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SMHSOP15B, Medication History Technician Workflow and How to Obtain the Best Possible Medication List at Strong Memorial Hospital

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PURPOSE

The purpose of this procedure is to standardize how technicians obtain a medication history and the subsequent best possible medication list.

SCOPE

Technicians obtaining medication histories must follow the procedures outlined in this document.

EXCEPTIONS

None

DEFINITIONS

ALF = Assisted Living Facility

BPML = Best Possible Medication List

MAR = Medication Administration Record

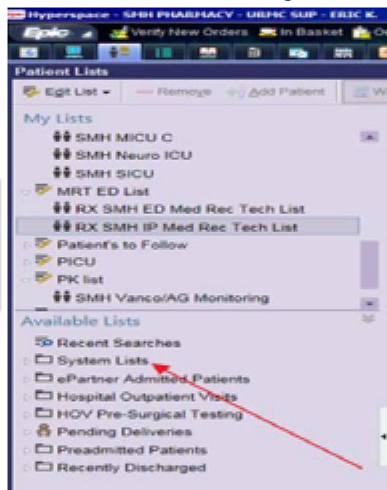
PTA = Prior to Admission

SNF = Skilled Nursing Facility

Med Hx = medication history

PROCEDURE

1. Set up your patient lists (you will only need to do this once)
   a. Go to "Patient Lists", click on the wrench to "Edit List", and select "Create My List".
   b. Name the list "Medication History Workflow".
   c. Select the following columns of data to start (they may be edited to each technician's individual liking): Patient Name/Age/Gender; DOB; Location; Admission Date; Patient Class; Med List Status; Prior to Admission Patient Score; Isolation/Infection; Discharge Med Rec Complete?; Expected D/C Date; Last Discharge; Length of Stay (Days).
   d. Once all columns are added click accept and your list will be built.
   e. To add your units to the list, first select "System Lists" and click to open "SMH Units" - find your units and click and drag them into your Med History Workflow list.



2. Selecting and reviewing your patients from the eRecord patient list.
   a. Click column header to sort based on Prior to Admission Patient Score acuity score.
      i. Work should be triaged based on prior to admission patient acuity score (i.e., higher score should take precedence over lower score), patient class of "inpatient", length-of-stay (patients with a long stay in the critical care units of 30 days or more would not be a high priority as their home medication list at this point is less impactful) and communication with the pharmacy specialist covering the unit.

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ii. If the pharmacy specialist covering a unit is absent and has no back-up coverage, the patients on this unit will be given the lowest priority since they do not have a pharmacist assigned to review the information and act upon it.

iii. If a fellow medication history technician is absent and has no back-up coverage, the remaining technicians will ensure all the units have coverage by focusing on the highest acuity patients on all units and dividing them equally amongst each other.

b. Review column header "Med List Status" to determine if another technician or pharmacist is already working on a patient, or if the medication history (med hx) is already completed.

   i. Do not work on a patient's medication list if "Med List Status" shows:

      - "In Progress: Pharmacy Technician" (another technician is working on the list)
      - "Acknowledged by Pharmacist" (med hx completed)
      - "Pending Pharmacist Review" (pharmacist still needs to review med hx)

c. For each patient selected for review perform the following:

   i. Under the Summary tab, select "Story" to obtain a brief synopsis of the patient such as their medical background, the reason for their hospital visit, their living situation (home vs facility), recent hospital stays and family information.

   ii. Review expected discharge date. Communicate with the pharmacy specialist covering that unit to determine whether it would be worthwhile to review patients with impending discharges.

   iii. Select the "LPOC" tab to review "Patient Contact Info" box which will list their preferred language. If there is an expected language barrier, interpretive services will need to be contacted prior to the interview.

      - For Spanish-speaking or deaf patients: utilize Web paging and search "Interpreter", then select "Interpreter Sign Language On Call" or "Interpreter Spanish Language On Call" or call extension x52222
      - For other language needs, utilize the Cyracom interpreter services by calling 1(800)481-3293 for account #501013287 and pin #2060

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d. Based on the information above, compile a list of patients which will be reviewed.

    i. Time permitting, patients can be added later in the day. If all patients on the assigned units are completed prior to the end of shift, offer to help fellow medication history technicians with their patient lists.

    ii. Any patient medication histories are not completed by the end of the day may be completed during the following shift or assigned to another medication history technician. Direct communication of medication history delays to the pharmacy specialist are only required if the pharmacist had indicated that they were anticipating the completion of a medication history.

