer and fuller, consensus emerges; what people believe to be true unfolds, and greater understanding occurs. Furthermore, in Habermas' view, gaining an understanding of the social, political, and cultural context of an issue provides a platform to facilitate change (Bohman, 2005). Using Habermas' CST as a guide, one is able to uncover new ideas and to identify those notions that need adjustment in order to bring about change.

Like Habermas, Stevens (1989) believes that critical social theory is optimal for uncovering the historical and environmental conditions that surround an issue. Stevens (1989) affirms that an understanding of the historical and environmental circumstances that inform nursing practice is essential to "conscientizing" people and stimulating

change. Thus, for this study, Habermas CST provided the basis for uncovering home health nurses' views on medication adherence promotion, bringing to light the circumstances and notions that contribute to the creation of such views. Habermas CST offered a suitable framework for this study because it provided a useful platform to explore the social, cultural, and political conditions that inform home health nurses' views about promoting medication adherence among community-dwelling elderly.

According to discourse theorists, discourse is a particular way of talking about and understanding the world or an aspect of the world (Jørgensen & Phillips, 2002). In addition to spoken language, discourse encompasses all other forms of communication (e.g., gestures and symbols) which people use to ascribe meanings to social or physical objects within their cultural or historical environment (Jørgensen & Phillips, 2002). Mills (2004) explains that discourse is a way of talking about an object, concept, or phenomenon and that it shapes thoughts, perceptions, and feelings about this object. Put in a different way, while the knowledge base in a society is responsible for framing the nature of discourses held by the constituency, discourses also feed back into the society to reinforce or further shape knowledge. Discourse theorists believe that discursive practices (what people say, write, and the interpretations attributed) have an iterative relationship with the social and cultural change that takes place within a group or the society (Jørgensen & Phillips, 2002). Health issues, such as medication adherence occur within sociocultural and environmental context. Using the discourse theory as a guide, and with particular emphasis on written and spoken methods of communication, the

researcher sought to describe the perspectives, and the contexts that inform the views of home health nurses about medication adherence among community-dwelling elderly patients.

The DT exposes a dialectical relationship between discourse, knowledge development, and productive activity; while the Habermas CST highlight that systemic structure can limit both discourse and action. When used in combination, the Habermas CST and the DT provided the best framework for describing home health nurses' views, as well as understanding the sociocultural and other contextual influences on these nurses' views regarding medication adherence promotion among community-dwelling elderly patients. Figure 1 depicts the relationship between the theoretical framework, methodology and methods utilized for this study, as well as how these contributed a systematic understanding of home health nurses' views regarding medication adherence promotion among community-dwelling elderly patients.

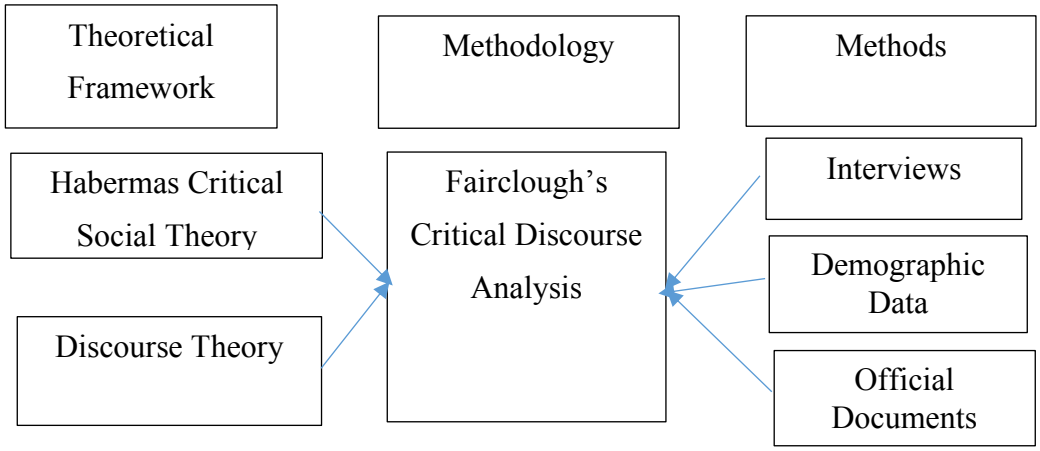

Figure 1. Study's theoretical framework, methodology, and methods.

Significance of the Study

Significance for Nursing Education

The researcher designed the study with the goal of eliciting the voice of home health nurses regarding promoting medication adherence among community-dwelling elderly patients. The study provided a premium opportunity to identify, and understand knowledge gaps that nurses have regarding promoting medication adherence. Nurse educators can use the knowledge gained from this study to enhance the current medication management curriculum in our nursing schools, and at nursing continuing education portals. Using the information gained from this study to bridge nurses' knowledge gaps is important considering that nurses are the largest of the health care profession groups; nurses also have the most direct interaction, and longest engagement with their patients (Benner, Sutphen, Leonard, & Day, 2010). Furthermore, nurses are also highly trusted by their patients (Rutherford, 2014). As a relationship-based enterprise, it is important that nurses are equipped with the state of the science knowledge as they interact with their patients, as this will further the credibility and influence of the nursing profession.

Significance for Nursing Practice

The knowledge gained from this study will optimize how nurses approach medication adherence promotion. The knowledge gained from this study will further empower nurses to practice with confidence. Based on the knowledge gained from this study, nurses will have information on best practice for promoting medication adherence

among elderly patients. Nurses will be able to provide strategic and systematic guidance to individual elderly patients about optimal medication-taking behaviors. Ultimately, as nurses utilize the knowledge gained from this study, they will contribute to better health outcomes of their elderly patients.

Significance for the Society and Policy

The knowledge gained from this study will inform healthcare policy decision-making and enactment. Home health nurses play a central role in the care of community-dwelling elderly patients. In coordinating the care needs of their patients, home health nurses liaise with a variety of stakeholders such as physicians, pharmacists and medical insurance organizations. Based on this positioning, home health nurses have valuable insights about the hindrances and facilitators of medication adherence among elderly patients. The insights offered by the home health nurse participants in this study will lend to a better understanding of issues related to promoting medication adherence among elderly patients. Furthermore, the knowledge gained from this study will provide supportive evidence on which policy decision makers can draw, to enact policy decisions that support elderly individuals in being adherent to their medication regimen.

Chapter Summary

The prevalence of poor adherence to their prescribed medication regimen among community-dwelling elderly patients makes promoting medication adherence among this population a health care priority. Home health nurses have the potential to contribute to the solutions necessary to effecting better medication adherence among the

elderly community-dwelling patients in our society. The available information from literature is diffuse regarding home health nurses' actual influences on medication adherence behavior among elderly community-dwelling patients. Using the DT and Habermas CST as a framework, the researcher described the views of home health nurses regarding medication adherence promotion among community-dwelling elderly patients and explored the sociocultural and regulatory influences on these nurses' views.

CHAPTER II

REVIEW OF LITERATURE

The purpose of this chapter was to review and comment on the literature in the areas of medication use and fostering medication adherence among community-dwelling elderly persons. This chapter concentrates mostly on literature written about the US contexts due to the close relevance to the focus of inquiry. The review comprises of the following areas, (a) terminologies describing medication-taking behaviors; (b) medication use among community-dwelling elderly patients; (c) medication adherence promotion among community-dwelling elderly patients; (d) regulatory environment and medication adherence promotion; (e) health professionals involved in medication adherence promotion; (f) home health as environment for promoting medication adherence; (g) and home health nurses as stakeholders in promoting medication adherence.

Terminologies Describing Medication-Taking Behaviors

Medication-taking behaviors have commonly been described by two main terminologies. Although the two terms do not have exactly the same meaning, "adherence" and "compliance" have been used interchangeably within the healthcare community to describe the medication-taking behavior of individuals. Compliance is the degree to which patient's medication-taking behavior matches the prescriber's

recommendations (Horne et al., 2005). The use of compliance is decreasing because of the view that the term minimizes patients' involvement in medication-taking decisions (Costa et al., 2015; Katz & Goldberg, 2007). Medication adherence is the extent to which the patient's medication-taking behavior matches agreed recommendations from the prescriber (Horne et al., 2005). Medication adherence has been adopted by many as an alternative to compliance because it: (a) underscores a collaborative relationship between the patient and the prescriber, (b) emphasizes that the patient is free to decide whether to adhere to the medical practitioner's recommendations, and (c) prompts the prescriber to explore reasons for the patient's dissonance, rather than apportioning blame (Costa et al., 2015; Horne et al., 2005; Katz & Goldberg, 2007).

Medication non-adherence occurs when a patient deviates from the agreed-upon recommendations, and it can be intentional or unintentional. Unintentional non-adherence arises from individual constraints (e.g., memory, dexterity, vision, etc.) and/or environmental limitations (e.g., problems of accessing prescriptions, cost of medicines, competing demands, etc.) that impede the patient's behavior from matching the agreed-upon recommendations from the prescriber (Horne et al., 2005). Intentional non-adherence to medications stems from the beliefs, attitudes, and expectations that influence patients' motivation to begin and continue with the treatment regimen (Horne et al., 2005). Since the root causes of poor medication adherence are disparate, differentiating between these two forms of non-adherence is helpful to the overall efforts of promoting medication adherence.

Medication use among Community-Dwelling Elderly Patients

The population of elderly Americans (65 years and older) is on the rise. Estimates reveal that this group will double from its current size of about 40 million to approximately 88 million by the year 2050 (Administration on Aging, 2015). With the "graying" of the U.S. population, projections show that the prevalence of chronic illness will increase, and so will the use of medications needed to manage these diseases. In a study of elderly clients receiving home healthcare, almost two-thirds were non-adherent with one or more of their medications, and a large number of intentional medication omissions were reported (Mager & Madigan, 2010). Some elderly patients are non-adherent to prescribed medications due to the belief that the medication is no longer needed because symptoms have been relieved (Holt, Rung, Leon, Firestein, & Krousel-Wood, 2014; Mager & Madigan, 2010).

Elderly patients' medication non-adherence also stem from lack of finances to procure medications (Holt et al., 2014; Mishra, Gioia, Childress, Barnet, & Webster, 2011), and knowledge deficit about how to take the prescribed medication (O'Quin, Semalulu, & Orom, 2015). Other reasons posed for non-adherence by community-dwelling elders are: forgetting to take medications, falling asleep prior to the scheduled time for taking medication, physical difficulty in taking the medication (swallowing), inability to hold the medication (dropped), or not being aware that the medication is prescribed (Ho, Taylor, Cabalag, Ugoni, & Yeoh, 2010; Mager & Madigan, 2010). Failure to adhere to medication regimens is associated with disease progression and the

development of complications resulting in poor health outcomes, emergency department visits, hospitalizations, re-hospitalizations, adverse drug reactions, and death (Ruppar et al., 2008). Thus, poor medication adherence among community-dwelling individuals is a multi-faceted phenomenon that adversely affects the individual elderly patient and has negative consequences for society as a whole.

Medication Adherence Promotion among Elderly Patients

Poor adherence to prescribed medications is an issue that has been present from the ancient times. An early physician, Hippocrates expressed his concern about medication non-adherence, thus: "Keep a watch… on the faults of the patients, which often make them lie about the taking of things prescribed. For through not taking disagreeable drinks, purgative or other, they sometimes die" (Brown & Bussell, 2011, p. 304). Since medication adherence is a necessity for any pharmacotherapy to achieve maximal benefit, considerable research efforts have been invested to identify and promote solutions to medication non-adherence. Relative to this current study, a review of literature from several electronic databases (Medline, Academic Search Complete, PsychINFO, HealthSource, and Cinhal) was performed using a combination of the following keywords: medication adherence, medication compliance, intervention, community-dwelling, and elderly. Efforts to promote medication adherence among elderly individuals were noted to include randomized and non-randomized trials, with interventions generally aimed at influencing the patient, medication, medication administration, or a combination of these three factors.

Commonly used interventions to foster elderly patients' adherence include medication education, disease education, motivational counselling, coaching on self-administration, and symptom monitoring (Banning, 2008; Ruppar et al., 2008). Approaches to improving elderly patient's adherence to their medications via targeting medication-related factors include simplifying administration dosing from a higher frequency to once or twice daily (Lindquist et al., 2012) and using medication packaging systems such as pill boxes or blister packs that can hold up to a week's worth of medications in separate compartments (Ruppar et al., 2008). The last broad approach that has been used to foster medication adherence in elderly patients involves making changes to aspects of medication administration by using medication reminders, where the elderly were prompted via telephone calls or video-phone calls to take their medications (Ruppar et al., 2008). While some of these interventions show a measure of effectiveness (Banning, 2008; Ruppar et al., 2008), findings from recent studies show that the problem of medication non-adherence persists among community-dwelling elderly persons (Meraz, 2017, Sirey et al., 2013). At the close of a Cochrane review that evaluated 182 randomized controlled trials, Nieuwlaat et al. (2014) were unable to identify a single effective, actionable, and affordable method of helping patients to follow prescribed medication treatments. Thus, there is a need for the research community to continue to search for more effective means of promoting medication adherence among community-dwelling elderly persons.

Regulatory Environment and Medication Adherence Promotion

The medication-related services of home health nurses are visible in publications by the regulatory agencies. In articulating the position of the Centers for Medicare and Medicaid Services (CMS), United HealthCare (a CMS contractor) affirms that the purpose of many homecare skilled nursing visits is to evaluate the effectiveness and safety of medication regimens; an additional purpose is to assess for, and educate patients about, medication side effects (United Health Care, n.d). This position of the CMS regarding promoting medication adherence is detailed in the CMS State Operations Manual (2014), which states that registered nurses (or therapists, where the only skill needed by the patient is therapy) must conduct a comprehensive medication assessment. This comprehensive medication assessment must **"**include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy" (p. 91).

The CMS State Operations Manual (2014) also prompts home health surveyors to interview home health agency staff in order to gain an understanding of the processes utilized when a patient is not following the medication regimen. In a publication by the West Virginia Medical Institute (2014), this CMS contractor offers guidance and resources to home health leaders and clinicians on improving patient's medication self-management ability. The author (West Virginia Medical Institute), recommends frontloading visits, conducting focused assessment to evaluate medication-taking

behaviors, care-conferencing patients who have a potential for not adhering to their medications, and enlisting the support of other members of the home healthcare team to improve patients medication adherence (West Virginia Medical Institute, 2014).

Health Professionals and Medication Adherence Promotion

A wide array of healthcare professionals including pharmacists, physicians, social workers, nurses, dieticians have served as interventionists to promote medication adherence in elderly patients. In a review of 63 interventional studies involving medication adherence promotion in the elderly, pharmacists exclusively delivered 37 studies and collaborated as a part of the multi-disciplinary team in five more of the studies (Ruppar et al., 2008). Nurses did not feature as interventionists quite as frequently; they accounted for 4 of the 63 studies evaluated by Ruppar et al. Interestingly, in a review that evaluated the relative efficacy of allied health professionals (nurses, pharmacists, research assistants), Doggrell (2010) concluded that one healthcare discipline did not show greater effectiveness over the other disciplines in being able to promote medication adherence.

Furthermore, Doggrell (2010) surmised that the issue of promoting medication adherence would benefit from further research. It is also worth noting that community-dwelling elderly patients who require more intensive services to take medications (i.e., elders with greater disability) did not benefit substantially from the telephonic-delivered pharmacy interventions delivered in the study by Zillich et al. (2014). This finding spurred Zillich et al. to conclude that a more robust in-person or telehealth solution may

be needed to accommodate the advanced needs of patients who have decreased functionality (2014). Given that home health nurses are already involved in medication management-related activities for their patients, it is conceivable that these nurses have better insights into the medication-taking behaviors of their elderly patients and thus are able to provide solutions that will promote optimal medication adherence among community-dwelling elderly patients.

Home Health Environment and Medication Adherence Promotion

The home health sociocultural environment includes professional organizations and agency-specific norms that guide home health nurses' activity. Many home health agencies advertise medication management as part of the services available to their clients. Phrases such as "we help your loved one understand and take their medications at the right time and in the right amounts; we look for medication conflicts and help to clear up any confusion" suggest a stance that promotes medication adherence among the patients served (Kindred at Home, 2015, para. 3). Additionally, texts such as: "gauging your ability to manage your medications; comparing your medication orders to all of the medications that you have been taking to avoid omissions, duplications, dosing errors or potentially dangerous drug interactions," suggests that the home health agency is interested in promoting medication adherence and the safe use of medications among their patients (Amedisys, 2012, para. 3). In a white paper written by the American Nurses Association (ANA), an organization that prides itself as being the voice of the nation's 3.4 million nurses, the ANA underscored the crucial role that community-practicing

nurses play in medication management and improving patients' medication adherence (ANA, 2012). Drawing from the statement of the ANA, one may surmise that the organization also puts a premium on home health nurses' actions to promote medication adherence among patients.

