**Case #3 – Observer**

* Listen carefully to the exchange between patient and clinician
* Complete the “High Performance Behaviors Checklist,” attached
* 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 asks for the outpatient pharmacy records, please give him/her the pharmacy list, attached.

If the clinician asks for other medication sources, say that they are not available (except for the bag of medications, which the patient should give the clinician if asked)

The PCP’s office is closed for the day.

**Notes:**

**“Gold Standard” Preadmission Medication List**

**(Do Not Share with Clinician)**

* Omeprazole 40 mg 1 capsule by mouth 30 minutes before breakfast for heartburn problems
* Metoprolol ER 12.5mg (**one-half** of the ER 25mg tablet**)** by mouth every morning for blood pressure
* Losartan 25 mg 1 tablet by mouth every morning for blood pressure
* ECASA 81 mg one tablet by mouth daily for stroke protection
* Atorvastatin 40 mg 1 tablet at bedtime for cholesterol
* Hydrocodone/Acetaminophen 5/325 mg 1-2 tablets every 8 hours as needed for hip pain (patient takes 1 tablet 2-3 times a day)
* Vitamin D2 1.25 mg capsule (50,000units) take once capsule by mouth once weekly (patient takes on Saturdays)
* Acetaminophen 500 mg 1 tablet by mouth twice daily as needed for headache or pain
* Patient does not take enoxaparin or ibuprofen (those are for after surgery)
* Patient stopped taking the diclofenac several weeks prior to surgery (per surgeon’s instructions) and does not plan to resume post operatively.
* Cetirizine 10 mg by mouth daily prn allergy symptoms (Patient has not taken in several months) – this does not need to be included on the gold standard list since not taken recently.

**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)   * Patient will only describe metoprolol ER dose correctly as one-half tablet if asked “how are you taking this med” or “describe how you take this”, rather than “are you taking the metoprolol ER one tablet daily?” |  |
| Uses probing questions to elicit additional information: non-oral meds, non-daily meds, PRN medications, non-prescription meds   * Patient will only describe Vitamin D if probed for non-daily medications or if probed after clinician contacted pharmacy. * Patient will only describe Tylenol if asked about OTC medications * Patient will only describe cetirizine if asked about seasonal medications |  |
| Uses other probes to elicit additional medications: common reasons for PRNs, meds for problems in the problem list, meds prescribed for 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)   * In this case, patient’s memory, patient’s bag of medications |  |
| 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)   * Once the metoprolol dose is explained rationally, the additional medications listed from the pharmacy and missing medication from the patient’s medication bag can be explained, the clinician should stop getting additional information. |  |
| 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)   * Clinician should seek to clarify / explain the following inconsistencies with additional sources: metoprolol ER, hydrocodone/apap, ibuprofen, enoxaparin, diclofenac, acetaminophen, cetirizine, and vitamin D. |  |
| 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.   * Clinician may miss correct hydrocodone/acetaminophen dose/frequency if he/she does not ask patient if medications are present |  |
| Uses resources like Drugs.com to identify loose medications (i.e., for a bag of medications, not in their bottles, provided by patient) |  |
| Returns to patient to review new information, resolve all remaining discrepancies   * Clinician should clarify “extra” medications from patient’s bag (e.g., OTC omeprazole) and from pharmacy records (e.g., enoxaparin) |  |
| 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 #3 – Outpatient Pharmacy Records**

**\*\*\* For Clinician \*\*\***

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

**Today is October 1, 2015**

* Omeprazole 40 mg take one capsule orally 30 minutes before breakfast
  + Last filled 9/12/15
* Metoprolol succinate ER 25 mg take one tablet daily
  + Last filled 9/12/15
* Losartan 25 mg take one tablet daily
  + Last filled 9/12/15
* Atorvastatin 40 mg take 1 tablet at bedtime
  + Last filled 9/4/15
* Vitamin D2 1.25 mg 50,000 units take one capsule once per week
  + Last filled 9/4/15
* Ibuprofen 800 mg take one tablet every eight hours as needed for pain
  + Last filled 9/29/15
* Enoxaparin 40 mg subcutaneously daily as directed
  + Last filled 9/29/15
* Diclofenac sodium EC 75 mg take one tablet by mouth two times per day
  + Last filled 9/2/15