3. Update the status on patient's prior to admission (PTA) medication list.

    a. Double click on patient's name from your patient list.

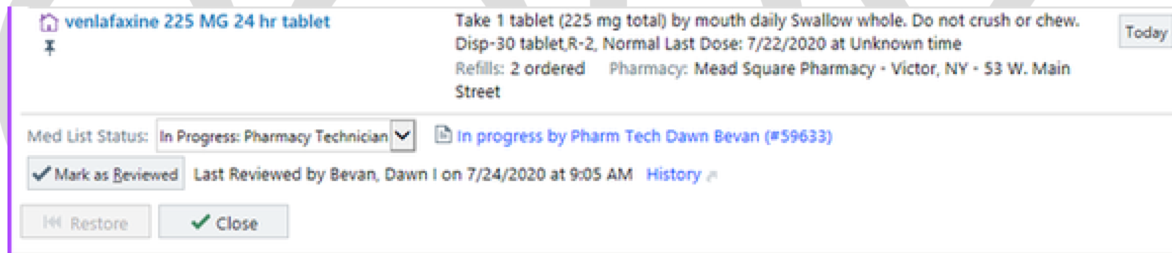
    b. Choose "Medication History" tab.

    c. Choose "Prior to Adm Meds" along left side column which will take you to Review Prior to Admission Medications.

    d. Change the Med List Status on the bottom of the med list to: "In Progress: Pharmacy Technician".

    e. Next to the Med List Status is a Reconciliation Comment box in which the technician's name and phone number will be entered. Click "Accept" to save changes.

    f. Click the "Mark as Reviewed" button under the med list status scroll bar.



4. Obtain prescription fill history (the following steps do not need to be performed in any particular order):

    a. Review the medications listed in Prior to Admission Medications List and evaluate them for completeness (drug name, dose, frequency, and indication for "prn" medications).

    b. Compare the above list to insurance claim history through "Dispense Report" in eRecord or DrFirst https://acmedhx101.drfirst.com/.

    c. If patient has had a recent hospital admission (within past 30 days), review their after-visit summary (AVS) for the list of medications.

        i. Click on the admission, then click on "IPAVS" on the right. This will show an updated medication list as instructed by the hospital, list any new medications and display which pharmacy they were sent to. (This may not be there most up to date medication list depending on how far back the admission was. Always consider that medication changes may have been made by outpatient providers between this last admission and new one).

        ii. If the patient had a review by a medication history technician at a recent admission, the information will be available under their encounter. Select Rx Consult, Medication History,

and Med Hx Review. The pharmacist's note may also be visible under the "Notes" tab.

d. If patient uses a retail pharmacy, call to confirm medication information, recent fills, and consistency of medication pick-up or delivery. This step may be skipped at the discretion of the medication history technician if there are no questions in the information provided by DrFirst or the patient interview.

   i. The patient's preferred pharmacy is found at the top of the Prior to Admission Medications list. Clicking onto the listed pharmacy will allow a full view of all pharmacies listed and allow edits to be made.

   ii. To update pharmacy information in eRecord go to Rx Consult; Medication History; Prior to Adm Meds and click on "Pharmacy":

      - **To change primary pharmacy:** highlight/click on the star to change primary pharmacies.
      - **Removing a pharmacy**: click on already highlighted star in order to remove the highlight and also remove it from their list.
      - **Adding a pharmacy:** Type in pharmacy name in field box. Type in fewer characters if pharmacy is not found. Some stores are listed differently (WalMart, Wal-mart, wal mart). Highlight the star if it is a preferred pharmacy and click "Accept".

   iii. Have patient information readily available such as date-of-birth.

   iv. For Mail order pharmacy, be prepared to provide patient phone number and address and Strong pharmacy NPI # 1609937796

   v. Focus on medications filled in last 90 days.