Home Health Nurses as Stakeholders for Promoting Medication Adherence

Home health nurses are important stakeholders whose views need to be taken seriously in order to develop meaningful solutions to the issue of poor medication adherence among community dwelling-elderly individuals. Settler et al. (2012) spotlighted the crucial role that home health nurses play in identifying and resolving medication discrepancies as patients are transitioned back to the community setting; Settler also postulated that nurses (in concert with physicians and pharmacists) can have a crucial influence in preventing negative medication-related outcomes. There is some evidence that supports the utility of home health nurses in promoting medication adherence. In specific terms, Owens (2006) found that caring behaviors by home health nurses influence and improve elderly patients' medication adherence, as well as decreasing barriers to adherence. Research indicates that community-dwelling elderly patients value the affirmation and education that they receive from nurses who practice in the community. These elderly patients attributed their medication adherence and feeling of being in control over their medication regimen to their nurses' interest, friendliness, willingness to provide quality information, and ability to act as counselors (Henriques, Costa, & Cabrita, 2012).

Elderly community-dwellers have also indicated that a medical advocate—someone who is not a physician or a pharmacist, but who is knowledgeable about medications—could facilitate medication adherence by improving elderly individuals' understanding of medications (O'Quin et al., 2015). While the elderly individuals in O'Quin et al.'s (2015) study did not label the medical advocate as a nurse, it is reasonable to expect that the support that these elderly patients need in order to be adherent to their medications lies within the professional purview of nurses. In the capacity of a medical advocate, home health nurses could provide education and reinforcement on medication-related advice to augment instructions given by the medication prescriber, and in this manner, promote medication adherence among community-dwelling elderly individuals.

Conversely, some of the available evidence does not substantiate the viewpoint that home health nurses contribute to promoting medication adherence among their community-dwelling elderly patients. For instance, in a study involving 113 community-dwelling elderly patients receiving home health services, Griffiths, Johnson, Piper, and Langdon (2004) did not observe significant improved medication adherence in the study participants. Furthermore, a more recent study revealed that elderly patients recently discharged from home health services had medication mismanagement issues such as the omission of prescribed medication and inclusion of discontinued medication, as well as discrepancies in the strength and frequency of their medication regimen (Lancaster, Marek, Bub, & Stetzer, 2014).

The inconsistencies with medication adherence noted among community-dwelling elderly patients who receive home health nursing services suggest that some obscure determinants may be impeding these community-dwelling elderly patients' medication-taking behavior. Additionally, home health nurses may have impediments that interact with their medication promotion efforts among their community-dwelling elderly patients. Among community healthcare professionals, nurses are the ones who interact with elderly patients during the most vulnerable periods of their lives (e.g., post-hospitalization). Consequently, nurses are distinctively likely to be privy to the barriers that preclude adherence in this population. Rather than giving up on the quest to find lasting solutions to the issue of poor medication-taking behaviors among the community-dwelling elderly, the state of knowledge can be advanced by critically exploring the perspectives of home health nurses about promoting medication adherence among community-dwelling elderly patients.

Chapter Summary

A review of literature revealed that medication non-adherence among community-dwelling elderly patients as a persistent issue that has multifaceted components. While varied approaches have been utilized over the years to foster resolutions, it is now realized that effective solutions must consider the unique needs of the community-dwelling elderly patient. Home health nurses interact closely with their patients and are thus in an ideal position to recognize the opaque reasons why some community-dwelling elderly patients do not adhere to their medications. Additionally, home health nurses

may be at an advantage in identifying effective means of promoting medication adherence among community-dwelling elderly patients. In sum, this review of literature indicates that it is timely and expedient to explore the views of home health nurses about promoting medication adherence among community-dwelling elderly patients. It is also important to contextualize the sociocultural and regulatory environment in which home health nursing practice occurs. Utilizing a comprehensive approach, one that seeks the perspectives of home health nurses, as well as the contextual influences on home health nurses' views, will deepen understanding of how to enhance medication adherence among community-dwelling elderly individuals.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

In addition to being a more cost-effective option, home healthcare appeals to many elderly individuals because they would rather receive the services that they need (e.g., nursing and therapy) in the comfort of their own home than be hospitalized (Landers et al., 2016). In the home care arena, nurses constitute the largest of the healthcare profession groups, far outnumbering physical therapists, occupational therapists, and social workers (The National Association for Home Care & Hospice, 2010). In a study by Henriques, Costa, and Cabrita (2012), community-dwelling elderly patients expressed that the counselling, coaching, and support that they received from nurses helped them to better understand information given by medical practitioners. Owens (2006) also found that home health nurses favorably influenced the medication adherence of the elderly home health clients in her study. Other studies, however, did not show home health nursing practice to favorably influence their elderly patients' medication adherence (Griffiths et al., 2004; Mager & Madigan, 2010).

The present study took a critical approach to describe and understand the views of home health nurses regarding promotion of medication adherence among community-dwelling elderly patients. This critical analysis approach also provided a platform to explain the moderating influences on home health nurses' views and contributed to a better understanding of how healthcare professionals can promote medication adherence

among community-dwelling elderly individuals. This chapter presents a discussion of the procedures that the researcher utilized for the collection and treatment of the data for this study.

Methodology

This study utilized Fairclough's Critical Discourse Analysis (CDA) methodology. CDA stemmed out of the work of a group of linguists at the University of East Anglia, England in the late 1970s, and became recognized as a distinct methodology in the late 1980s (Blommaert & Bulcaen, 2000; Threadgold, 2003). CDA has its theoretical underpinnings in the critical social theories that were developed by Norman Fairclough, Ruth Wodak, and Teun van Dijk (Blommaert & Bulcaen, 2000). According to CDA researchers discourse is "an instrument in the social construction of reality, and is both constitutive of, and constituted by social practices" (Jørgensen & Phillips 2002, pp. 91-92). Thus, CDA researchers seek to understand not only the content of a discourse, but also the social structures and power systems that create and direct the operation of that discourse. The goal of analysis in CDA is to explore the ideological framework of a discourse that has become deep-rooted over time, such that people begin to treat such as common and natural (Gee, 2005). CDA is a collection of methodological approaches; the common goal of analysis is to link the linguistic and the social, while the specific methodological approach chosen is guided by the research question being asked and the particular discursive event under scrutiny (Weiss & Wodak, 2003).

According to Fairclough, CDA attempts to study the processes of power and describe how these processes use discourse in subtle, yet controlling ways (Fairclough, 2001). Critical discourse analysts do not envision language as being powerful in and of itself; rather, they view language as powerful as a consequence to how it is used, who uses it, and the context of usage (Wodak, 2001). Fairclough therefore advocates for situating language within the specific context of social practices of which it is a part (Fairclough, 2001). The approach to CDA offered by Fairclough has application to a wide variety of critical social and health studies. For example, Rowland and Kitto (2014) utilized Fairclough's CDA to understand how different health care stakeholders in an acute care hospital talk about, think about, and know about patient safety. Schofield, Tolson, and Fleming (2012) used Fairclough's CDA methods to gain understanding into how nurses understand and care for older people with delirium in the acute hospital.

Fairclough's CDA methodology involves three iterative analytical steps: (1) textual analysis, (2) discursive practice analysis, and (3) social practice analysis. Figure 2 provides a diagrammatic depiction of Fairclough's three-dimensional CDA methodology, illustrating how each of the dimensions interrelates to the others. While textual analysis essentially serves to describe the text, discursive practice analysis serves to interpret the text, and social practice analysis serves to explain the text. It is important to highlight that the processes in Fairclough's CDA methodology are not linear; each of the processes feeds into the others, and when used cohesively, they lead to greater illumination about an issue.

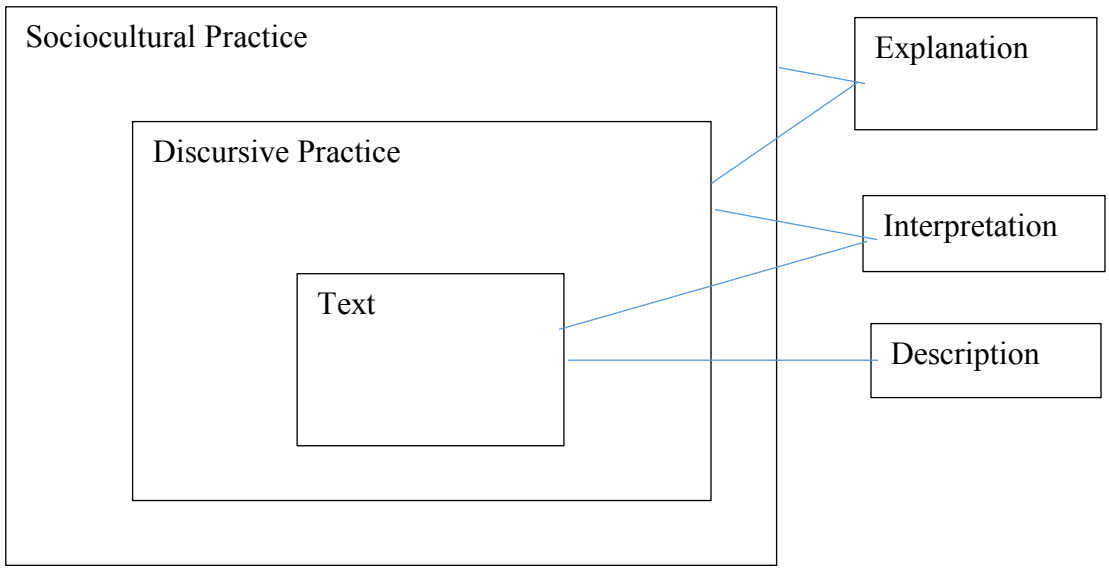

Figure 2. Depiction of Fairclough's CDA methodology.

Through textual analysis, the researcher can elucidate the meaning (i.e., the action, representation, and identity) that is embedded in the text, and thus infer the text producer's attitude toward an issue (Fairclough, 2003). Textual analysis involves an examination of the vocabulary, grammar, semantics, as well as organization and cohesion at and beyond the sentence level (Fairclough, 2010). In other words, the researcher used systematic and detailed linguistic analysis of the text to decipher how the text producers identify themselves, construct relations with or act toward others, and convey their ideas/beliefs through language (Fairclough, 2003). Fairclough (2010) describes *discursive practices* as particular social patterns and styles of language use found in texts (written, verbal, or visual) and employed by the text producer to communicate with others. For instance, particular patterns of language use or discursive

practices are associated with legal, medical and political professions. According to van-Dijk (2009), discursive practices are socially conditioned ways of communicating, and they serve to regulate and reinforce action, thereby exert power. Analysis at the discursive practice level involves examining texts for intertextuality—that is, analyzing how creators of texts incorporate preexisting discourses and genres to create new texts (Jørgensen & Phillips, 2002). Hence, analyzing texts at the discursive practice level enables the researcher to identify text producers' positions of strength in relation to an issue.

Social practice analysis examines the sociocultural context (e.g., historical, political, institutional, economic, and social environment) in which a text is produced. An understanding of this context privileges the researcher to assess the text within the environment in which it is created; it also enables the researcher to explore how the language used within the text may be connected to specific operations of power or domination occurring at a broader level. In this study, the researcher utilized Fairclough's CDA methodology to describe and interpret home health nurses' discourses and to explain the sociocultural and regulatory contexts that influence these nurses' promotion of medication adherence among community-dwelling elderly patients.

Role of the Researcher

CDA espouses that discourses can be limited by people's positions of power (Fairclough, 2001). To facilitate uninhibited communication, the researcher assumed a posture that supported a balance of power between the participants and the researcher

(Liu, 2010). The researcher fostered participants' empowerment through various strategies including: (a) deferring to their choice of interview location and time, (b) assuming a non-dominant attitude, (c) fostering a dialogic rather than an inquisitorial environment, and (d) engaging participants to freely talk in their own way. Additionally, the researcher maintained reflexivity throughout the research process. Reflexivity involves being keenly aware of what is influencing a researcher's internal and external responses, and at the same time being cognizant of the researcher's relationship to the research topic and the participants (Dowling, 2006). Specific to this research endeavor, the researcher recognized that her previous experience as a home health nurse was likely to influence how she received and interpreted the data. Thus, the researcher maintained a reflexive journal and logged the details of how she may have influenced the results of each interview.

Methods

This section provides information about research methods. It begins with a brief description of the study setting, and it is followed by discussion about sampling, data collection, data analysis, and the trustworthiness of the study. This dissertation research was approved by the institutional review board (IRB) at Texas Woman's University prior to commencement of the study (see Appendix A).

Study Setting

The setting of this study was located in the greater Houston, Texas area of the US. Houston is the fourth largest city in the US and is one of the most ethnically diverse cities

in the nation (The City of Houston, 2016). The 2016 data compiled by the United States Census Bureau (n.d.) showed that about 2.1 million people reside in Houston and that 9% of the residents are 65 and older. In terms of ethnicity, the city's population comprises 44.7% Hispanic residents, 24.9% White residents, 22% Black residents, and 6.87% Asian residents. The most common foreign languages in Houston, Texas are Spanish (774,763 speakers), Vietnamese (31,851 speakers), and Chinese (27,297 speakers) (Data USA, n.d.). The researcher thus made a strategic decision to locate the study in the greater Houston area, since this location had the likelihood of increasing the diversity of participants, and, as such, contributing to the richness of data and study rigor.

Study Sampling

This study was designed to elucidate the views of home health nurses on promoting medication adherence among community-dwelling elderly patients. The study was also designed to capture the sociocultural and regulatory contexts that inform home health nurses' views about medication adherence promotion among community-dwelling elderly patients. The study used texts from official documents and individual interviews related to medication adherence promotion. There were two main sources of data involved: (a) four official documents relevant to medication adherence promotion in the home health industry, and (b) 13 individual interviews with home health nurses who work in the greater Houston area. The sample criteria were as follows:

Criteria for Document Selection

This study was designed to explore the impact of sociocultural and regulatory influences on the views of home health nurses on promoting medication adherence among community-dwelling elderly patients within the U.S. context. In the US, healthcare laws regulate home health agencies, and their activities are overseen by governmental agencies such as the Centers for Medicare and Medicaid Services at the federal level (CMS State Operations Manual, 2014). The Texas Department of Aging and Disability Services (DADS) is an example of a state regulatory agency that oversees the activities of home health agencies at the local level (Texas Health and Human Services, 2015). Thus, the criteria for selection were that the document was: (a) an official document, (b) provided by or referenced by the study participants, (c) issued by an organization or agency based in the US, (d) related to the topic of medication adherence promotion, and (e) intended to reach a target audience of home health stakeholders.

A total of four documents met the criteria for document inclusion, and these were included as part of the texts analyzed for this study. Specifically, the documents analyzed were the: (a) CMS Drug Regimen Review Standard, (b) Medication List and Monitoring Policy, (c) Outcome and Assessment Information Set (OASIS) Medication Assessment, and (d) Home Health CAHPS (HH CAHPS) Medication Survey. The paragraphs that follow provide descriptions of each of the documents analyzed for this study.

The CMS Drug Regimen Review Standard (see Appendix H) is a part of a broader document—the CMS State Operations Manual—issued by the CMS to guide

service delivery by home health agencies to clients (CMS State Operations Manual, 2014). The CMS State Operations Manual, a publicly available document, provides guidance to CMS Surveyors on certifying and recertifying home health agencies; these agencies are then able to provide home health services to eligible patients and seek reimbursement for provided services from the CMS. The CMS Drug Regimen Review Standard articulates the medication management standards to which home health agencies must adhere when providing services to patients (CMS State Operations Manual, 2014).

The Medication List and Monitoring Policy (see Appendix I) is a part of the Home Health Agency Policy and Procedure Manual of one of the home health agencies located in Texas (Aspen Healthcare Services, 2007). The Home Health Agency and Procedure Manual was located by conducting an online search via a public search engine. Many of the participants in this study explained that their home health agency policy guided their medication adherence promotion activity. However, the participants wanted to protect the identity of their home health agency, and therefore were not willing to provide the researcher a copy of their actual home health agency policy. Based on the knowledge that the State of Texas requires that home health agencies operating within its jurisdiction maintain a medication management policy (Texas Health and Human Services, 2015), the researcher conducted an online search and identified an agency policy authored by one of the home health agencies in the state of Texas. The Medication List and Monitoring Policy was excerpted from the home health agency policy that was

identified through the online search, and it was then included as part of the documents analyzed in this study.

The OASIS Medication Assessment (see Appendix J) is an excerpt from the Outcome and Assessment Information Set (OASIS–C2). OASIS–C2 is a document authored by the CMS, and it constitutes part of the comprehensive assessment that qualified home health clinicians (RNs and Therapists) are required to complete on their patients (Outcome and Assessment Information Set, 2017). For this study, questions related to medication management on the OASIS–C2 were identified (questions: M2001, M2003, M2005, M2010, M2016, M2020, M2030, M2020), labelled as the OASIS Medication Assessment (see Appendix J), and analyzed.

The Home Health CAHPS (HH CAHPS) Medication Survey (see Appendix K) is an excerpt from a broader document, the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HH CAHPS) Survey. According to the CMS, the purposes of many home health skilled nursing visits are to evaluate the effectiveness and safety of medication regimens, and to assess for and teach about medication side effects (2011). The CMS utilizes the HH CAHPS Survey to gather the perspectives of home health patients about the services they have received from their home health agency (CMS, 2010). The results obtained from the HH CAHPS Survey are collated and used to rate the quality of a given home health agency, and this information is displayed in public domains (Home Health CAHPS, 2014). Stakeholders in home healthcare services are

able to readily access the quality rating of a given home health agency and use such information to make decisions about receiving care from a home health agency.

