Case #1 – Clinician

- Be the clinician taking a best possible medication history
- Use the space below to document your best possible medication history

It is Thursday October 1, 2015 at 9:00am, you are going to see patient Victoria Kaminsky in the Emergency Department

You are working with a computer system that allows you access to longitudinal medical records for the patient, and the computer provides you with the information below.

You can use the attached checklist of high performance behaviors and the supplied pocket guide to help you.

Patient VK is a 62 year old female whose date of birth is 09/21/1953.

Reason for Hospital Admission: Knee Swelling and Pain

Past Medical History: HTN, DVT, Chronic Headaches

Allergies: lisinopril – cough; thiazides: rash; and clonidine: rash

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Medications (based on ED discharge summary 2 years ago):

Amlodipine 5mg PO daily

Vitamin B complex 1 tablet daily

High Performance Behaviors

• Asks the patient open-ended questions about what medications she or he is taking (i.e., doesn't read the list and ask if it is correct)

• Uses probing questions to elicit additional information: non-oral meds, non-daily meds, PRN medications, non-prescription meds

• Uses other probes to elicit additional medications: common reasons for PRNs, meds for problems in the problem list, meds prescribed by specialists

• Asks about adherence

• Uses at least two sources of medications, ideally one provided by the patient and one from another "objective" source (e.g., patient's own list and ambulatory EMR med list)

• Knows when to stop getting additional sources (e.g., if patient has a list or pill bottles and seems completely reliable and data are not that dissimilar from the other sources, and/or the differences can be explained)

• Knows when to get additional sources if available (e.g., if patient is not sure, relying on memory only or cannot resolve discrepancies among the various sources of medication information)

• When additional sources are needed, uses available sources first (e.g., pill bottles present). Then obtains pharmacy data. If the medication history is still not clear: obtains outpatient provider lists, pill bottles from home and/or other sources.

• Uses resources like Drugs.com to identify loose medications (i.e., for a bag of medications, not in their bottles, provided by a patient)

• Returns to patient to review new information, resolve all remaining discrepancies

• Gets help from other team members when needed

• Educates that patient and/or caregiver about the importance of carrying an accurate and up to date medication list with them

Case #1 – Observer

- Listen carefully to the exchange between patient and clinician
- Complete the "High Performance Behaviors Checklist"
- Compare the clinician's final medication list to the "gold standard," attached
- Be prepared to give feedback to your colleagues:
    - Did they use high performance behaviors?
    - Did they achieve an accurate Best Possible Medication History (BPMH)?

If the clinician calls for any of the following: pharmacy medication list, Primary care physician's medication list, or neurologist's medications list, you should given them a copy of these materials which are contained in your packet.

If PCP is asked about the blood clot 30 years ago, say it was after surgery, clear precipitant, on anticoagulation for 6 months, then stopped it, has not had a problem since.

Notes:

"Gold Standard" Preadmission Medication List
(Do Not Share with Clinician)

- ASA 81mg (1 tablet) by mouth daily "for heart"
- Amlodipine 10mg by mouth daily "for blood pressure"
- MVI 1 tablet by mouth daily "for general health"
- Acetaminophen 500mg (1 tablet) by mouth bid PRN for pain or headaches (takes several days per week)
- Albuterol Inhaler: 1-2 puffs inhaled q6h PRN for shortness of breath, currently using it 1 puff a day

- Patient does not take vitamin B complex which was self discontinued

High-Performance Behaviors Checklist

Asks the patient open-ended questions about what medications she or he is taking (i.e., doesn't read the list and ask if it is correct)	☐
Uses probing questions to elicit additional information: non-oral meds, non-daily meds, PRN medications, non-prescription meds • Patient will only describe MVI and Albuterol inhaler if prompted	☐
Uses other probes to elicit additional medications: common reasons for PRNs, meds for problems in the problem list, meds prescribed by specialists • Patient will only mention Tylenol if prompted by headaches or neurologist	☐
Asks about adherence • Patient will mention non-adherence with vitamin B complex if asked	☐
Uses at least two sources of medications, , ideally one provided by the patient and one from another "objective" source (e.g., patient's own list and ambulatory EMR med list) • In this case, patient's memory, patient's bag of medications in the purse are some of the possible sources	☐
Knows when to stop getting additional sources (e.g. if patient has a list or pill bottles and seems completely reliable and data are not that dissimilar from the other sources, and/or the differences can be explained)	☐
Knows when to get additional sources if available (e.g., if patient is not sure, relying on memory only or cannot resolve discrepancies among the various sources of medication information)	☐
When additional sources are needed, uses available sources first (e.g., pill bottles present). Then obtains pharmacy data. If the medication history is still not clear: obtains outpatient provider lists, pill bottles from home and/or other sources. • Other sources available in this case include PCP and neurologist medication lists	☐
Uses resources like Drugs.com to identify loose medications (i.e., for a bag of medications, not in their bottles, provided by a patient)	☐
Returns to patient to review new information, resolve all remaining discrepancies • Clinician should clarify medications including those from patient's bag, and dose of amlodipine	☐
Gets help from other team members when needed	☐
Educates the patient and/or caregiver of the importance of carrying an accurate and up to date medication list with them	☐

Case #1 – Outpatient Pharmacy Records

*** For Clinician ***

The patient's pharmacy is able to provide you with the following information (recently filled medications).