   vi. If the pharmacy prefers to fax the list, have them send it to 585-276-2726 (the fax machine in the 5th floor office 5.6729)

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e. For patients receiving medication therapy that will not be captured through insurance claims (at clinics or through the Veterans Affairs system):

   a. Review "CareEverywhere" in eRecord for documentation. Before accessing any documents, be sure to click the "update" button to capture the most recent information.

      i. Veterans Affairs: scroll down to the patient medication history which will display active medication orders, doses, and date of last fill. Unless there is a question or discrepancy, no follow-up phone call needs to be made to the VA to confirm the medications

      ii. Hemodialysis Centers: click into "Summary of episode" note and review "Medications: Prescribed Medications for Dialysis Treatments". Add any "active" medications to patient medication list and note that they are given at dialysis. Do not use the section listing home medications as a reference as these are not a reliable source.

      iii. Medications received in clinics (Clinic Administered Medications or CAM): select "Chart Review" tab, select "Meds", unclick box denoting "Current Meds Only" and look for column "AMB/CAM/IP" and search for medications listed under "CAM" . Details can be found by clicking into the order. These are commonly methadone doses or long-acting injectables.

f. For patients admitted from a facility (group home or skilled nursing facility (SNF)) Look at patient's paper chart on unit to find med list/MAR form (**current** MAR is preferred to simple medication list)

   i. Check to see if the MAR has been scanned into the patient's electronic chart (typically found under the media tab).

   ii. Some URMC facilities are linked to eRecord. Their MAR may be accessed by selecting their admission to the facility and viewing the MAR report or by selecting that patient's current admission, clicking into Medications and filtering by admission to show medications and recent administrations from the facility.

   iii. If the MAR is not in the chart, call institution to go over medications or have them fax the list to 585-276-2726 (5th floor office 5.6729) Place a copy of MAR or medication list in the patient's chart.

5. Interview patient and/or caregiver (see Appendix I to review information that needs to be obtained).

   a. To ensure safety, please follow hospital policy for standard precautions (Policy 2.2) and isolation patients (Disease Chart for Isolation Precautions - Section IV) when conducting an interviewing.

   b. The patient listed in bed "A" or "1" will be by the door and the patient in bed "B" or "2" will be by the window.

   c. Use PTA list in eRecord and any information obtained via Surescripts or DrFirst. If there is NO information from either database, call the pharmacy before the interview and use this as a source of truth.

   d. Introduce yourself to patients and family members.

   e. Verify patient's identity using 2 identifiers (name and date-of-birth).

   f. Ask patient/caregiver if it is an appropriate time to discuss their medications. If family or friends are present, ask the patient if they prefer to have the discussion in private.

   g. Inquire which pharmacy(-ies) the patient utilizes and their locations (cross compare this with the pharmacy information collected from Step 4d).

      i. Ask patient if they have a preferred pharmacy.

      ii. Determine if they utilize other pharmacies for specific medications or supplies. For example: Wegmans for short-term meds like antibiotics, but Express Scripts for mail order pharmacy for chronic meds.

   h. Clarify patient's medication allergies.

      i. Verify with patient a "no known allergies" status.

      ii. For patients with allergies listed, clarify any "unknown reactions" if possible.

         - To correct allergies in eRecord: go to Rx Consult; Medication History; Allergies:

            a. To add a new allergy:

               - Type in medication/allergen to "Add a new agent" field box and enter as much information as possible: Reaction (select from drop-down menu or select "other" and enter comments in box); Severity (High, Medium, Low); Reaction Type (Allergy, Contraindication, Intolerance, Unspecified).