The HH CAHPS Survey consists of 34 questions and covers topics such as (a) communication about care, (b) pain, (c) prescription medication and over-the-counter drugs use, (d) the care received from the home health agency, (e) staying informed about scheduling, and (f) global ratings (Home Health CAHPS, 2014). Questions 4, 5, 11, 12, 13, and 14 on the HH CAHPS Survey relate to prescription drug and over-the-counter drug use; these were deemed relevant to this study's purpose, as well as to answering the research questions. Hence, the researcher excerpted questions 4, 5,11,12,13, and 14 from the HH CAHPS Survey, labelled the excerpt as HH CAHPS Medication Survey (see Appendix K), and included it as part of the documents analyzed for this study.

Criteria for Sampling Participants

The study's inclusion criteria for participants were: (a) being a registered nurse (RN) or a licensed vocational nurse (LVN), (b) minimum of 18 years of age, (c) currently employed by a home health agency at the time of the study, and (d) minimum of six months' work experience in a U.S. home health agency directly providing nursing services to adult patients. The decision to include RNs and LVNs was based on the belief that gaining the perspectives of these two populations of nurses would lead to a fuller understanding of medication adherence promotion among community-dwelling elderly patients. Both RNs and LVNs are involved in the delivery of care within the home health environment; however, the scope of services that each of these professionals can deliver

is regulated by their educational preparation and the Nurse Practice Act. For example, while RNs are responsible for conducting the comprehensive assessment and initiating the nursing care plan, LVNs' input includes conducting a focused assessment and contributing to the nursing care plan (Texas Board of Nursing, 2013). Hence, the researcher believed that soliciting the views of both types of nurses would be likely to reveal both the initial and subsequent impressions of home health nurses, as well as provide distinct contextual factors that these nurses perceive as influencing their medication promotion activities among their elderly patients. Nurses who have only pediatric home health experience were excluded from participation since the pediatric population was not the focus of this study.

Sampling began with purposive sampling to maximize the heterogeneity of the sample. This approach was augmented by using snowballing sampling to ensure that an adequate number of participants were recruited for the study. Recruitment was done by distributing hard copies of the recruitment flyers in person, and distributing electronic copies of these flyers via email to home health agencies located in the greater Houston area (see Appendix B). Potential participants who contacted the researcher were screened via the telephone to ensure that they met the study eligibility requirements (see Appendix C). At the conclusion of the phone screening, potential participants who met these requirements and wished to proceed with the study were provided with more information about the study, and the researcher asked them to provide a convenient time and location for conducting the interview.

Protection of Human Subjects

Approval for the study was obtained from the IRB of Texas Woman's University prior to beginning data collection. The researcher also sought permission from appropriate personnel within HH agencies in the greater Houston area and distributed hard copies and an electronic version of the study flyers in the facilities, with the goal of directly or indirectly reaching prospective participants. The study flyer included a phone number where interested candidates could contact the researcher to express their interest in the study (see Appendix B). The researcher conducted a phone screening to ascertain that interested candidates met the study's inclusion criteria (see Appendix C). During the process of recruitment, the researcher explained the study and answered any questions regarding the research process. Participants were informed of standard principles of protection, including the right to withdraw participation at any time without penalty.

Data Collection

Data for the study was obtained from the following two sources: (a) semi-structured individual in-person interviews that included obtaining demographic data from each participant, and (b) publicly available documents, which participants referred to, and which were related to medication adherence promotion in the home health environment. Participants were interviewed about their views, and about formal or informal organizational policies that have shaped their views on promoting medication adherence among their community-dwelling elderly patients (see Appendix E). The demographic form administered at the beginning of the interview solicited information such as

participants' highest education level, number of years of experience in home health, gender, and languages in which participants communicated (see Appendix F). Some of the interview questions asked were:

1. Can you tell me what promoting medication adherence among the elderly means to you?

2. Please, describe how you have promoted medication adherence among your home health elderly patients.

3. Can you tell me about the challenges that you have experienced regarding promoting medication adherence among your elderly patients?

4. How would you describe your home health agency's attitude on promoting medication adherence?

Minimal, open-ended probes such as "Can you tell me more about that?" and "How did you feel about that?" were used, as needed, to clarify information provided by the study participants. The interviews were audio-recorded and transcribed verbatim by the researcher shortly after the completion of the interview. The researcher also took field notes during interviews (see Appendix G). At the completion of each interview, the researcher verbally thanked each participant for their participation in the study and gave each participant a gift card of twenty dollars as an incentive for participation. The researcher also made a note of participants who expressed interest in getting a copy of the interview transcript as well as the study findings (at the conclusion of the study).

Four publicly available documents that relate to home health nursing practice were critically appraised for discourses on promoting medication adherence: (a) CMS Drug Regimen Review Standard (see Appendix H), (b) Medication List and Monitoring Policy (see Appendix I), (c) OASIS Medication Assessment (see Appendix J), and (d) HH CAHPS Medication Survey (see Appendix K). The rationale for including these documents as a part of the analysis was to obtain an understanding of the influences of such discourses on home health nurses' views. Moreover, the goal of CDA-guided research is to understand a group's way of talking, as well the influences that regulate the productive activity or practice of group members (Hammersley, 2014). The researcher performed preliminary data analyses concurrently with data collection.

Data Management

The researcher strategically managed the data utilized in this study. The official documents were treated as independent textual sources for the study. All four documents were publicly available online, so there was no confidentiality issue involved. Each document was labeled according to its title and uploaded into NVivo 11, a qualitative software program for the organization and analysis of unstructured, non-numerical data (QSR International, n.d.). The researcher selected NVivo 11 for this study because the software has provisions for organization, classification and interrogation of data; these features assisted in building up a body of evidence from which the researcher generated inferences.

Identifiable data in this study consisted of demographic questionnaires collected right before the interviews began with individual study participants. Interviews were conducted in a location that allowed for privacy and at a time that each participant felt was most convenient for him or her. Each participant was asked to complete a study consent form (see Appendix D), demographic questionnaire (see Appendix E). After participants completed these steps, the one-to-one interview commenced using the study's interview protocol (see Appendix F). Interviews were recorded via a digital recording device and transcribed verbatim by the researcher soon after the completion of each interview.

During transcription, no identifying data were transcribed. Each set of materials from each individual participant (the demographic form, audio-taped interview, and interview transcript) was assigned a unique alpha-numeric identifier (e.g., the first RN interviewed was assigned RN 1) in order to maintain confidentiality. A list that matched the real name and the code names was stored in an encrypted file within a password-protected computer, accessible only to the researcher. The demographic forms and interview transcripts were uploaded into NVivo 11 software located in the researcher's password-protected computer, where they were accessible only to the researcher. The interview audiotapes were stored in a locked cabinet in the researcher's office. Upon completion of all interviews and transcriptions, the recording device was wiped clean. Consent forms were kept in a locked file cabinet in the researcher's office. Only the

researcher had access to the consent forms, and they were separated from the recorded interview data files in order to maintain anonymity and confidentiality.

Data Analysis

Data analysis for this study followed Fairclough's (2003) CDA framework. The analytical process proffered by Fairclough is a three-dimensional framework that involves an analysis of the text, the discursive practice, as well as the sociocultural practice pertaining to a given concern (Fairclough, 2010). Text analysis focuses on analysis at the word level, and it serves to describe studies' findings. Textual analysis involves examining the use of linguistic tools such as word groups, grammar, figures of speech, and storytelling. Word groups are words that appear together and have similar contextual meaning. Grammatical analysis of a given text helps to identify the actors and subjects in the various statements as well as the knowledge or activity that the author of the text wishes to convey Figures of speech are usually deployed to serve an overall argument, and they could be used to simplify what would otherwise be a complicated argument. Storytelling is a common and effective linguistic skill that is used discursively to convince or to buttress a point (Schneider, 2013).

Discursive practice analysis examines the production and interpretation of the text—that is, how actors interact and negotiate with their environment—and thus provides interpretations of the findings of the textual analysis. Analysis of the discursive practice contributed to identifying other texts or discourses that text producers draw upon to communicate their views. Discursive practice analysis highlights the knowledge and/or

the power positions of the producers of texts. Sociocultural practice analysis served to provide broader explanations in the present study. Fairclough's (2003) CDA framework was optimal for this study since the goal of analysis was not limited to obtaining the perspectives of participants, but also included gaining a contextual understanding of those perspectives (Johnson, 2013).

In order to address the specific research questions of this study, the interview data were first analyzed as a unit, separate from the official documents. Each of the official documents was also analyzed separately using Fairclough's (2003) CDA framework. The final step of the data analysis involved analysis across data sources, comparing and contrasting the data in the official documents with the interview data. This strategy was adopted to bring to light how the discourse in the official documents may have influenced home health nurses' views about promoting medication adherence among their community-dwelling elderly patients.

For the interview transcript, the researcher utilized the following analytical strategy. First, the researcher read through all the texts as a whole and made notes about her general impressions. This initial reading was followed by re-reading each transcript carefully, one line at a time, and highlighting the salient words (guided by the research purpose and questions, as well as the researcher's initial impression from reading all the transcripts). The researcher then coded the highlighted words and phrases into tree nodes using NVivo 11 software. Coding into tree nodes involves generating categories and sub-

categories in NVivo 11 by dragging a highlighted piece of evidence into its categories or sub-categories (Bazeley, 2007).

The next step in applying Fairclough's (2003) CDA framework involved using discursive practice analysis to gain knowledge of how home health nurses interact with their environments. As such, the researcher examined the text to identify other texts that the home health nurse participants invoked as they communicated their views about promoting medication adherence. Other texts that the participants directly or indirectly referred to include: "OASIS," "policy and procedure," "Medicare," "nursing standards," and "survey." Words, phrases or sentences that overtly or covertly suggested intertextuality were coded into NVivo 11. This analysis of discursive practices provided an understanding about the influences on the home health nurses' viewpoint, thereby enabling the researcher to identify and interpret how home health nurses negotiate their positions in relation to promoting medication adherence among community-dwelling elderly patients.

The next step according to Fairclough's (2003) CDA framework is to explain the text in a way that takes broader societal issues into account. Thus, sociocultural practice analysis was completed by examining the text of interview transcriptions for words or phrases that pointed to broader societal issues pertinent to medication adherence promotion. Specifically, the researcher examined documents that the study participants referred to in the course of their interviews to look for areas of convergence and convergence. The textual documents that were examined as part of the sociocultural

practice analysis include the: (a) CMS Drug Regimen Review Standard, (b) Medication List and Monitoring Policy, (c) OASIS Medication Assessment, and (d) HH CAHPS Medication Survey. Since each of the dimensions in Fairclough's (2003) CDA framework is iterative, analysis involved going back and forth, re-reading the text, and rearranging the codes and categories throughout the analytical phase. Analysis also involved identifying and exploring connections between the categories.

Analysis of the official documents was performed using Fairclough's (2003) CDA framework. Thus, the researcher followed an analytical approach that was similar to the one used for the interview text analysis. For the documents, the researcher started analysis by reading each of the policy documents multiple times to obtain an overall understanding of the text. Next, the researcher slowly re-read each document, being careful to highlight the relevant words, phrases and sentences (guided by the research purpose and questions and the researcher's initial impression from reading the document) and coded these into categories in NVivo 11. Using Fairclough's (2003) CDA framework, the researcher conducted discursive practice analysis to gain knowledge on how the text of each document interacted with its environment. To meet that objective, the researcher examined the text for evidence of intertextuality—that is, how the producers (creators of the documents) used other texts to convey their message. All identified intertextualities were coded into NVivo 11. Analysis of sociocultural practices was done by examining the official documents for references to broader issues at the societal level. The researcher analyzed the documents by going back and forth between

the three levels of analysis (textual, discursive practice, and sociocultural practice), reading the texts over, and rearranging the categories to provide further insight into the data that emerged.

The last phase of the analysis involved a complete examination of the codes across data sources. During this process, the researcher coded areas where the data converged, as well as where they diverged, and did the final rearranging of the categories at that junction. This last phase of analysis afforded the researcher a comprehensive understanding of the perspective of the home health nurse participants' views regarding medication adherence promotion among community-dwelling elderly patients. Comparing data across sources also provided insight as to the sociocultural and regulatory contexts that influence these views.

Trustworthiness

Arriving at a single truth in the study of a social phenomenon is unlikely because such a study involves participants who have their own viewpoints, and unavoidably, the study may reflect the researcher's own values, beliefs, and partial understanding (Taylor, 2001). Consequently, reflexivity is crucial to the discussion of trustworthiness in discourse analytical study; this is particularly true for studies that involve interviewing, because researchers essentially become part of the language practices of the study by conversing with participants during interviews (Rogers, Malancharuvil-Berkes, Mosley, Hui, & Joseph, 2005). Hence, one consideration that the researcher kept at the fore while conducting this discourse analysis study was to remain aware of her own values, beliefs,

social identity, and professional knowledge in relation to the study. Throughout the study process, the researcher kept notes of any changes that she made, and she regularly reflected on the notes to evaluate how her perspectives influenced the study process, the interview data, and the overall interpretation of the data. The researcher also took regular breaks from data analysis, thus maintaining a balance between engagement and reflexivity.

In addition to self-reflection, the researcher harnessed other methodological approaches highlighted by Crowe (2005) to enhance the trustworthiness of this study. These approaches included using a combination of purposive and snowball sampling techniques to ensure that experienced home health nurses who service patients in diverse demographic areas and home health nurses from both genders were included in the study. Furthermore, the researcher: (a) continued sampling until data saturation was achieved, (b) offered participants the opportunity to clarify and provide the researcher feedback throughout the course of the interview, (c) provided the participants the opportunity to read their interview transcript and provide the researcher feedback, and (d) provided a clear description of the data gathering, analytical, and interpretive processes used in the study. The researcher also consulted an expert in CDA to challenge the assumptions that related to her data collection as well as interpretation of the findings.

Chapter Summary

In summary, this chapter provided information on the methodology and methods that were used to study the views of home health nurses about promoting medication

adherence among community-dwelling elderly patients. An overview of Fairclough's CDA methodology and its underpinnings by the Habermas critical social theory and the discourse theory was presented. Aspects of the methods utilized were discussed and included: (a) study setting, (b) data source and sampling, (c) recruitment strategy, (d) researcher's role, (e) data collection, and (f) data analysis. Strategies to ensure scientific rigor, as well as the protection of human subjects, were also presented as a part of the methodological approach.

CHAPTER IV

ANALYSIS OF DATA

The first purpose of this critical analysis discourse study was to describe the views of home health nurses on promoting medication adherence among community-dwelling elderly patients. The second purpose of this study was to explore the sociocultural and regulatory contexts for home health nurses' discourse formation. The three questions that the researcher sought were:

(1) What are home health nurses' views about medication adherence promotion among community-dwelling elderly patients?

(2) How are home health nurses' views about medication adherence promotion among community-dwelling elderly patients created within and informed by their sociocultural contexts?

(3) How are home health nurses' views about medication adherence promotion among community-dwelling elderly patients influenced by healthcare regulations?

Data for the study were obtained from two sources: 1) 13 audiotaped, semi-structured, face-to-face interviews that were subsequently transcribed verbatim by the researcher; and 2) four publicly accessible official documents related to medication adherence promotion to which participants had referred during their interviews. This chapter presents the following: (a) descriptions of the interview participants, and a report

of the findings that resulted from the analysis of the interview transcripts; (b) an overview of the official documents analyzed, as well as the findings from the analysis of the official documents; and (c) analysis of how findings from the interviews relate to discourses in the official documents.

Interview Text Analysis

Participants Details

This section on participant details presents an overall demographic description of the participants; it is followed by more specific detail about the individual participants. Although providing descriptions of participants is not required for a CDA study, researchers such as Osborn (2009) and Jones (2014) have included participant descriptions as part of their studies. For this particular study, the researcher decided to provide descriptions of individual participants to fulfill one of the underlying reasons for conducting this study, which was to give a voice to home health nurses on an issue that directly influences their practice. Secondly, descriptions of individual participants help to contextualize the depth, emotions, and contrasts among the opinions conveyed by the study participants. Table 1 presents an overview of the demographic characteristics of the study participants.

Table 1

Overview of the Demographic Characteristics of Participants

Demographic Characteristics of Participants

Characteristic	n	%
Professional License		
RN	10	76.9
LVN	3	23.1
Highest Completed Education		
Associate	2	15.4
Diploma	3	23.0
Bachelors	4	30.8
Masters	4	30.8
Home Health Work Experience		
1 – 3 Years	1	7.7
4 - 6 Years	6	46.2
7 –10 Years	1	7.7
>10 Years	5	38.4
Gender		
Female	10	79.9
Male	3	23.1

A total of 13 nurses, 10 registered nurses (RNs), and three licensed vocational nurses (LVNs) participated in the study. In terms of gender, 10 of the participants were female, while three of them were male. All participants worked for sole proprietary home health agencies, described their ethnicity as Black/African American, and communicated only in English. All of the participants agreed to their interview being audio-recorded. Eligibility screening was done by phone on all participants prior to the interview date to assure that participants met the study's inclusion criteria (see Appendix B). Interviews were conducted between February and July of 2017. Interview duration ranged from 20 to 60 minutes; the average duration was 40 minutes.