- Amlodipine 10mg (two 5mg tablets) by mouth daily, 30 day supply dispensed 12 days ago
- Albuterol inhaler 1-2 puffs q6h prn shortness of breath, 1 inhaler dispensed 1 month ago
- Vitamin B Complex 1 tablet daily, 30 day supply dispensed 1 year ago

Case #1 – Primary Care Physician's Medication List

*** For Clinician ***

The patient's clinician is able to provide you with the following information

Amlodipine 5mg tablets, take 2 by mouth daily "for blood pressure"

Vitamin B complex 1 tablet daily

Case #1 – Neurologist's Medication List

*** For Clinician ***

Amlodipine 10mg (two 5mg tablets) by mouth daily "for blood pressure"

Acetaminophen 500mg (1 tablet) by mouth bid PRN for pain or headaches

Vitamin B complex 1 tablet daily

Case #1 – Patient

Be the Patient and Follow Your Role:

Today is October 1, 2015. You are Victoria Kaminsky, a 62 year old female whose date of birth is 09/21/1953. You have come to the Emergency Department by yourself with knee swelling and pain. Your past medical history includes high blood pressure, blood clot in your leg (after surgery 30 years ago, no problems since), and chronic headaches. Your allergies are: lisinopril – cough, thiazides: rash, and clonidine: rash.

The clinician entering the room has access to some of your longitudinal medical records.

For role play purposes: If the clinician asks for your pill bottles, you should give them the sheet with the picture of pills – tell the clinician you have these in a container in your purse. If the clinician recognizes the need to look these up in an online database like Drug.com, then hand them the list of what those medications are. Both of these are in your packet.

If asked about prescribers: you have a PCP and a neurologist for headaches. If asked, can supply contact information for each one: PCP is Dr. James Smith, White River Medical Associates, Springfield. Neurologist is Dr. Jane Cross, Springfield Neurology Partners, Springfield.

Role Play Regarding your Medications as Follows:

- **If asked if you have a list of medications:**
  Explain that you do not keep a list

- **If asked to list or describe what medications you take (without any other prompts) you state:**

  Baby aspirin and Amlodipine (You decided ASA might be good for your heart)

  You think dose of amlodipine is 5 mg, but you're not sure

- **If asked if you have medication bottles present, or for your pharmacy's name or number:**
  You do not have your medication bottles with you but you do have some of your medications with you in your purse (see above). You do know your pharmacy: Walgreen's located on Spruce Street in Springfield.

- **Only if asked about non-prescription medications do you know the following:**

  You remember you take a multivitamin (Centrum Silver) 1 tablet daily for your general health.

- **If asked about your headaches (on your problem list) or if anything is prescribed by a specialist**
  You also take Tylenol 1 pill twice a day several days each week as needed for pain or headaches (which was recommended by a neurologist you saw for headaches). You don't know the strength but have some in your purse. *You can provide pills in purse, pass on the loose pills picture as above*

- **If asked about Non-Oral meds:**

  You use an albuterol inhaler when you feel short of breath which you got from a "Convenient MD" stop last month when you had a cold that made you short of breath. You have been using the albuterol inhaler 1 puff daily for a month. You do not know how often you could use it.

  If asked about adherence: You take your medications most days, but discontinued Vitamin B complex of your own accord. Maybe you miss your pills 1 day a week on average.

You deny any issues with costs/copayments/insurance coverage, running out, side effects, and deny thoughts of your medications not working if asked

If asked about specific medications after clinician has accessed sources of medication information:

If asked if you take Amlodipine: 5 mg (take 1 tablet) or 10 mg (take 2 tablets): you know you used to be on 5 mg (1 tablet), but a year ago your PCP increased the dose to 10 mg (2 tablets). So you do take 2 tablets of amlodipine daily.

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Final Correct list (for your use only) after you have been asked multiple probing and clarifying questions:

(Do Not Share with Clinician)

- ASA 81mg (1 tablet) by mouth daily "for heart" (which was omitted from patients prior pre-admission med list)
- Amlodipine 10mg by mouth daily "for blood pressure" (your home pharmacy can verify prescription for 5mg tablets take 2 by mouth daily – not just 5mg daily)
- MVI 1 tablet by mouth daily for general health (not vit B complex which was self discontinued)
- Acetaminophen 500mg (1 tablet) by mouth bid PRN for pain or headaches (takes several days per week)
- Albuterol Inhaler: 1-2 puffs inhaled q6h PRN for shortness of breath, currently using it 1 puff a day

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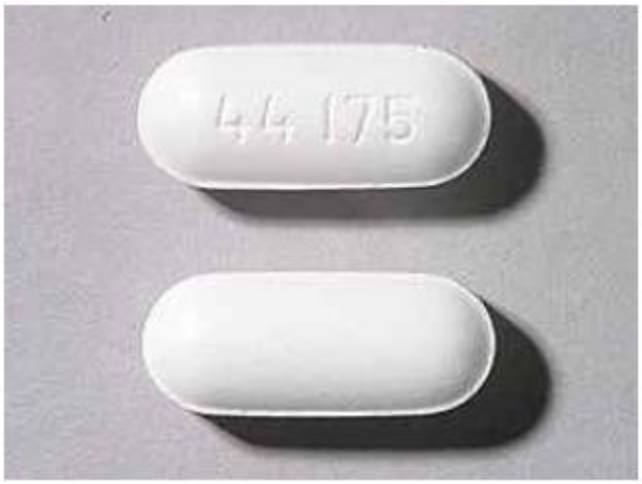
Case #1

Loose pills in a small unmarked container in purse

For Clinician



And

Case #1

Loose pills in a small unmarked container in purse: Identified

For Clinician

If clinician recognizes need to use a Pill Identifier:

White tablet is acetaminophen 500mg

Orange tablet is aspirin 81mg