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b. To modify or delete allergies:
  - Click on specific drug/allergen.
  - To delete choose delete button.
  - To change information type in additional comments or choose a different reaction type.

i. Ask patient/caregiver who manages/takes care of patient's medications.
  i. If another person manages patient's medications:
    - Ask patient for their permission to be contacted.
    - Find contact information (name, relationship to patient, phone #).
    - If patient does not have contact info you can look in eRecord.

j. Ask if patient/caregiver has a medication list or medication bottles to review. Use to cross reference with DrFirst, Surescripts and/or eRecord.

k. Use interview skills/techniques from Marquis video and handouts.

l. Compare PTA list with the patient/caregiver **and focus on the discrepancies including the following:**
  i. Discrepancies between eRecord PTA list, DrFirst, Surescripts, and/or patient/caregiver list(s).
  ii. Medications on list they are NOT taking anymore and, if known, why (e.g., did not tolerate, outside provider stopped, completed therapy, cost, general non adherence, etc.).
  iii. Medications on list they are taking differently than what is listed and, if known, why (did not tolerate, outside provider changed regimen, completed therapy, cost, general non adherence, etc.).
  iv. Medications they are taking at home but are NOT on the eRecord PTA list including:
    - Prescription medications
    - Over-the-counter medications (medications they do not need a prescription to obtain)
    - Herbal medicines
    - As needed medications (clarify the indication for them as well)
      a. Ibuprofen every now and then for pain
      b. Zolpidem some nights for sleep
      c. Try to find how much and how often they take these as needed medications:
        - Zolpidem 5mg tablet at night for sleep about twice a week
        - Albuterol inhaler for shortness of breath: have not taken in months
    - Medications taken on a non-daily basis (once a week, once a month, every other day, etc.).
      a. Clarify weekly Methotrexate dose and which day it is administered.
      b. For Long-Acting Injectable Antipsychotics (see Appendix II for list), obtain dose

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and last administration date. Consider opening "Medication" tab in eRecord and filtering by the specific medication. Double click on the most recent administration - the date and dose should be listed toward the bottom of the screen.

v. Focus on certain medications whose regimens may change frequently.
   - Warfarin/Coumadin/Jantoven
   - Tacrolimus/Prograf
   - Cyclosporine/Neoral, Sandimmune, Gengraf
   - Furosemide/Lasix
   - Torsemide/Demadex
   - Bumetanide/Bumex
   - Insulins
     a. Find how patient was taking any of the above medications before admission to the hospital.
     b. Determine what formulation and strength tablet/capsule they were using:
        - Insulin: vials vs pens
        - Warfarin: 6mg every day using one 5mg tablet + one 1 mg tablet

vi. Close the interview by thanking the patient for their time.
   - If the patient had any questions or requests for a pharmacist, notify the pharmacist as soon as possible.

6. Documenting PTA eRecord medication list:
   a. Adding a medication (patient taking a medication which is not already on the list).
      i. Rx Consult—Medication History—Prior to Adm Meds—"New home med" (search field at top of list).
      ii. Type in name or part of name into new home med field and select correct formulation.
         - If medication is not listed, choose "Database Lookup" tab at top of the list. This will provide more selections.

      iii. Follow the instructions to fill out home regimen including dose, route, frequency, and indications (if prn medication) and press "Accept".
      iv. Choose "Order Note" icon to the right of the medication.
         - Type in smart phrase "Added" next to this medication (more information on smart phrases listed below).

   b. Changing medication regimen (patient no longer taking medication or taking differently than what is listed).
      i. Choose "Order Note" icon to the right of the medication.
      ii. Type in how patient taking at home or if they stopped taking medication.
      iii. NEVER remove a medication from this list.

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iv. Use "Smart phrases" as much as possible when correcting medication list.