Participant 1 (denoted as RN 1) was the first registered nurse interviewed for this study. RN 1 is a female. She contacted the researcher to enroll in the study, having been made aware of the study by a colleague of hers. An in-person interview was scheduled for a day, time, and location that were convenient for the participant. RN 1 reported that she holds a Bachelor in Nursing degree and that she has worked in the home health industry for a total of 6 years. RN 1 also reported that she is the owner of a sole proprietorship home health agency, and that due to the small size of the agency, she continues to conduct patient visits as well as necessary administrative activities in the office. The interview took place in a private office space within the premise of the home health agency and lasted about 40 minutes. The participant appeared relaxed and displayed full engagement throughout the interview. This participant requested that a copy of the transcribed interview be emailed to her; however, the participant did not send any follow-up email to the researcher to refute or clarify any portion of the interview transcript.

Participant 2, denoted as RN 2, stated that she became aware of the study through copies of the study flyer that were distributed at the home health agency where she works. RN 2 contacted the researcher by phone to express her interest in participating in the study, at which point RN 2 was screened and deemed eligible for participation. RN 2's interview took place mid-morning on March 12, 2017 in a quiet location that ensured privacy. RN 2 reported that she holds a Master of Nursing Science degree and has worked in the home health industry for more than 10 years. RN 2's demeanor was warm

and engaging throughout the interview. At the conclusion of her interview, RN 2 thanked the researcher for the opportunity to be a part of the study. RN 2 also stated that she found the interview very interactive and gave the researcher the names and contact information of three potential participants. One of the potential participants given by RN 2 subsequently agreed to participate in the study, while the other two potential candidates declined participation due to busy schedules.

Participant 3, denoted as RN 3, was the third registered nurse interviewed for this study. After seeing a copy of the study flyer, this participant contacted the researcher by phone and expressed interest in participating in the study. RN 3 was screened via the phone and met the study's inclusion criteria. RN 3's interview occurred in the living room of her home on the evening of March 20, 2017, and the session lasted for about 45 minutes. RN 3 reported that she holds a Bachelor in Nursing degree and has been working in the home health field for over 10 years. This participant's commitment to providing quality care to her patients and upholding the values of the nursing profession was palpable throughout the interview. In addition, the participant spoke in an animated, energetic tone and provided examples via storytelling to support her viewpoint.

Participant 4, denoted as RN 4, was the fourth registered nurse interviewed for this study. RN 4 contacted the researcher via the phone number listed on the study flyer to express her interest in participating, and she stated that she became aware of this study through one of her nursing colleagues. The researcher conducted an eligibility screening by phone to assure that RN 4 met the study's inclusion criteria. RN 4's interview

occurred during the afternoon of March 31, 2017 and was about one hour long. The interview took place in a conference room within the home health agency office where RN 4 works. RN 4 reported that she is part-owner and the Director of Nursing Services of a small-sized, sole-proprietorship home health agency; she also stated that although she has other nurses working for her, she continues to conduct patient visits herself. RN 4 indicated on the study's demographic form that she has an Associate's degree in Nursing, and that she has worked in home health care for between 7 and 10 years (see Appendix E). At the onset of the interview, RN 4 appeared anxious and expressed misgivings that she may not know the right answers to the researcher's questions. The researcher reassured the participant, emphasizing that there were no right or wrong answers and that RN 4 only needed to express her views as candidly as possible. Thereafter, RN 4 appeared more relaxed, and she freely articulated her views throughout the course of the interview. RN 4 also requested that a copy of the transcribed interview be emailed to her; however, she participant did not send any follow-up email to the researcher to refute or clarify any portion of the interview transcript once this was emailed to her.

Participant 5, denoted as RN 5, is an Assistant Director of Nursing at a home health agency in the greater Houston area. This participant was referred to the researcher by one of the earlier participants in the study. The researcher contacted RN 5 by phone and explained the purpose of the study to her. Once RN 5 expressed her willingness to participate, the researcher conducted a phone screening to ensure that RN 5 met the study's inclusion criteria. RN 5's interview occurred on March 31, 2017 at her office

space inside a home health agency, and it lasted for approximately 20 minutes. RN 5 reported that she holds an Associate's degree in nursing and has been employed as a home health nurse for between four and six years.

Participant 6, denoted as RN 6, was recommended as likely to be interested in the study by an earlier study participant. The researcher contacted RN 6 by phone, explained the purpose of the study to him, and sought his participation. Once RN 6 confirmed his interest in participating, the researcher conducted a telephone screening to determine that this participant met the study's inclusion criteria. The in-person interview with RN 6, which lasted for one hour, took place on April 10, 2017 at his office within a home health agency. RN 6 holds a Master of Nursing Science degree and reported that he has worked in the home health field for between four and six years. According to RN 6, the home health agency where he works is jointly owned by him and another nurse, and both nurses and a few other part-time nurses conduct patient visits due to the small size of the home health agency. RN 6 appeared very self-assured and knowledgeable about medication adherence promotion.

Participant 7 is denoted as RN 7. This participant contacted the researcher via the phone number listed on the study flyer, and he stated that he had heard about the study from one of his colleagues in the home health agency where he is employed. After RN 7 expressed his interest participating in the study, he was screened via phone to ensure that he met the study's inclusion criteria. RN 7's in-person interview occurred at his office space within the home health agency where he works, and it lasted for approximately 45

minutes. According to RN 7, he has worked as an RN in the home health field for between four and six years. The participant also reported that he holds a Master of Nursing Science degree. RN 7 appeared at ease, and he freely expressed his opinion throughout the interview process. RN 7 also requested that a copy of the transcribed interview be emailed to him; however, he did not send any follow-up email to the researcher to refute or clarify any portion of the interview transcript once this was emailed to him.

Participant 8, denoted as RN 8, stated he became aware of the study via a copy of the study's flyer that was posted at a home-health agency in Houston, and he contacted the recruiter via the phone number listed on the study flyer. RN 8 was screened by phone and found to be eligible to participate in the study. RN 8 holds a Bachelor in Nursing Degree. He stated that he has been working as home health nurse for over 10 years and that he had worked as a Director of Nursing Services at a home health agency for seven years. At the time of the interview, this participant reported that he was working part-time three days a week visiting patients. RN 8 appeared relaxed and confident, and he freely expressed his thoughts about medication adherence promotion.

Participant 9, denoted as RN 9, reported that she has been working as a home health nurse for between four and six years. RN 9 contacted the researcher by phone to indicate her interest to participate in the study after the researcher made a brief presentation about the study at one of the home health agencies in the Houston area. Screening for eligibility was done by phone prior to the in-person interview. RN 9

reported that she has a Bachelor's degree in Nursing and works full-time visiting with home health patients in their homes. Throughout the interview, RN 9 displayed poise, and she readily shared her perceptions about medication adherence promotion among her elderly patients in the community.

Participant 10, denoted as LVN 1, was the first Licensed Vocational Nurse to be interviewed for this study. This participant contacted the researcher to express her interest in the study, stating that she became aware of the study through the study flyer that was posted in the break room at her home health agency. The interview with LVN 1 occurred on May 25, 2017 and lasted approximately 45 minutes. LVN 1 is a female who has worked as a nurse in the home health arena for over 10 years, and she holds a diploma in Vocational Nursing. LVN 1 was initially guarded with her responses, seemed awed that the researcher holds a Master in Nursing Science degree, and sought endorsement from the researcher relative to her responses. The researcher was able to change the power dynamics of the interview by reminding LVN 1 that her purview and experience from working in home health makes her a subject-matter expert. The researcher also encouraged LVN 1 to be forthright with her opinion and statements, as there were no correct or wrong responses. Thereafter, the interview progressed easily, with LVN 1 freely sharing her perspectives and experiences.

Participant 11, denoted as LVN 2, was the second Licensed Vocational Nurse interviewed for this study. One of the earlier participants in this study informed the researcher that this participant was likely to be a rich source of information and provided

the researcher with her contact phone number. The researcher contacted the participant by phone and provided her with information about the study. Once the participant expressed her willingness to be a part of the study, the researcher conducted a phone screening to assure that the participant met the eligibility criteria. LVN 2's in-person interview occurred on June 4, 2017. LVN 2 reported that she has been working as a home health nurse for more than 10 years and holds a diploma in Vocational Nursing.

Participant 12, denoted as RN 10, was the 10th RN interviewed for this study. This participant contacted the researcher and stated that she became aware of the study via a study flyer that was posted at her place of employment. The researcher deemed RN 10 to meet the study's eligibility criteria via phone screening, at which point the participant agreed to be interviewed on June 15, 2017 at her house. The in-person interview session with RN 10 lasted for about 40 minutes. RN 10 reported that she has a Master of Nursing Science degree and has worked as a home health nurse for between four and six years. RN 10 was fully engaged for the duration of the interview, as she offered her perspectives freely, providing examples to support her views.

Participant 13, denoted as LVN 3, was the third Licensed Vocational Nurse interviewed for this study. LVN 3's interview was conducted on July 2, 2017 in her home, with the interview session lasting about 40 minutes. LVN 3's demeanor was warm and engaging. She was fully focused on providing responses to the interview questions. According to LVN 3, she has been a home health nurse for between one and three years.

She described her job role as conducting follow-up visits after the initial visit/assessment had been done by the home health RN.

Coding of the Interview Text

Each individual interview transcript was transcribed verbatim by the researcher and uploaded into NVivo 11, the qualitative analytical software that was utilized as a part of the analytical strategy for this study. Analysis of the interview transcript followed Fairclough's (2003) CDA framework, described extensively in Chapter Three. The interview text was analyzed from the purview of linguistics and grammar, discursive practice, and sociocultural practice. The coding approach initially entailed reading through all the texts as a whole and making notes about the researcher's overall impression. This was followed by re-reading each transcript, one line at a time, and highlighting pertinent words and phrases (guided by the research questions and the researcher's initial impressions from reading all the transcripts). The highlighted words and phrases were then coded into tree nodes using NVivo 11 software.

The discursive practice analysis was guided by the purpose of the study as well as the researcher's professional knowledge of the home health industry. Thus, the researcher interrogated the text for the presence of words or phrases that the participants might have drawn from other texts. The words and phrases that may have been drawn from other texts include: "OASIS," "policy and procedure," "Medicare," "Survey," and "nursing standards." Words, phrases or sentences that overtly or covertly suggested intertextuality were coded in NVivo 11. Coding for sociocultural practice analysis was done by

examining the interview text for words or phrases that pointed to broader societal issues, such as changes in health care rules and regulations, related to medication adherence. After focusing on the words/phrases, the sentences/texts were read in context of the researcher's conversation with the participant, during the interview. Specifically, the researcher examined texts from documents that the study participants referred to in the course of their interviews for areas of convergence and divergence. The textual documents that were examined as a part of the sociocultural practice analysis included the: (a) CMS Drug Regimen Review Standard, (b) Medication List and Monitoring Policy, (c) OASIS Medication Assessment, and (d) HH CAHPS Medication Survey. Since each of the three dimensions in Fairclough's (2003) CDA framework is iterative, analysis involved going back and forth, re-reading the text, and rearranging the codes and categories throughout the analytical phase.

Findings from the Interview Text

The findings that emerged from the coding of home health nurses' interview texts were categorized into five areas: (a) medication adherence promotion as providing nursing care, (b) medication adherence promotion adherence as engaging patients and caregivers, (c) medication adherence promotion as requiring multiple reinforcements, (d) medication adherence promotion as preventing adverse outcomes, and (e) medication adherence as requiring team effort. The paragraphs that follow provide a thorough discussion of these categories. Additionally, direct quotations from the interview text are presented to clarify and support the findings of the study.

Medication adherence promotion as providing nursing care. The home health nurses in this study viewed medication adherence promotion as being a part of the nursing care that they provide to their elderly patients. The participants used phrases and words such as quality care, go a step further, ongoing assessment, educate, coordinate services, advocacy, and challenging to describe their view about medication adherence promotion. To these home health nurses, promoting medication adherence involves assessing the elderly patient so as to identify barriers to adherence and provide solutions that support adherence. This viewpoint is exemplified by the statement made by RN 4:

> During the assessment you may realize that the patient is very forgetful… and sometimes, it could be a result of no one to remind them to take it (medication). So we go a step further. We either arrange a pill box, or we arrange for a social worker to go in there and get the patient a provider aide. (RN 4)

The nurse participants also reported supporting their elderly patients' medication-taking behavior by conducting regular, ongoing assessments of their elderly patients. The nurse participants conveyed that ongoing medication review is a requirement. For instance, RN 2 stated that nurses are required to do medication review at admission visit and at every follow-up visit on all patients. The study participants further explained that ongoing medication review sensitizes the home health nurse to any changes that might have occurred to the elderly patient in between the home health nurse's visits. One of the participants, RN 4, provided details regarding her routine during home health nurses' visits to elderly patients' homes. This participant described her routine actions and the

questions that she asks as, “every week that a nurse goes to see a patient we do reconciliation…we also ask: have you been to the doctor’s office since I came, have you been to the ER, anything new?” (RN 4).

The study participants also explained that it is their duty to provide medication-related education to their elderly patients. This obligation and commitment to educating elderly patients was included in RN 4’s statement:

> So nurses, we have that duty and responsibility to teach. So when we go in the community we teach. We teach family members, we teach patients. We teach whoever is around them (elderly patients) that can help them to be complaint with whatever medicine they are on. (RN 4)

The participants explained that specific elements are included during medication education, and that these elements include medication action, medication schedule, as well as other particular elements for a given medication. According to RN 6, “we let the patient know the reasons for the medications, those that are supposed to be taken in the morning and those that are supposed to be taken before meals or after meals, or according to how the doctor prescribes.”

The study participants’ accounts noted that home health nurses coordinate services with the pharmacy, physicians, and social workers as part of medication adherence promotion among community-dwelling elderly patients. One of the

participants, RN 7, provided a stepwise detail about how he coordinates services with the pharmacy team on behalf of his elderly patients:

> When I go to the patient's house, I review all their medication list based on their plan of care and make sure that each and every medication in the plan of care are all in there (at the patient's home). If they are not in there (at the patient's home), I make sure I call the pharmacy myself to get those medications refilled. When I go home, I also follow up with the patient, have you picked up the medication? Or if I come the next visit, I will check again to see if that medication has already been picked up from the pharmacy. (RN 7)

Participants explained that coordination of services is often necessary when a patient cannot afford the cost of a medication. In such instances, the home health nurse notifies the physician of the patient's financial barrier and recommends a social worker consult to assist the elderly patient with locating funding sources to procure medications. The statement by RN 3 elaborates on such a scenario:

> If they don't have enough money to buy all the medications…what you can only do is to just arrange for social worker to help them. Telling the doctor's office to give an order for social worker and they can go and give them opportunity to have low-priced medication, apart from generic. (RN 3)

The participants in this study also expressed that there are instances when their best efforts to provide medication adherence promotion, as part of the nursing care that

patients need, meet with challenges. In this alternative viewpoint, the study participants stated that there are occasions when referrals to the social worker do not bring about solutions for some elderly patients who are unable to afford their prescribed high-cost brand name medications. Using the medication Lyrica as an example, RN 9 explained that this drug's high cost combined with its lack of coverage by most insurance plans contributes to poor adherence on the part of many elderly patients who are prescribed this medication. According to RN 9, when such a barrier to adherence is brought to the physician's notice, "the doctor will say, okay, do gabapentin, but it is not as effective" (RN 9).

Medication adherence promotion as engaging patients/caregivers. The findings from the analysis of participant interviews showed that home health nurses consider engaging with elderly patients and their caregivers as an important aspect of promoting medication adherence. The accounts of the study participants show that home health nurses engage their elderly patients verbally, nonverbally, and by providing tangible resources. Participants expressed that dialogue with elderly patients contributes to promoting medication adherence. This view of the importance of engaging elderly patients is represented by the following statement: "So it's in the communication and in the caring-feeling and they will tell you stuff, but if you don't they will keep things away from you" (RN 5). Home health nurses also use verbal engagement to solicit support for their elderly patients from the patients' family and caregivers. This use of verbal

communication and engagement to optimize medication adherence is shown in the statement by RN 2:

> Also, we talk to the family members that are around. We let them know that these are the medications that the client is taking and let them also know that they should please help to encourage the patient to take their medication. (RN 2)

Analysis of the participants' language also showed that home health nurses believe that nonverbal, affective behaviors support medication adherence promotion among elderly patients. Some of the affective behaviors that the participants cited include: providing nursing care, listening to them, and having patience with them. RN 9's statement exemplifies this view: "When they know that you care and you are doing it out of love, and they know how important it is for them to take their medication, they will comply."

The study participants also spotlighted the importance of relating with each elderly patient as a unique individual. For example, LVN 1 explained the importance of individualizing medication adherence promotion efforts in the statement below:

> Nurses must always remember each patient is an individual and each patient is not to be compared with the other. They are all different. If one approach does not work, try a different approach. Give patients a choice, this shows that you are respecting them as individuals, and giving the patient some of the control. (LVN 1)

The study participants also reported that they provide their elderly patients with tangible aids, such as medication organizers, pill boxes, and pill cutters, so as to promote medication adherence. For example, RN 3 reported that "on our own side, we provide them pill boxes, even [pill] cutters, anything that will make it easy for them."

While the participants in this study acknowledged the importance of engaging elderly patients as a means of promoting medication adherence, interviews also revealed a less-dominant discourse in which the participants represented patients and family as difficult to engage. According to RN 6, "Sometimes the patient is not really being interested or is apathetic. When they don't have that zeal, there is really nothing or practically little that you can do." The study participants' explanations also showed that community-dwelling elderly patients might have other priorities that do not align with medication adherence. As an example, RN 7 reported that one of his elderly patients chose to spend her limited resources buying cigarettes, rather than procuring her medications. This participant described his experience as follows: "I told her, the money you used to buy this cigarette; you could have used that money to buy the medication instead of the cigarette which will even harm your health" (RN 7). Home health nurses also noted that their efforts to engage the family of the elderly patients to ensure medication adherence do not always work, as these family members have competing demands on their time. One home health nurse explained the situation as, "But then family members are busy with their own business, they don't really take the time" (RN 5).

Medication adherence promotion as requiring multiple reinforcements. Study participants depicted medication adherence promotion as requiring multiple reinforcements in order to change the medication-taking behavior of elderly patients. According to home health nurses in the study, a great deal of patient education is required to optimize medication adherence; hence, re-education is usually necessary. For example, RN 4 explained that home health nurses have many instructional materials to share with their patients, stating:

> And then because it is too much information at the same time, we do it gradually. With one medication, we can take a week or two to teach on one medicine. If we are not teaching the patient, we are teaching the family. At least somebody needs to remember and apply it. (RN 4)

The study participants' accounts also included other circumstances that require follow-up and reiteration of instructions. The home health nurses explained that upon noticing any issue with medication adherence, they immediately educate the elderly patient and caregivers, then conduct follow-up on the effectiveness of their intervention. One of the participants, RN 6, described how he relates to his patients and their family members upon noticing medication-related issues:

> I speak with the family member and the patient and then the next day, depending on the situation, I call to do a follow-up. Okay, did you take your medication today? How many did you take? At what time did you take it? If I get an answer that is different than what it is supposed to be, I will have to either do another

> education or make a visit to make sure the patient is adhering to the medication. (RN 6)

Home health nurses in this study explained that the majority of their elderly patients have cognitive decline and cited this decline as the reason why multiple reinforcements are needed to foster medication adherence. RN 13's statement below describes the approach that this participant takes when elderly patients forget to take their medications.

> If it is forgetfulness, then I will have to have a plan that will work with that patient. What will work best for them, and I will follow-up on that so that they know it is really important. Most of the interventions are not just a one-time thing, it can last up to three weeks just to get them used to doing things differently and to understanding that this is very important. (RN 13)

Medication adherence promotion as preventing adverse outcomes.

Medication adherence promotion as preventing adverse outcomes was identified from a distinct pattern of language used by the participants as they shared their views on promoting medication adherence among community-dwelling elderly patients. In their accounts, participants expressed that they educate their elderly patients about medication side effects, untoward reactions, and the dangers of taking expired medications and double-dosing. Participants explained that they focus on medication safety among their elderly clients because the elderly are fragile. For example, LVN 1 explained her focus on preventing adverse outcomes by stating, "There are certain medications you have to be

very careful about medicating elderly people. Because some medications, the body of the elderly is not able to handle very well."

The participants also reported that some of their elderly patients' actions could result in the elderly patient taking expired medications. According to RN 3, some of her elderly patients add the contents of their old medication bottle to newly filled prescription bottle, making it difficult to determine the expiration date of a particular medication. The participants in this study stated that they regularly discuss and inquire about presence of side effects from their elderly patients. For instance, RN 2 expressed that she regularly asks her elderly clients about the occurrence of side effects by asking the following question: Are there things that they have noticed since they started taking the medicine? The home health nurses in this study also expressed that a part of their patient education is to instruct their elderly patients about the danger of taking medication doses beyond what is prescribed. The relation between ensuring safe use of medication and promoting medication adherence is shown in the account by RN 1:

> …when you are dealing with patients who are not taking their medications correctly. Let's say you have a patient that is hypertensive and maybe they have taken too much, and exhibit symptoms of dizziness and then what? It increases their risk for falls. Hence safety and compliance, everything all ties together. (RN 1)

The language used by the participants shows that home nurses encounter challenges as they attempt to balance promoting medication adherence and safeguarding

their elderly patients from untoward effects of some medications. One participant's reports describe the push-and-pull experiences that home health nurses go through as they balance promoting medication adherence and preventing negative medication side effects among elderly patients.

> For example, you go see your patient and the blood pressure is 100/67, and you know they need to stop this medicine they are taking and you think the blood pressure is going to bottom even lower, and you can't reach the doctor and you've called a couple of times, you can't reach the doctor and the patient is telling you that they have to take their medication because the doctor says they should take it, those are challenges. But in that situation, you hold it and you keep trying to reach the doctor. Because if you are already on 100/60, it means when you take the medication, they can get hypotensive. (RN 9)

Medication adherence as requiring team effort. The findings from the analysis of the interview data show that most of the participants view optimal medication adherence promotion as requiring team collaboration. The participants affirmed that promoting medication adherence among community-dwelling elderly patients requires collaboration between the clinical team members, the elderly patient, and the patient's caregivers. One participant, RN 6, explained his view of promoting medication adherence: "I don't think it is something that a single person or a single person can do, it's something that has to be coordinated… the home health agency and the family should be involved. It is a multidisciplinary approach." The study participants also noted that it

is important for all clinical team members to buy into the medication adherence promotion enterprise. According to RN 10, "I believe that everyone that is involved in the care one way or the other, physical therapists, everyone, ask that question and emphasize the need for them to take their medication."

The statements made by the study participants showed that while some viewed elderly patients' family and members of the clinical team as contributing their share to medication adherence promotion, other study participants did not share this viewpoint. Specific to their experience with family involvement, some of the home health nurses reported that they have experienced deep commitment from their elderly patients' family members. The following statement by RN 1 is representative of such a viewpoint.

> Once we present the issue on hand, it is usually taken care of right there and then, even with the family. A lot of times, it's just that they don't understand how it all goes together. We have a team approach. (RN 1)

An alternative view was presented by some of the participants regarding the actual contributions from elderly patient's family members. According to reports from these participants, the actions of family members sometimes sabotage medication adherence promotion efforts. An example of this viewpoint was noted in a statement by RN 9.

> Family members trying to act like the doctor or trying to be the nurse and think that because the blood pressure was 130/70 and is normal, I decided not to give

> my dad, or my mom, the medication… when families are not compliant, it makes it hard for the patient to be compliant. (RN 9)

The reports from the participants also showed that home health nurses did not perceive interdisciplinary team members as being consistently supportive of medication adherence promotion efforts. Some of the participants had a positive view of their working relations with other members of the interdisciplinary care team and referring facilities, while other participants expressed that the relationship could be improved. One participant, RN 9, voiced concerns about working relationships with physicians.

> If you are having a hard time communicating with the doctor as well on managing that medication. You have called a couple of times, you can't reach the doctor and the patient is telling you that they have to take their medication because the doctor says they should take it, those are challenges. (RN9)

Other participants, however, reported successful collaborations with physicians, a view exemplified by this statement from LVN 3: "So far working with physicians has been very smooth. I went to a patient's house… she was on Novolog. I called the physician's office; they were able to rectify the situation. And told me how much she should be taking, like instant."

The findings from the discourse of the participants also revealed that home health nurses hold divergent views regarding the discharge practices of inpatient facilities in

relation to medication adherence promotion. For instance, one participant who had a favorable view about the handover process stated,

> When the client comes from… nursing home or assisted living and we get them for home health care, … they communicate to the home health agency and let us know what the client has been taking and if there are issues with medications, they are very quick to help us, to give us answers and to let us know what it is that we need to know. So we have had very good experiences with these places. (RN 2)

However, other participants believed that handover from facilities to home health could be improved. In her statement, RN 1 touched on the suboptimal handover.

> We have a big issue. We have patients that are coming from the hospital setting.… Please make sure that everything is posted the way it's supposed to be. List the active medications, and also what is to be discontinued... as it would kind of make things easier for the home-health nurse coming on. (RN 1)

Several of the accounts by the participants in this study included statements where home health nurses champion efforts to remove barriers that prevent elderly patients from adhering to their medications. Using financial barrier as an example, one of the participants explained that,

> If you have a patient that is unable to afford a particular medication, of course you notify the doctor to see if there is, another alternative treatment that he could give

> that is affordable. But if not, if that is the only treatment that is in place, we try to get a social worker around there to see if they can assist them with the cost difference so that they can get their medication. (RN 1)

The statements from the participants also indicate that the home health practice environment spurs some home health nurses to take the lead on medication adherence promotion. One of the participants, RN 8, touched on home health nurses' leadership within the context of their practice environment.

> Home health is different than, say, hospital. The nurse [home health nurse] oftentimes will dictate the course. When the nurses make their rounds, whether it is three times a week, or once a week, they see different things when they see the patient. They make assessments; they make recommendations to the doctor. (RN 8)

The preceding paragraphs provided a thorough discussion of the five categories that emerged from the analysis of the home health nurses interview texts. Direct quotations from the interview text were presented to clarify and support the findings of the study. The home health nurses in this study viewed important components of promoting medication adherence as: (a) providing nursing care, (b) engaging patients and caregivers, (c) requiring multiple reinforcements, (d) preventing adverse outcomes, and (e) requiring team effort. An additional viewpoint noted from the discourse of the participants is that home health nurses encounter constraints as they strive to promote medication adherence among their elderly patients. Such constraints include contending

with the indifference of elderly patients and/or family members toward medication adherence, delayed responses from physicians and inpatient facilities when home health nurses need clarification on medication-related questions, and working with patients who struggle to afford their medications. The paragraphs that follow will present the findings that emerged from the analysis of the official documents that were included as a part of this study. Direct quotations from the official documents are also included to support and clarify the reported findings.

Document Analysis

Document analysis also utilized Fairclough's (2003) CDA framework, which involves textual analysis, discursive practice analysis, and sociocultural practice analysis. A total of four documents were analyzed. The documents analyzed include the: (a) Centers for Medicare and Medicaid Services (CMS) Drug Regimen Review Standard, (b) Home-Health Agency Medication List and Monitoring Policy, (c) Outcome and Assessment Information Set (OASIS) Medication Assessment, and (d) Home Health CAHPS (HH CAHPS) Medication Survey. Table 2 presents a brief overview of the official documents included as part of the data analyzed for this study.

Table 2

Overview of the Official Documents

Agency	Title of Document	Year of Publication	Genre
Centers for Medicare & Medicaid Services (CMS)	CMS Drug Regimen Review Standard	2014	Regulation
Centers for Medicare & Medicaid Services (CMS)	HH CAHPS Medication Survey	2014	Survey
Aspen Healthcare Services	Medication List and Monitoring Policy	2007	Regulation
Centers for Medicare & Medicaid Services (CMS)	OASIS Medication Assessment	2017	Technical Document

The CMS Drug Regimen Standard is a part of a broader document – the State Operations Manual – issued by the CMS to guide the service delivery of home health agencies to patients (CMS State Operations Manual, 2014, p. 129). The OASIS Medication Assessment is an excerpt from a broader document – Outcome and Assessment Information Set (OASIS–C2). OASIS–C2 is authored by the Centers for Medicare and Medicaid Services, and it constitutes part of the comprehensive assessment that qualified home-health clinicians are required to complete on their patients (Outcome and Assessment Information Set, 2017). The Medication List and Monitoring Policy is a

part of the Policy and Procedure Manual of a home health agency located in Texas (Aspen Healthcare Services, 2007), and it provides guidance to the agency staff on the standard of care for patients. The HH CAHPS Medication Survey is an excerpt from a broader document, the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HH CAHPS Survey). The HH CAHPS Survey is used to rate the quality of home health agencies, and this information is displayed on public domains (Home Health CAHPS, 2014). Stakeholders in home healthcare (patients, caregivers, physicians and other referral sources) can readily access the quality rating of a given home health agency and use this information to decide whether they wish to receive services from that agency. The researcher selected these four documents for analysis, firstly, because the documents were referred to by the interview participants; and, secondly, because the researcher believed that the selected documents would provide answers to the research questions, and questions, and address the overall purpose of the study.

Coding of the Official Documents

For the official documents examined in this study, the researcher started analysis by reading each of the policy documents multiple times to obtain an overall understanding of the text. Next, the researcher slowly re-read each document, being careful to highlight the relevant words, phrases, and sentences (guided by the research purpose and questions, as well as the researcher's impressions from reading all the transcripts), and coding these into categories in NVivo 11, the qualitative analytical software utilized in this study. Using Fairclough's (2003) CDA framework, the

researcher conducted discursive practice analysis to gain knowledge of how the text of each document interacted with its environment. Analysis of sociocultural practices was done by examining these official documents for references to broader issues at the societal level. The researcher analyzed the documents by going back and forth between the three levels of analysis (textual, discursive practice, and sociocultural practice), reading the texts over, rearranging the categories as further insights into the data emerged.

Findings from the Official Documents

The findings that emerged from the analysis of official documents were categorized into four areas: (a) monitoring medication compliance, (b) monitoring medication safety, (c) notifying the physician, and (d) communicating with patient/caregiver. The paragraphs that follow provide a thorough discussion of the categories. Direct quotations from the documents are presented to clarify and support the findings of the study.

Monitoring medication compliance. The findings showed that three of the official documents (the CMS Drug Regimen Review Standard, the Medication List and Monitoring Policy, and the OASIS Medication Assessment) utilized the word "compliance" in relation to the medication-taking behavior of patients. The language of the CMS Drug Regimen Review Standard directly addresses the subject of medication compliance. According to the standard, "comprehensive assessment must include a review of all medications the patient is currently using in order to identify any …

noncompliance with drug therapy" (see Appendix H, para. 1). Furthermore, the CMS Drug Regimen Review Standard states that upon determining that a patient is experiencing problems with his/her medication, the qualified clinician (RN or therapist) must notify the physician.

Similar to the CMS Drug Regimen Review Standard, the Medication List and Monitoring Policy incorporates the noun "compliance" in its statement about providing oversight on patients' medication-taking behavior. The Medication List and Monitoring Policy also includes statements about the obligation of health care team members as regards patient medication management. For example, Procedure 5 on the Medication List and Monitoring Policy obligates home health agency nursing staff to assess on an ongoing basis the "patient's response to the medication and the patient/caregiver's compliance with the medication regimen" (see Appendix I). In addition, the Medication List and Monitoring Policy requires that compliance concerns be communicated to the physician. Furthermore, this document tasks the agency RN with the overall responsibility of coordinating the efforts of monitoring the medication regimen (see Appendix I).

The language in the OASIS Medication Assessment regarding medication compliance focuses on the intention that surrounds a patient's medication-taking behavior. The OASIS Medication Assessment requires the clinician completing the assessment to indicate a patient's ability to prepare and take all medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals

(see Appendix J). Put in a different way, the OASIS Medication Assessment seeks information about unintentional medication non-adherence that the patient may exhibit. To avoid misinterpretation, OASIS Medication Assessment clarifies that the focus of the assessment is *not* on the patient's willingness (referred to as compliance) within the document (see Appendix J).

The fourth official document analyzed in this study is the HH CAHPS Medication Survey. Unlike the other three official documents discussed in the preceding paragraphs, the HH CAHPS Medication Survey does not utilize the word "compliance" in relation to the medication-taking behavior of patients. Rather, this survey uses everyday language, such as "talk with you about when to take your medication," to gather information relative to home health clinicians' monitoring of patients for medication compliance (see Appendix K).

Monitoring medication safety. Discourse about monitoring medication safety was noted in all of the four official documents analyzed for this study. According to the statement in the CMS Drug Regimen Review Standard, home health agencies are required to conduct a comprehensive assessment of their patient's medications with the goal of identifying any potential adverse effects and drug reactions. The CMS Drug Regimen Review Standard further describes potential adverse effects and drug reactions as "ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy" (see Appendix H, para. 1). The language utilized in the Medication List and Monitoring Policy also addresses monitoring patients' medication

safety; this document utilizes words identical to those seen in the CMS Drug Regimen Review Standard to describe potential adverse effects and drug reactions. The Medication List and Monitoring Policy specifically places the responsibility of monitoring medication safety on the agency RN.

According to Procedure 4 on the Medication List and Monitoring Policy, "The Registered Nurse will monitor medications for potential adverse effects and drug reactions including ineffective drug therapy, significant side effects, significant drug interactions and duplicate drug therapy" (see Appendix I). The OASIS Medication Assessment also includes discourse regarding monitoring for patients' medication safety. Similar to the CMS Drug Regimen Review Standard and the Medication List and Monitoring Policy, the language of the OASIS Medication Assessment prompts the qualified clinician (RN or therapist) to assess for any potential clinically significant medication issues (see Appendix J). The OASIS Medication Assessment takes monitoring medication safety further; clinicians are expected to educate the patient/caregiver about self-monitoring for medication side effects and adverse drug reactions, as well as how and when to report problems that may occur (see Appendix J).

Similarly, the HH CAHPS Medication Survey has discourse on monitoring medication safety. Consistent with its genre (i.e., the classification and style of the document), the HH CAHPS Medication Survey utilizes easy-to-understand language to describe and inquire about monitoring medication safety. Unlike the other regulatory and technical documents reviewed in this study, the HH CAHPS Medication Survey is geared

toward obtaining the opinion of patients, who have varied levels of education. Thus, the language noted in the HH CAHPS Medication Survey consists of everyday vocabulary, and it asks the survey respondent (either the home health patient, or their proxy) whether home health staff discussed medication side effects with the home health patient (see Appendix K).