c. SmartPhrases:
   i. These are commonly used phrases that are recorded in eRecord.
   ii. To access them type .TOC to view possible selections.
   iii. Primarily use smart phrases when entering information about patient's medications.
   iv. Press F2 button to navigate between *** fields or {URMC RX MED LIST STATUS:27295} field to select appropriate text.
   v. .TOC smart phrases as of July 2020:
      - Added - use this if the medication was not previously on the list and you added this. Specify if this was added by the patient or by a doctor.
      - Regimen adjusted by provider - use this selection if you find out a doctor changed the directions from what is on the list. **Specify what the doctor told them and what they are taking.**
      - Provider advised patient to stop taking - use this if the provider discontinued the medication and the patient is no longer taking.
      - Patient stopped taking medicine on their own - use this if the patient stopped taking the medication and **list reason they are not taking it (if known).**
      - Patient stopped taking medicine due to side effects - use this if the patient stopped taking the medication due to side effects and list any side effects they verbalize.
      - Therapy completed - use this if the patient has discontinued use of a short medication course (for example, an antibiotic).
      - Patient using insulin pens not vials at home. Please remove vial order at discharge. See new insulin pen order.
      - Tablet/capsule strength incorrect.
      - Patient taking differently - **specify exactly what they are taking.**
      - Surescripts (insurance billing information).
      - Patient states still taking, pharmacy last filled on *** for a *** supply.
      - Medication list inclusive of all medications. Medication History performed by: {URMC RX PHARM TECH NAME}.
      - Medication list inclusive of all medications, but not OTC medications. Medication History performed by: {URMC RX PHARM TECH NAME}.
      - Medication list contains possible inaccuracies due to lack of consistent and credible information from patient/caregiver/pharmacy.
      - Duplicate. Please remove at discharge.
      - Home Coumadin/warfarin regimen: *** (using *** mg tablets).
      - Formulation incorrect, see new order.
      - ***mg total daily dose using #*** ***mg tablet/capsule combined with #*** ***mg tablet/capsule.
      - Patient takes on ***

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- Last dose received ***; next dose due ***
- Start date: *** of ***-day regimen.
- Patient not receiving at SNF/ALF.
- Patient states still taking, fill history unavailable from known pharmacies.
- Patient uncertain if taking, pharmacy last filled on *** for a ***-day supply
- Patient not using.
- Patient has not started taking medication.
- Needs refill. No supply at home. Last dose ***
- Patient receives at dialysis.

d. Check boxes to the right of medications listed under "Taking" that the patient was taking prior to admission. Uncheck the boxes if the patient was not taking prior to admission.

e. Finalizing medication list once the BPML is completed:

i. Rx Consult—Medication List—Prior to Adm Meds, find the status scroll bar at bottom of medication list.

- Click button "Mark as Reviewed" (below Med List Status scroll bar).
- Change Med List Status to "Pending pharmacist review".
- The medication history for this patient is complete and you can proceed to the next patient.

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7. Document the medication history in the Med Hx Review SmartForm:

a. After eRecord PTA medication list has been updated, fill out the Med Hx Review.

i. To document a new medication history, enter the "Rx Consult" tab and click on "Medication History". The "Med Hx Review" is listed first in the left-sided column. Select +New Reading.

ii. If a Med Hx Review is already started, it may be resumed by clicking on the blue Date/ Time stamp.

- Enter the information provided from the sources utilized.
- For interventions, make the appropriate selection and enter the number of medications that fell under that category. For example, if 3 medications were removed from the PTA list, select the "Removed Med" button and enter "3" in the corresponding "Number of Medications Removed" field which displays after clicking on the intervention button.

b. Documentation entered into the "Med Hx Review" includes the following:

i. Where did the patient come from?

- Home / Assisted Living Facility / Skilled Nursing Facility / Group Home/ Shelter / Independent Living Facility / Other

ii. Does the patient know their medications well?

- Yes - select if there are no concerns regarding the accuracy of the information provided and the patient does not require pharmacist education.

- No - select if the information provided seems unreliable, or if the patient may benefit from pharmacist education.
- Leave unanswered if the patient/caregiver could not be interviewed to confirm the medication list or if the medication list was obtained from a facility-provided MAR.

iii. Sources of prescription information:

- Patient (includes information provided from written medication list, medication bottles, and/or interview)
- Family Member (Parent / Spouse / Child / Sibling / Other) - document name/phone number
- Caregiver - document caregiver name/phone number
- Outside Med Reconciliation - If fill history was obtained through DrFirst, SureScripts, or eRecord Willow ambulatory dispense report
- Pharmacy – (URMC Outpatient / Wegmans / CVS / Walgreens / Rite Aid / Walmart / Mail Order / Costco / VA / Other). If the pharmacy being contacted is listed as their "preferred" then the name and number do not need to be listed in the comment box
- Medical record Info Source – includes SNF/LTC facility MARs (add name of facility and phone number to comment field), Recent AVS, List from PCP, CareEverywhere, and eRecord searches (Chart Review)
- Other

iv. Any Medisets/Compliance Packaging? Yes / No (this includes use of pillboxes)

v. Interventions:

- **Added med**
  a. Use when entering a completely new medication that is not previously on the medication list.
- **Removed med**
  a. The patient states they are no longer taking the medication and it has not been filled recently at known pharmacies, or the medication is not listed on the SNF/ALF MAR.
  b. When a patient states they are no longer on a medication, it is recommended to follow up by asking why they stopped taking the medication (did their provider direct them to stop? If so, what was the reasoning?), and how long have they been off the medication.
  c. Do not remove medications that are held for surgery or ones the patient stopped taking on their own because of cost or adverse effects.
- **Increase dose/frequency**
  a. Medication dose increased from what is listed on PTA medication list.
  b. Medication frequency is increased from what is listed on PTA medication. For example: Drug is listed on PTA medication list as taking once daily but patient is taking twice daily.

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- **Decrease dose/frequency**
    a. Medication dose decreased from what is listed on PTA medication list.
    b. Medication frequency decreased from what is listed on PTA medication. For example: Drug is listed on PTA medication list as taking twice daily but is taking once daily.
- **Refills needed on a medication**
    a. Pharmacy or patient states they are out of refills (document in yellow notes).
- **Currently taking medication they should have run out of**
    a. Please ask follow up questions including who prescribes the medication and which pharmacy provides it. Sometimes a patient has been admitted to hospitals or rehab facilities for lengthy periods of time and may have a back-up supply – consider asking them if this is the case.
- **Prescription on file with the outpatient pharmacy that they have never picked**
    a. Note which medication and document why it wasn't picked up (if known) in yellow notes.
- **Change in dosage form**
    a. Change the way the drug is supplied.
    Examples include:
    Patient takes liquid, but tablets are listed on the PTA medication list
    Medication should be extended release (XR, CR, ER, etc) but immediate release (IR, chewable) is on PTA medication list
    Ointment on PTA medication list, should be cream
    Patient using nebulized drug versus inhaler
- **Change in route of administration**
    a. Example: medication should be per G-Tube but listed as PO
- **Changed tablet/capsule strength**
    a. The capsule or tablet strength is incorrect but the dose is in the PTA medication list correctly.
    Example: Patient is taking two 25 mg tabs daily and in the PTA medication list it is listed as 50 mg tab once daily.
- **Adherence concerns**
    a. Patient admits to not taking a medication consistently even though they are supposed to be on it.
    b. Please ask and document the reason for non-adherence (i.e. cost, living situation, forgets to take, or other) if known.
        a. determine if that patient uses adherence aids: auto-refills, delivery of prescriptions, pillboxes, use of a daily alarm on their phone, etc.
- **Updated missing information**

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a. The PTA medication list contained a drug with incomplete information. Each drug needs to include dose, route of administration, frequency, and PRN reason.

vi. Is the patient taking:

- Warfarin (Coumadin / Jantoven):
  a. Managed by? (enter which provider follows the patient's therapy)
- Buprenorphine/Naloxone (Suboxone / Bunavail / Zubsolv)
  a. Managed by? (enter the provider or clinic managing therapy)
  b. How much Suboxone do they have left at home?
- Methadone:
  a. Dose confirmed (enter clinic where dose was confirmed) *Note: if the patient is getting methadone from their retail pharmacy for pain management, this information does not need to be filled in*

vii. Completed by:

- Medication history technician names listed for selection.
- If name not found, select *** and enter name in comment box.

viii. Comments:

- Enter any comments for the pharmacist in the comment field. This is where you can communicate concerns or information that doesn't fall into a listed category.
- If there is particular concern for a patient's medication history, reach out to the pharmacist covering the unit to communicate it to them directly.

8. Once all of the information has been entered, click the "Close" button to save your work.

ADDITIONAL RESOURCES

SMHSOP15A - Medication History Technician Competency and Credentialing

REFERENCES

None

Attachments

Appendix I

Appendix II

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Image 01

Image 03

image 05

Interpreter Services Resources.pdf

List of longacting injectable antispychotic.docx

Practice Advancement Phone List.docx.pdf

Approval Signatures

Step Description	Approver	Date
Pharmacy Administrator	Travis Dick	3/2/2022
Policy Owner	Siobhan De Urioste	3/2/2022

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