Notifying the physician. The findings from the document analysis showed that three out of the four official documents analyzed for this study, had statements about notifying the physician for medication related issues. The documents that addressed physician notification are the: (a) CMS Drug Regimen Review Standard, (b) Medication List and Monitoring Policy, and (c) OASIS Medication Assessment. The HH CAHPS Medication Survey did not have any statements about notifying the physician for medication-related issues. The language used in the CMS Drug Regimen Review Standard about physician notification is strong and mandates that a home health agency RN or therapist notify the physician of patient's medication-related concerns. The guidelines in the CMS Drug Regimen Review Standard stipulate that "If the qualified clinician (RN or therapist) determines that the patient is experiencing problems with his/her medications or identifies any potential adverse effects and/or reactions, the physician must be alerted" (see Appendix H, para. 3). Similarly, the Medication List and Monitoring Policy also addresses physician notification, requiring the home health agency staff to notify the physician if adverse response, lack of response, and/or compliance issues are noted in a patient (see Appendix I). The physician notification

statement in the OASIS Medication Assessment pertains to contacting a physician or physician-designee within one day of identifying a potential clinically significant medication issue (see Appendix J).

Communicating with patient/caregiver. The importance of medication-related communication with the patient and/or caregiver is addressed by three out of the four official documents reviewed for this study. The CMS Drug Regimen Review Standard did not include any statement on communicating with patients/caregivers. The documents that addressed home health agency and patient/caregiver medication-related communication are the: (a) Medication List and Monitoring Policy, (b) OASIS Medication Assessment, and (c) HH CAHPS Medication Survey. Procedure 7 on the Medication List and Monitoring Policy stipulates that: "Changes in the medication regimen … as well as communicated to the patient and/or caregiver" (see Appendix I).

The OASIS Medication Assessment asks whether the clinician gave the patient/caregiver instructions on precautions for high-risk medications (e.g., hypoglycemia medication and anticoagulants), as well as instruction regarding how and when to report problems that may occur. Furthermore, the OASIS Medication Assessment asks the clinician if the patient/caregiver was instructed on monitoring for adverse drug reactions, significant side effects, and how and when to report problems that may occur (see Appendix J). The HH CAHPS Medication Survey also addresses medication-related communication between the home health clinician and the patient/caregiver. The HH CAHPS Medication Survey asks the respondent (the

patient/caregiver) if the home health clinician talked with the patient/caregiver about all the prescriptions and over-the-counter medications. Additionally, the HH CAHPS Medication Survey includes a statement that probes for evidence of discussions between the home health clinician and the patient/caregiver regarding the purpose and side effects of new or changed medications (see Appendix K).

One aim for this study was to understand the contextual influences on home health nurses' views regarding medication adherence promotion among community-dwelling elderly patients. To meet that objective, the researcher conducted an analysis across data sources to identify how regulatory and health care official discourses might influence home health nurses' views on promoting medication adherence among their community-dwelling elderly patients. Specifically, each of the five interview categories was examined for evidence of intertextuality (shaping of a text's meaning by another text) with the official documents. Areas of convergence or divergence between the interview texts and the official documents were noted. The discussions presented in the paragraphs that follow highlight linkage found between participant discourse and the findings from the official documents. Direct quotes and statements from the interview texts and from the official documents that provide illuminations are also provided, as these help to clarify and support the claims of the study.

Linking Text from the Interview and Official Documents

Four out of the five categories representing home health nurses' views about promoting medication adherence among their elderly patients converged with findings in

the official documents examined in this study. These categories include the view regarding medication adherence promotion as: (a) providing nursing care, (b) engaging patient/caregiver, (c) avoiding adverse events, and (d) requiring team efforts. The category of "medication adherence promotion as requiring multiple reinforcements" was not identified in any of the official documents analyzed for this study.

Discourse supporting the view of medication adherence promotion as providing nursing care was a prominent aspect of the statements made by the home health nurse participants in this study. The participants verbalized nursing standards of practice such as patient assessment and education, and they referenced their home health agency policy to give support to statements made about medication adherence promotion. In their discourse, the study participants also referred to OASIS Assessment, Medicare regulations, and surveys that are conducted by Medicare. Furthermore, intertextuality was evidenced, as phrases that the participants used to describe their views about medication adherence promotion were identical or similar to words and phrases found in the official documents. For example, the participants stated that they are required to conduct a complete assessment on their elderly patient's medication to determine whether the patient is adherent. This expectation regarding assessing patients for medication adherence and instituting interventions to promote adherence was also found in the language used in the CMS Drug Regimen Review Standard.

> The comprehensive assessment must include a review of all medications the patient is currently using in order to identify … noncompliance with drug

> therapy… If the qualified clinician (RN or therapist) determines that the patient is experiencing problems with his/her medications …the physician must be alerted (see Appendix H).

The views of the participants regarding medication adherence promotion as providing nursing care also align with the language of the Medication List and Monitoring List Policy. This policy assigns an agency RN the overall responsibility of coordinating the efforts to monitor a patient's medication regimen; requires agency nursing staff to assess and monitor patient/caregiver compliance with medication regimens; and requires staff to communicate compliance concerns to the physician (see Appendix I). In a similar manner, the OASIS Medication Assessment prompts the qualified clinician (RN or therapist) to assess and report the patient's ability to adhere to the dosage and schedule of their medication regimen (see Appendix J), while the HH CAHPS Medication Survey probes about instructions on the medication schedule given to the patient by the home health agency clinician (see Appendix K).

The participants' language concerning the topic of medication adherence promotion as engaging patients and caregivers is congruent with the language used in three of the official documents. The study participants emphasized the notion that engaging elderly patients and their caregivers is an important aspect of medication adherence promotion. A similar discourse was found in the Medication List and Monitoring Policy, which underscores the importance of the patient/caregiver unit in the medication adherence enterprise by requiring patients and/or caregivers to be assessed for

compliance with the medication regimen. In addition, the Medication List and Monitoring Policy require any change in the medication regimen to be communicated to the patient and/or caregiver (see Appendix I). The OASIS Medication Assessment also has statements that touch on engaging patients and their caregivers. Specifically, the OASIS and Medication Assessment requires that the qualified clinician (RN or therapist) provide drug education, which must include instructions on all the patient's prescribed high-risk medications (see Appendix J). The discourse on engaging patients and caregivers is similarly present in the HHCAHPS Medication Survey. This official document asks the patient or their proxy about whether their home health provider provided education and discussions about the purpose, schedule and side effects of their medications (see Appendix K).

The study participants' language regarding medication adherence promotion as avoiding adverse outcomes is consistent with the discourse about medication safety noted in all four of the official documents examined for this study. The study participants utilized words such as side effects, taking expired drugs, double-dosing, falls, and dizziness to describe the adverse outcomes that they monitor for, and about which they also educate their elderly patients and caregivers. Language similar to that used by the nurse participants was also noted in the CMS Drug Regimen Review Standard and in the Medication List and Monitoring Policy. Both of these documents present significant side effects, significant drug interactions, and duplicate drug therapy as potential adverse effects and drug reactions, and both require home health clinicians to intervene if such

potential adverse effects and drug reactions are observed in a patient (see Appendices H and I). The language of the OASIS Medication Assessment prompts the RN or therapist (qualified clinicians) to assess the patient for any potentially clinically significant medication issues such as medication side effects and adverse drug reactions; it also requires them to educate the patient/caregiver on how and when to report problems that may occur (see Appendix J). Similar to the other three official documents examined for this study, the HH CAHPS Medication Survey specifically references medication side effects and asks the survey respondent (the patient or their proxy) whether home health staff talked with them about medication side effects (see Appendix K).

In the category, medication adherence promotion as requiring team effort**,** the language used by study participants converged with the discourse found in all four official documents. The participants opined that elderly patients and their caregivers, nurses, social workers, home health aides, therapists, as well as physicians, are all essential to medication adherence promotion. The statements found in the official documents suggest support of a multidisciplinary approach to medication adherence promotion. For example, the CMS Drug Regimen Review Standard clearly identifies the patient, RN, therapist, and physician in its discourse, and it includes language recognizing that individual home health agencies may have additional protocols on patient's medication review and management (see Appendix H).

Similarly, the Medication List and Monitoring Polic*y* identifies the patient and their caregiver, nursing staff, physician, and it holds all persons involved with a patient's

care responsible for the patient's medication management (see Appendix I). The OASIS Medication Assessment identifies the clinician, the patient/caregiver, and the physician in its discourse on medications. For instance, the language of the OASIS Medication Assessment requires the clinician (RN or therapist) to recognize adherence and/or other issues that may negatively influence a patient's well-being and to notify the patient's physician within 24 hours of such observations (see Appendix J). The OASIS Medication Assessment also requires that patients and their caregivers be given medication-related education (see Appendix J). The language of the HH CAHPS Medication Survey does not directly identify individual health care team members as responsible for patient's medication management. Rather, this official document uses the terminology, home health providers, to identify members of the health care team who provide medication-related services to home health patients (see Appendix K).

Summary of the Findings

Chapter Four presented the findings of data analysis and began with a description of the sample. Next, the coding process that was used to identify and connect discourses into categories was presented. The participants in this study view medication adherence promotion as: (a) providing nursing care, (b) engaging patient/caregiver, (c) requiring multiple reinforcements, (d) avoiding adverse events, and (e) requiring team effort. Within these main categories, a recurring discourse was that home health nurses' best efforts at medication adherence promotion is impeded by insufficient commitment from elderly patients and their caregivers, physicians, as well as inpatient facilities. The

findings that emerged from the analysis of official documents were categorized as: (a) monitoring medication compliance, (b) monitoring medication safety, (c) notifying the physician, and (d) engaging patients and caregivers. Analysis that involved comparing findings across data sources was also done. This latter analysis showed that home health nurses' views on medication adherence promotion as: (a) providing nursing care, (b) engaging patient/caregiver, (c) avoiding adverse events, and (d) requiring team effort converged with the discourse found in the official documents examined for this study. The participant's view that was categorized as "medication adherence promotion as requiring multiple reinforcements" was not found as a discourse in any of the official documents. Chapter Five will present a discussion of the findings, implications of the study, and the limitations of the study.

CHAPTER V

SUMMARY OF THE STUDY

The purpose of this qualitative study was two-fold: to describe the views of home health nurses on promoting medication adherence among community-dwelling elderly patients, and to explore the sociocultural and regulatory contexts for home health nurses' discourse formation. Using in-depth, face-to-face interviews, thirteen nurses, ten RNs and three LVNs practicing in the greater Houston, Texas area were asked to express their views on medication adherence promotion among community-dwelling elderly patients. In addition, four official documents related to medication management practices and medication adherence promotion in the home health environment were also analyzed. The official documents examined were the: CMS Medication List and Monitoring Policy, Medication List and Monitoring Policy, OASIS Medication Assessment, and HH CAHPS Medication Survey. This study was theoretically framed by the Habermas critical social theory and the discourse theory. The methodological framework used to analyze the data was Fairclough's (2003) CDA methodology.

This chapter offers a brief recapitulation of the findings that emerged from the data analysis followed by a comprehensive discussion of the findings of the study. Using a critical discourse analysis lens, the findings from analysis of the interview are discussed in light of findings from the official documents and in context of the sociocultural and regulatory environment of home health care practice. This chapter also includes a

discussion of how the study findings might contribute to knowledge both within the discipline of nursing and across multiple disciplines. Limitations of the research are presented. The chapter concludes with recommendations for nursing educators, home health agency leaders, and policymakers. Suggestions for further research are also included in this chapter.

Overview

The researcher utilized Fairclough's (2003) CDA framework to examine the study's data sources—the participants' interview text and the official documents—and to explore a linkage between findings across these two data sources. For the interview data, the researcher identified words, phrases, and statements, which were categorized into five areas: (a) medication adherence promotion as providing nursing care, (b) medication adherence promotion as engaging patients and caregivers, (c) medication adherence promotion as requiring multiple reinforcements, (d) medication adherence promotion as preventing adverse outcomes, and (e) medication adherence promotion as requiring team effort. The findings from analysis of the official documents were categorized into four areas, namely: (a) monitoring medication compliance, (b) monitoring medication safety, (c) notifying the physician, and (d) engaging patients and caregivers. Comparison of findings across data sources revealed that the categories of home health nurses' views on medication adherence promotion as providing nursing care, engaging patient/caregiver, requiring multiple reinforcements, avoiding adverse events, and requiring team effort were convergent with the language found in the official documents. However, one area of

home health nurses' views (medication adherence promotion as requiring multiple reinforcements) was absent from the discourse in the official documents. This chapter is organized with a view of discussing the categories that were constructed from the participant interview text in light of the discourses found in the official documents, as well as in relation to other research studies.

Discussions of Findings

The category, medication adherence promotion as providing nursing care, was constructed from words and phrases (e.g., education, and coordination of care) that home health nurses utilized, as they described their views and activities relative to promoting medication adherence among their elderly patients. Statements prompting the home health professional to conduct comprehensive assessment of home health patients' medication regimen, educate patients about medication(s), and coordinate services to optimize the medication-taking behavior of home health patients were also noted on the official documents.

The participants in this study expressed that promoting medication adherence is included as part of the care that a nurse provides to his or her patient, and that their work in this area is guided by their agency policy and procedures as well as by government regulations on quality of care. In a general sense, the participants also indicated that nursing professionalism guided their medication adherence promotion efforts. These participants reported that they conduct in-depth assessments of each elderly patient, and they choose interventions to promote medication adherence based on these assessments.

For example, when the assessment reveals that an elderly patient is forgetful, these home health nurses seek solutions to issues of sub-optimal adherence by instituting reminder systems such as pill boxes. The participants' viewpoint about forgetfulness as a deterrent to medication adherence among elderly individuals is supported by Rodgers et al. (2017) who reported that mild cognitive deficits (indicated by a Mini-Mental State Examination (MMSE) score of 21- 24) were associated with lower medication adherence among community-dwelling elderly persons.

The participants' statement about providing pill boxes as tangible support to encourage elderly patients' medication adherence is also supported by the literature. Studies show pill boxes to be one of the most common methods used by older adults to improve medication adherence (Gould, Todd, & Irvine-Meek, 2009; Naditz, 2008; Raehl, Bond, Woods, Patry, & Sleeper, 2002; Rife et al., 2012). It is noteworthy, however, that although pill boxes are widely utilized by elderly patients, their use does not guarantee adherence to medication regimen. Studies have shown that only 53% to 68.1% of the older adults adhered correctly to their prescribed regimens while using pill boxes (Gould et al., Todd & Irvine-Meek, 2009; Hayes et al., 2009; Hayes, Larimer, Adami, & Kaye, 2009). Thus, it is important that home health nurses remain vigilant in order to ascertain that the pill box intervention is resulting in improved medication adherence for the elderly patient in question.

Patient education was one of the key interventions that the home health nurses in this study identified as being useful for promoting medication adherence among their

elderly patients. The participants indicated that they regularly gauge their elderly patients' knowledge of their medications and then provide education to bridge knowledge gaps. The value of educating patients to promote medication adherence is supported by the findings from other studies (Jin, Kim, & Rhie, 2016; Ratanawongsa et al., 2013; Vanhaecke Collard, Michaut, Caillierez, Parra, & Bonnefoy, 2017).

In a study on factors affecting medication adherence among elderly people, Jin et al. (2016) found that providing sufficient explanation and consultation about medication was the strongest predictor of adherence among elderly individuals. In a cross-sectional study of 9,377 diabetic patients (mean age = 59.5 years), Ratanawongsa et al. (2013) noted that patients who viewed their health care providers as providing quality communication, such as being understanding of patients' problems with treatment and involving patients in decisions, were more likely to be adherent to their diabetic drug regimen. Similarly, Vanhaecke Collard et al. (2017) showed that therapeutic education with a written document resulted in improvement in medication knowledge (drug names: 67% vs 76%, $p = 0.048$; indications: 80% vs 91%, $p = 0.010$; dosages: 83% vs 92%, $p = 0.003$) and medication adherence ($p = 0.0036$) among elderly patients (average age 81.9 years old).

The participants in this study reported coordinating social worker referrals as one of the activities that home health nurses undertake to promote medication adherence. Social workers are engaged to assist elderly patients with identifying financial resources whenever medication cost is limiting medication adherence. Other studies have identified

financial cost as a reason why elderly patients do not adhere to their medication regimens. For instance, a study by Holt et al. (2014), as well as another by Mishra et al. (2011), revealed lack of finances to procure medications as a reason why the elderly do not adhere to their medications. Similarly, the elderly community-dwelling individuals in the narrative study by Meraz (2017) reported that being able to afford their drugs is of particular concern to them, and they often wondered what they would do if they could no longer afford the cost of their medications. The statements from the participants in the current study, on how they promote medication adherence by coordination of services with physicians and social workers are supported by the literature. For example, Sommers, Marton, Barbaccia, and Randolph (2000) found that chronically ill community-dwelling elderly patients who received collaborative care services from teams of a primary care physician, a nurse, and a social worker had fewer hospital admissions, as well as lower dollar expenditure, when compared with a control group who received care as usual from their primary care physician.

An alternative viewpoint expressed by the participants in this study was that in situations involving brand-name medications, home health nurses' best efforts to resolve financial obstacles to medication non-adherence among their elderly patients is often ineffective. A study by Maciejewski, Farley, Parker, and Wansink (2010) showed that reducing the copay on brand-name medications results in improved medication adherence (in a population served by commercial health insurance plans). However, the findings from Maciejewski et al. (2010) might not transfer directly to community-dwelling elderly

patients, who tend to be on very limited income and thus may not be able to afford even the lowest copays associated with brand-name medications. This finding underscores the need to further examine the impact of zero-copay generic and brand-name medications (where medically necessary), on medication adherence among community-dwelling elderly patients.

The category, medication adherence promotion adherence as engaging patients and caregivers, was identified based on participants' discourse about providing client-centered care and connecting one-on-one with individual elderly patients. The participants listed caring, listening, gaining trust, and taking our time as invaluable attributes that pave the way, causing the elderly to be receptive to home health nurses' medication adherence promotion efforts. The language in three of the official documents (the Medication List and Monitoring Policy, the OASIS Medication Assessment, and the HHCAPHS Medication Survey) also highlights communicating with the patient and caregiver about medications as an activity that is required of home health professionals.

The participants' statements about using affective behaviors to gain the trust of their patients are supported by the literature. In a systematic review of studies done across varied clinical settings (home health, hospice, hospitals, long-term care, and mentalhealth), Rortveit et al. (2015) concluded that nurses who have communication and practical skills, in addition to being friendly, warm, caring and non-judgmental are perceived to be trustworthy by patients. Specific to adherence, Musa, Schulz, Harris, Silverman, and Thomas (2009) found that higher levels of patients' trust in healthcare

professionals and services were associated with greater willingness to seek medical treatment and adhere to treatment recommendations.

In addition, in a recent meta-analysis that examined 47 studies, Birkhäuer et al. (2017) concluded that patients with higher levels of trust in their health care professionals showed more positive health behaviors and reported more satisfaction with treatment and higher quality of life. The value of engaging the caregivers of elderly patients in efforts to promote medication adherence, noted by the participants in this study, is also supported by literature. Studies by DiMatteo (2004) and Magrin et al. (2015) show that the functional support (emotional, instrumental, and informative) that patients receive from their social network contributes to improved medication adherence.

Among community-dwelling elderly individuals, Reinhard, Feinberg, and Choula (2012) and Meraz (2017) found that family and informal caregivers influenced adherence in tangible ways such as filling pill boxes, picking up prescriptions from the pharmacy store, and making sure that medication lists are up-to-date. Bogardus et al. (2004) also found a greater medication adherence among geriatric patients when family/caregivers were included in the medical plan of treatment. Thus, the discourse put forth by the home-health nurse participants in this study about using affective behaviors such as attentive listening, establishing trust, and exhibiting caring behaviors as an avenue to engage community-dwelling elderly patients and their caregivers is conceivable. When health care practitioners employ such intrapersonal skills, they are able to coach and

positively influence the medication-taking behaviors of community-dwelling elderly individuals.

A divergent view on engaging patients and caregivers relative to medication adherence promotion was noted from some of this study's participants. The participants described meeting an impasse when elderly patients, families, and/or caregivers respond to their medication promotion overtures with opposition or indifference. While the participants gave a thorough description about the indifference of some elderly patients toward improving their medication-taking behavior, none of the participant's statements noted the possibility that the apathetic attitude of such elderly patients may be due to depressive symptoms. Even though the OASIS Assessment requires that the home health agency RNs assess the neurocognitive and the behavioral status of the client, there was no evidence that the RNs in this study recognized a possible connection between an elderly patient's mood state (which they described as apathy and nonchalance) and that patient's poor medication-taking decisions. In a 2010 study, Krousel-Wood et al. identified a strong association between the presence of depressive symptoms and low antihypertensive medication adherence among community-dwelling adults, 65 years of age and older.

Furthermore, the language used by some of the participants in this current study suggest that home health nurses feel discouraged when their medication promotion efforts are challenged by the family/caregiver of the elderly patient. Although such feelings of frustration as expressed by home health nurses may be justifiable, seeking to

understand why family/caregivers might challenge given instructions could help home health nurses to persevere with their efforts to promote medication adherence among their elderly patients. What the participants in this study perceive to be an oppositional stance by the patient's family or caregiver could in fact be a bid to advocate on behalf of their elderly loved ones. Evidence from literature show that the role of caregivers to the elderly often includes questioning changes in the medications and/or upholding the medication beliefs and preferences of their elderly loved ones. (While, Duane, Beanland, & Koch, 2013). Hence, when probed, actions construed as over-zealousness by home health nurses could actually reflect attempts by family and caregivers to advocate for the interest of their loved ones. Rather than being intimidated or exasperated when efforts to promote medication adherence do not receive the needed uptake from elderly patients and their family member, home health professionals should employ behavior-changing techniques to foster buy-in from resistant patients and caregivers.

Based on the statements made by the home health nurses in this study, it was evident that the participants did not have the skill set to sway the lukewarm attitudes of elderly patients or the opposition of some caregivers toward medication adherence efforts. When asked about trainings or in-services received on medication adherence promotion, majority of the participants in this study were not able to specify any actual training that they had received on the subject matter. Studies have shown that providing in-services on medication management to home health nurses is a worthwhile endeavor. For example, Mager and Morrissey Ross (2013) found that home health nurses who

received targeted medication management training showed increased frequency of asking to see their patients' medications as well as discussing medication side effects and medication administration schedules with their patients.

A different study by Mager and Campbell (2013) showed that pre-licensure nursing students benefitted from a simulated training on home-care medication management. In this quasi-experimental study, the interventional group showed statistically significant improvement in their knowledge of managing medications and pre-filling patient medication boxes in comparison to the control group (Mager & Campbell, 2013). Regular in-services on medication adherence promotion would expose home health nurses to current best practices; it would also empower those nurses to deal with the various barriers that can constrain their medication adherence promotion efforts medication promotion enterprise among community-dwelling elderly patients.

The researcher constructed the category, medication adherence promotion as requiring multiple reinforcements, from words and phrases that home health nurses used to describe the repetitive efforts required to optimize elderly patient's medication-taking behavior. The nurses used phrases such as "It is not a one-time thing" and "it is not as easy as I am making it sound" to communicate that promoting medication adherence among their elderly patients requires dogged persistence. Several studies have shown the value of reiterating information as a means of promoting adherence. For instance, Van Camp, Huybrechts, Van Rompaey, and Elseviers (2012) conducted a study to evaluate the efficacy of education and continuous counselling on promoting better adherence to

phosphate binders among patients with End Stage Renal Disease. These researchers found that the medication adherence rate among the intervention group who received bi-weekly personalized counselling increased from 83% to 94% after 13 weeks. Among the control group who only received a one-time education on phosphate binders, the medication adherence declined from 86% to 76% after 13 weeks (Van Camp et al., 2012). In a study involving patients with diagnosis of glaucoma, Sleath et al. (2015) found that if healthcare providers educated patients about how to administer their glaucoma eye drops, patients were significantly more likely to take their doses on time ($p = 0.02$) and to take the correct number of prescribed doses each day ($p = 0.008$).

While none of the official documents examined for this study specifically addressed the intensity of efforts needed to promote medication adherence, it is known that negative outcomes occur when elderly patients do not adhere to their medication regimen (Ruppar et al., 2008). It is thus conceivable that home health nurses perceive a heightened need to provide multiple reinforcements via reminders, pillboxes, and cue cards. In this way, they seek to steer their elderly patients toward positive medication-taking behavior and thereby promote better health outcomes.

The category, medication adherence promotion as preventing adverse outcomes, was constructed from words and phrases that home health nurses used to describe the safeguarding measures that they utilize while promoting positive changes in the medication-taking behavior of their elderly clients. A common thread noted from the participants' explanations was that home health nurses educate patients about medication

side effects, untoward reactions, and the dangers of taking expired medications taking more than the prescribed dosage of medications. A congruent commitment to preventing negative side effects from medication use was also found in the official documents examined for this study. These official documents obligate home health clinicians to conduct medication-related assessments that scrutinize patients for the presence of significant side effects, significant drug interactions, and duplicate drugs. The documents also direct home health clinicians to notify the physician if such potential adverse effects and drug reactions are observed in a patient.

It is evident that the outlook of the home health nurses regarding promoting medication safety is in synergy with the expectations stipulated in the official documents that guide the operations of home health agencies. A broader understanding of this discourse can be realized by reviewing discussions on the quality of care in the U.S. healthcare system which originated from an Institute of Medicine (IOM) report first published about two decades ago. In a report titled "Improving Quality and Safety," the IOM identified the U.S. healthcare

system as falling short across six dimensions (Health Affairs, 2011) and recommended that quality improvements should be focused in twenty areas, including medication management and medication errors (Corrigan & Adams, 2003). Specific to the home care arena, quality improvement areas that home health agencies are required to address include providing drug education on all medications to patients/caregivers. The results of how individual Medicare-certified home health agencies compare to other home health

agencies on medication management and other home-health quality improvement domains are displayed on publicly accessible domains, so that consumers can factor those results into their decisions regarding home health agency selection. Since medication management and prevention of medication errors are linked to the quality scores of home health agencies, it is reasonable to expect that home health agencies (and, by proxy, home health nurses) will have an interest in promoting medication safety among their patients, including the elderly.

While it is appropriate to applaud regulations that require home health nurses to notify physicians about patient medication-related concerns, it is also important to highlight system barriers that hinder home health nurses' efforts to provide quality medication management and medication safety among their patients. In particular, in discussing the regulation that requires home health nurses to notify physicians promptly about medication-related concerns, the participants in this study reported that the physician notification process is fraught with challenges. For example, the physicians often do not have up-to-date information on the patient and thus are unable to resolve such medication-related issues in a timely manner.

Similar to the statements made by the home health nurses in this study, home health nurses in a study by Jones et al. (2017) reported that they often received incomplete or inaccurate medication lists from discharging inpatient facilities. These home health nurses further explained that attempts to seek clarification from primary care providers (PCPs) were often unhelpful, as the PCPs were not in the loop about the patient

care; some were not even aware that their patients were hospitalized (Jones et al., 2017). Efforts to improve timely resolution of medication-related concerns should include mechanisms that grant home health agencies and physicians direct access to the electronic health records of patients to whom they are actively providing services.

The category, medication adherence promotion as requiring team effort, was constructed from words and phrases that home health nurses used to describe the collaborative efforts needed to optimize medication adherence among community-dwelling elderly patients. The professional care team members identified by the participants as being essential to the optimization of medication adherence include nurses, social workers, therapists, and pharmacists as well as physicians. Similarly, the language in use noted from the CMS Drug Regimen, the Medication List, and Monitoring List Policy conveys the importance of professional collaboration to optimize patients' medication-taking behavior.

The statements made by the participants in the study reveal areas of opportunity to enhance collaboration between home health nurses and physicians. For instance, participants reported having trouble in contacting physicians about issues related to their elderly patients' medications. Pesko, Gerber, Peng, and Press (2017) showed that poor/failed communication between home health nurses and physicians is associated with an increased risk of hospital readmission among high-risk patients. Although home health nurses gain valuable insights into both medication regimen complexity and patient and family perspectives while they are in the patient's home, these insights are not often

conveyed to the PCP due to communication barriers between the home health nurse and the PCP (Smith et al., 2016).

To promote medication adherence and safe medication use among community-dwelling elderly patients, home health nurses need timely response from their elderly patients' physicians. For their part, home health nurses report doing all within their purview to promote medication adherence. Moreover, home health nurses and agencies face negative repercussions if they do not conform to the standards guiding their enterprise. There is a need for accountability from all stakeholders in order to promote medication adherence among community-dwelling elderly patients. Specific to patients receiving home health services, there is a need for regulations that mandate timely physician response when home health nurses send alerts on patient-related issues. Such a regulation would should include a mechanism to reward timely physician response and apply consequences for physicians who delay in responding to notifications sent by home health nurses.

Another area of concern described by this study's participants is the suboptimal handoff from inpatient facilities to home health agencies. The participants' statements showed that the handoff documents might not reflect the patient's most current medication regimen. This particular discourse about sub-standard handoff from inpatient facilities to home health agencies is underscored by the findings of Setter et al. (2012). These interdisciplinary researchers highlighted deficiencies in care as patients transitioned from one level of care to another, and they urged health care teams to work

together to optimize patient's outcomes. The discourse that emerged from this current study showed that providing a clear and current medication list when patients are discharged from the community setting remains a goal that is yet to be achieved.

This study's findings indicate that policies that support seamless communication about medication and other patient care issues are needed. Such policies would contribute to better medication adherence by elderly patients and lead to improved outcomes for elderly patients when they are discharged from inpatient care back to the community setting. The available information shows that Health Information Technology can contribute to more effective communication among stakeholders. For example, home health nurses in the study by Sheehan et al. (2018) reported that the use of the HOME Tool, a Web-based Health Information Technology tool (accessible to the home health nurse, the PCP, and the patient/family caregiver) resulted in improved medication-related communication between home health nurses and PCPs. Policies that support the use of password-protected Health Information Technology systems, such that clinicians involved in the care of a given patient will have access to clinical records, are likely to promote more effective communication on medication-related concerns and thereby foster better medication adherence among community-dwelling elderly patients.

Implications

Nursing Education

The views expressed by the home health nurses in this study about the indifferent attitude of some elderly patients and the lack of cooperation by the caregivers suggest

that the current nursing education on behavioral health care may be inadequate. The participants voiced concerns that some elderly patients and their caregivers do not engage with the medication adherence promotion efforts of home health nurses. However, subsequent statements made by the participants showed that these nurses did not see a need to explore the disinterest of such elderly patients and their caregivers further. There is a need to enhance the current behavioral health component of the nursing education curriculum, such that nurses have heightened awareness to the interconnections between patients' physical behaviors and emotional and psychological status.

Home Health Agency Leaders

The majority of the home health nurses in this study stated that they had not received any specific medication adherence training or in-service education. Given the frequency of poor medication-taking behavior among community-dwelling elderly patients, there is a need for home health agencies to sponsor in-services that will inform home health nurses about current best practices in medication adherence promotion. Home health agencies should seek collaborative relationships with neighboring pharmacy stores (retail and specialty) and pharmacy schools, so that pharmacists from these arenas could be invited to serve as guest speakers at regularly scheduled in-services.

Interdisciplinary Research

The statements made by the home health nurses in this study revealed that financial barriers to procuring medications remain an issue for some community-dwelling elderly patients, creating a significant barrier to optimal medication adherence. This is an

area of opportunity for future interdisciplinary studies between the fields of nursing, pharmacy, social work, and medicine. A key area to evaluate is adherence to identified brand-name medication(s) among community-elderly patients.

Policy

This study brought to light two areas in medication adherence promotion among community-dwelling elderly people that could be improved through policy development and enactment. There is a need for policies that drive timely response by physicians when home health agencies seek clarification on medication-related concerns. Such policies should be closely tied to physicians' quality of care metrics, and ultimately to an aspect of physician reimbursement for services provided to home health patients. A closely aligned policy is one that ensures that inpatient facilities conduct a seamless and comprehensive handoff when discharging patients back to the community. Inpatient facilities that adhere to stipulated handoff standards should rewarded, while inpatient facilities with poor handoff practices should be penalized.

Study Limitations

This dissertation study has several limitations. While it is not the goal of a CDA study to produce generalizable findings, it is important to acknowledge that the sample for this study was conducted within a specific geographical region of the US and that that such knowledge should be taken into account when drawing inferences. Second, this study is also limited in that it only includes discourses from the perspective of home health nurses working in a sole proprietorship setting. It is possible that home health

nurses working in a home health agency that is part of a regional organization, national corporation, or consortium may have different discourses of promoting medication adherence among community-dwelling elderly patients. Third, the documents included in this study were limited to publicly available official documents referenced by the study participants. It is possible that other documents within the sociocultural environment, official or otherwise, influence home health nurses' views about medication adherence promotion among their community-dwelling elderly patients. Fourth, while CDA acknowledges the co-creation of knowledge, it is important to highlight that the researcher's interests and prior knowledge may have unwittingly shaped the research development and dissemination of the study findings.

Chapter Summary

This chapter presented an overview of the findings that emerged from the data analysis. Using a critical discourse analysis lens, the findings from analysis of the interviews were discussed in light of findings from the official documents, and in the context of the sociocultural and regulatory environment of the home health care practice arena. This chapter also provided recommendations for nursing educators, home health leaders, and interdisciplinary researchers. This chapter also included recommendations on how the study findings can be harnessed to inform policies that will spur clinicians to be better engage in medication adherence promotion. Limitations of the research were also presented.

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APPENDIX A

IRB Approval Letter

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378
email: IRB@twu.edu
http://www.twu.edu/irb.html

DATE: January 19, 2017

TO: Ms. Olusola Adeniran
Nursing

FROM: Institutional Review Board (IRB) - Denton

Re: Approval for Home Health Nurses' Views of Promoting Medication Adherence Among Community-Dwelling Elderly Patients (Protocol #: 19409)

The above referenced study has been reviewed and approved by the Denton IRB (operating under FWA00000178) on 1/19/2017 using an expedited review procedure. This approval is valid for one year and expires on 1/19/2018. The IRB will send an email notification 45 days prior to the expiration date with instructions to extend or close the study. It is your responsibility to request an extension for the study if it is not yet complete, to close the protocol file when the study is complete, and to make certain that the study is not conducted beyond the expiration date.

If applicable, agency approval letters must be submitted to the IRB upon receipt prior to any data collection at that agency. A copy of the approved consent form with the IRB approval stamp is enclosed. Please use the consent form with the most recent approval date stamp when obtaining consent from your participants. A copy of the signed consent forms must be submitted with the request to close the study file at the completion of the study.

Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Anita Hufft, Nursing
Dr. Fuqin Liu, Nursing
Graduate School

APPENDIX B

Recruitment Flyer

Recruitment Flyer

Study Title: Home-Health Nurses' Views of Promoting Medication Adherence Among Community-Dwelling Elderly Patients

I am a student working on my PhD in nursing at the Texas Woman's University. I would like to invite you to participate in my research study. As part of my coursework, I will be conducting a research study about promoting medication adherence among elderly patients who live in the community. The purpose of this research study is to understand the views of home health nurses regarding promoting medication adherence among community-dwelling elderly patients.

I am looking for individuals who are currently working as Registered Nurses (RNs) or Licensed Vocational Nurses (LVNs) in a home health agency that provides services to the adult population. To be part of the study, you need to be 18 years or older and have been in your position for at least six months. Your participation in the study is voluntary and participants may withdraw from the study at any time without penalty.

The research project will involve an interview at a location of your choice. The interview will be approximately 90 minutes. You will receive a $20 gift certificate upon the completion of the interview.

If you are interested please contact me, Olusola Adeniran, at 832-605-7171, or oadeniran@twu.edu

Please note that there is a potential risk of loss of confidentiality in all email, downloading, and internet transactions.

O Adeniran, MS, RN

Texas Woman's University

APPENDIX C

Eligibility Screening Script

Opening

Telephone Screening Directions for the Researcher:

- **Remember to get participant's contact information.**
- **Make the telephone screening to be conversational.**

Say:

- Hello, this is Olusola Adeniran.
- Thank you for your interest in the research study. You must meet the study eligibility screening to be selected for the study.
- Is this a good time to talk about the study? It will take about 10 minutes.

  If YES, continue with the script below.

  If NO, "Is there a more convenient time for you? – arrange a convenient time to call back.
- As you may have learned from the study flyer, I am a doctoral student at Texas Woman's University College of Nursing. Before I talk about the study, I would like to ask you a few questions to make sure that you meet the inclusion criteria for this study.
- Confirm volunteer meets study eligibility

Now I will read you the study eligibility criteria, after each statement, please reply Yes or No.

Inclusion Criteria	Response	Results
Are you a Registered Nurse or a Licensed Vocational Nurse	Y N	If no, ineligible
Are you 18 years or older	Y N	If no, ineligible
Do you provide nursing services to adult patients on behalf of your HH Agency	Y N	If no, ineligible
Have you worked in this position for at least six months	Y N	If no, ineligible

If ineligible, say: "I am so sorry you cannot participate in the study because **state the reason**. I still want to thank you for your interest.

If eligible, say: Great! You are eligible. I will like to give you a brief description of the study:

- The study consists of participating in an interview during which I will ask you about your views on promoting medication adherence on community-dwelling elderly patients.
- If you are considering taking part in the study, I will arrange a meeting with you. I will get permission from you before I ask the questions.
- There is a $20 gift certificate that will be given to you at the completion of the interview
- Your responses are confidential. A code name, not your real name will be placed on all documents. No one but I will know your real name.
- Your participation in the study is totally voluntary.
- You don't have to answer all the questions. You can stop your participation in the study at any time.
- Do you have any questions about the study?
  If NO, continue with the script below.
  If YES, answer the questions**.**
- Do you think that you would like to participate in the study?
  If YES, continue with the script below.
  If NO, say "thank you for your time"
- Would you like to arrange a date/time for the study?
  If YES, arrange date/time and place for study. Date: _____ Time: _____ Place: _____
  If NO, "is there a more convenient time for you?" Arrange a convenient time to call back.

APPENDIX D

Consent Form

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Study Title: HOME HEALTH NURSES' VIEWS OF PROMOTING MEDICATION ADHERENCE AMONG COMMUNITY-DWELLING ELDERLY PATIENTS

Investigator: Olusola Adeniran, MS.....oadeniran@twu.edu 832/605 - 7171

Advisor: Fuqin Liu, PhD.....fliu@twu.edu 940/898 – 2420

Explanation and Purpose of the Research
You are being asked to participate in a research study for Ms. Adeniran's Dissertation at Texas Woman's University. The purpose of this research is to learn about how home health nurses view promoting medication adherence among elderly patients who live in the community. You are being asked to participate in this study because you have identified yourself as a home health nurse.

Description of Procedures
As a participant in this study you will be asked to spend 90 minutes of your time in a face-to-face interview with the researcher. I will ask you questions about your views about promoting medication adherence among elderly patients living in the community. I will also ask you some questions about your background such as your educational background and work experience.
The interview will be audio recorded and then written down so that I can be accurate when studying what you have said. If you would like, a copy of the written down interview can be mailed to you so you can let me know if it is accurate.

In order to participate in this study, you must be at least 18 years of age, a RN or LVN, currently working in a home health agency, and have at least six months experience of providing nursing services to adult home health patients.

Potential Risks
There is a potential risk of loss confidentiality in all email, downloading, and internet transactions. Confidentiality will be protected to the extent that is allowed by law. The interview will be held at a private location that you and I have agreed upon. A code name, not your real name, will be used during the interview. No one but I will know your real name. A list that matches the real name and code name will be stored separately in an encoded file within the researcher's password protected computer that will be used to collect all data, and this list will be destroyed four years after the completion of the study. The signed consent form, the interview tapes and the written interview will be stored in a locked cabinets in my office. The interview tapes will be destroyed by one year after the completion of the study, and the written interview will be destroyed four years after the completion of the study. I will be the only one who hears the tapes or reads the written interview. The results of the study will be reported in scientific magazines or journals but your name or any other identifying information will not be included.

Initials: _____

A second risk in this study is loss of anonymity. Although, anonymity cannot be guaranteed because of the nature of this study, the following steps will be taken to minimize this risk:

(a) No names will be used during the interview, but should someone accidentally say a name in the interview, that name will be redacted from the transcript.
(b) Participants will also be advised of the importance of not mentioning specific patient names, times, or locations in order to protect patient privacy. However, should someone accidentally say a specific patient name, times, or locations in the interview, that information will be redacted from the transcript.
(c) Only the researcher will have access to the transcripts, so as to maintain the confidentiality of the participants.

A third risk in this study is loss of time for participants. The interview will last approximately 90 minutes depending on the amount of information you have to share. Your participation in the study is voluntary, and you may choose to stop your participation at any time.

Another risk in this study is that participants may get fatigued. Participants may take breaks as needed, or stop participating at any time.

Participation and Benefits

Many people find it helpful to have someone listen to their viewpoints and experiences. The information you provide will provide a better understanding about promoting medication adherence among elderly patients who live in the community. The hope is that this information will be of use to other home health agency personnel, health care providers, and regulatory agencies.
At the conclusion of the interview, you will receive a $20 gift card as a benefit of participating in the study.

If you would like to know the results of this study I will mail them to you*
Your involvement in this study is completely voluntary and you may withdraw from the study at any time.

Questions Regarding the Study

You will be given a copy of this signed and dated consent form to keep. If you have any questions about the research study you should ask me; my phone number and email are at the top of this form.
If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

_____ _____
Signature of Participant Date

* If you would like a copy of the written down interview to be emailed to you tell us your email address
Email: _____

* If you would like to know the results of this study tell us where you want them to be sent:

Email: _____ Postal Address: _____

_____

Approved by the
Texas Woman's University
Institutional Review Board

Appendix E

Demographic Form

Participant ID: _____

Interview Date: _____

Principal Investigator: Olusola Adeniran, RN, MS

Directions: I am going to ask you about your background. For each question please choose ***one option*** that ***most closely applies*** *to you.*

1. What is your present position?

☐ Registered Nurse

☐ Licensed Vocational Nurse

☐ Other (Please name) _____

2. How long have you worked in the field of Home health?

☐ Less than 1 year

☐ 1 - 3 years

☐ 4 - 6 years

☐ 7 - 10 years

☐ More than 10 years

4. What is your highest ***completed*** level of education?

☐ Associate

☐ Diploma

☐ Bachelors

☐ Masters

☐ Doctorate

☐ Other (Please name)_____

5. What is your gender?

☐ Female
☐ Male
☐ Decline to State

6. In what group do you mostly place yourself?

☐ African-American/Black
☐ African Indian/Alaskan Native
☐ Asian/Pacific Islander
☐ Caucasian
☐ Hispanic/Latino
☐ Other (Please name) _____

7. Which of the following best describes your agency?

☐ Part of a regional organization
☐ Part of a national corporation/franchise
☐ VNA or member of a consortium
☐ Sole proprietorship
☐ Other (Please name) _____

8. In addition to English, what other language do you communicate with? (select all that apply)

☐ Spanish
☐ Vietnamese
☐ Chinese

☐ Urdu

☐ Arabic

☐ Other (Please name) _____

APPENDIX F

Interview Protocol and Question Guide

Interview Protocol and Question Guide

Figure 1 Interview Protocol

Time of Interview: _____

Date: _____

Place: _____

Interviewer: Olusola Adeniran, RN, MSN

Participant's Code: _____

1.Exchange of greetings and pleasantries

2. Have Participant Complete Consent and Demographic Information Form

3. Questions:

a. Please tell me about your experiences working with elderly patients in home-health?
b. Please tell me about your experiences on medication use among your elderly patients in home-health?
c. Who do you think should be responsible for promoting medication adherence among elderly home-health patients?
d. How have you promoted medication adherence behaviors among your elderly patients in home health?
e. What are the challenges that you have experiences with promoting medication adherent behaviors among your elderly patients in home health?
f. Please describe your experiences with medication adherence promotion among the different types of elders (for example, racial groups, gender and economic status)
g. Please tell me about trainings or in-services that you have attended on medication adherence promotion. Who sponsors or pays for such trainings
h. What are the other sources where you gain information about promoting medication adherence among the elderly

i. How would you describe your supervisor or manager's attitude toward promoting medication adherence?
j. Does your agency have policies and procedures on promoting medication adherence
k. What does the insurance payer (e.g. Medicare, Medicaid or Private Insurance Companies) say regarding promoting medication adherence among community-dwelling elderly patients?
l. What does your professional association (e.g. Association of HH Organization, The Board of Nursing) say regarding promoting medication adherence among community-dwelling elderly patients?
m. What does the nursing Code of Conduct say about promoting medication adherence?
n. Are there any other things that you would like to tell me about promoting medication adherence among your elderly patients in the community that I may not have asked?

4. Thank the individual for participating in the interview, assure of confidentiality of responses.

APPENDIX G

Field Note Guide for Home Health Nurse Interview

Field Note Guide for Home Health Nurse Interview

Participant ID: _____

Interview Date: _____

Interview setting:

Characteristics of interviewee (dress, demeanor, distractions):

Notes for Interviewer (e.g., questions that “worked”, questions that “flopped”, areas that needed improvement, aspects that went well)

APPENDIX H

CMS Drug Regimen Review Standard

The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

Interpretive Guidelines §484.55(c) The expected outcomes for this Level 1 standard are:

• The comprehensive assessment consistently includes a thorough review of the patient's medications, including all prescribed and over-the-counter medications the patient is using, to identify any potential adverse effects and drug reactions;

• The patient's medication list or medications are reviewed and the medication profile/list is updated; and

• The physician is notified promptly regarding any medication discrepancies, side effects, problems or reactions.

See also §484.30(a) This requirement applies to all patients being serviced by the HHA, regardless of whether the specific requirements of OASIS apply. For patients to whom OASIS does not apply, the drug regimen review must be conducted in conjunction with the requirements at §484.18, Condition of Participation: Acceptance of patients, plan of care, and medical supervision. The drug regimen review must include documentation of ALL medications the patient is taking. Review medications on the current physician plan of care and in clinical record notes to determine the accuracy of the medication regimen. This may be included as part of the case-mix, stratified sample of clinical records. Determine if clinical record documentation includes medication review, etc. In therapy only cases, determine the HHA's policy for medication review. Drugs and treatments ordered by the patient's physician and not documented on the care plan should be recorded in the clinical record. This includes over-the-counter drugs. If the qualified clinician (RN or therapist) determines that the patient is experiencing problems with his/her medications or identifies any potential adverse effects and/or reactions, the physician must be alerted. The label on the bottle of a prescription medication constitutes the pharmacist's transcription or documentation of the order. Such medications are noted in the patient's clinical record and listed on the physician plan of care. This is consistent with acceptable standards of practice. Federal regulations do not have additional requirements. If questions are raised through interview or record review, examine the HHA's policies on drug review and actions.

Onsite Activity - Interview clinical staff, asking them to describe their process of drug regimen review including:

• How are potential adverse effects and drug reactions identified? • What steps does the HHA require its personnel to take?

• What process is followed when a patient is found to be noncompliant?

• How is the drug regimen review completed if the patient is receivingm only therapy services?

• How are drugs reviewed when medication orders are modified or changed after the start of care comprehensive assessment in multi-discipline cases and in therapy-only cases? Probes §484.55(c)

• What is the HHA's policy for drug regimen/medication review?

• How does the HHA respond to medication discrepancies and prescriptions from physicians other than the physician responsible for the patient's home health care?

• If HHA personnel identify patient sensitivity or other medication problems, what actions does the HHA require its personnel to take?

REFERENCES

CMS State Operations Manual (2014, May 5). Standard: Drug Regimen Review.

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APPENDIX I

Medication List and Monitoring Policy

Medication List and Monitoring Policy

PURPOSE

To outline a process for ongoing medication monitoring.

POLICY

An Agency RN will be responsible for coordinating the efforts of monitoring the medication regimen by compiling assessment data through a collaborative effort of all Agency staff involved in the patient's care. A medication profile/list will be maintained on all patients.

Medication monitoring will include appropriate date/information to develop an accurate patient medication history and a current, complete medication profile. This data will be available to all Agency staff involved in the patient care.

Assessments of a patient's response to the medication regimen are used when evaluating the continuation of the medication regimen, evaluating patient's compliance, and/or identifying problems.

PROCEDURE

1. Agency will maintain a current, accurate list of all prescription and over-the-counter (OTC) medications taken by the patient (Medication Profile). Oxygen therapy including liters per minute, route and frequency will be documented on the medication profile.

2. A prescription is considered an order from a physician that has been transcribed by the pharmacist. The medication will be documented in the medical record and added to the subsequent Plan of Care.

3. This medication profile will also include:

- dosage
- administration schedule
- route
- initial order and discontinuation dates where applicable
- Indication whether the medication is new (N) or changed (C).

4. The Registered Nurse will monitor medications for potential adverse effects and drug reactions including ineffective drug therapy, significant side effects, significant drug interactions and duplicate drug therapy.

5. Agency nursing staff will assess on an ongoing basis the patient's response to the medication and the patient/caregiver's compliance with the medication regimen.

6. Adverse patient response, lack of patient response, and/or compliance concerns will be communicated to the physician as well as documented in the medical record.

7. Changes in the medication regimen will be documented in the medical record either on the medication profile or on a verbal order, as well as communicated to the patient and/or caregiver. Changes in medication regimen will be documented on the Medication Profile at least every 30 days.

REFERENCES

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APPENDIX J

OASIS Medication Assessment

OASIS Medication Assessment

1. (M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues? Identifies if review of the patient's medications indicated any potential clinically significant medication issues.
2. (M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?
3. (M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?
4. (M2010) Patient/Caregiver High-Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?
5. (M2016) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?
6. (M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)
7. M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.
8. (M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation or injury

REFERENCES

Outcome and Assessment Information Set. (2017, January 1). Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-C2-Guidance-Manual-6-17-16.pdf

APPENDIX K

HHCAHPS Medication Survey

HHCAHPS Medication Survey

SURVEY INSTRUCTIONS

Answer all the questions by checking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this: 4, 5, 11, 12, 13, 14

☑ Yes ➔ **If Yes, go to Q1 on Page 1.**

☐ No

4. When you started getting home health care from this agency, did someone from the agency talk with you about all the **prescription and over-the-counter medicines** you were taking?

   ☐ Yes

   ☐ No

   ☐ Do not remember

5. When you started getting home health care from this agency, did someone from the agency ask to **see** all the prescription and over-the-counter medicines you were taking?

   ☐ Yes

   ☐ No

   ☐ Do not remember

11. In the last 2 months **of c**are, did you take any new prescription medicine or change any of the medicines you were taking?

   ☐ Yes

   ☐ No ➔ **If No, go to Q15.**

12. In the last 2 months of care, did home health providers from this agency talk with you about the **purpose** for taking your new or changed prescription medicines?

   ☐ Yes

   ☐ No

   ☐ I did **not** take any new prescription medicines or change any medicines

13. In the last 2 months of care, did home health providers from this agency talk with you about **when** to take these medicines?

- ☐ Yes
- ☐ No
- ☐ I did **not** take any new prescription medicines or change any medicines

14. In the last 2 months of care, did home health providers from this agency talk with you about the **side effects** of these medicines?

- ☐ Yes
- ☐ No
- ☐ I did **not** take any new prescription medicines or change any medicines

REFERENCES

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