Comprehensive Medication Review Initiative

A partnership of the Wisconsin Pharmacy Quality Collaborative (WPQC) and United Way of Dane County

User Manual

-Student Volunteer-

United Way
of Dane County

WISCONSIN PHARMACY
QUALITY**COLLABORATIVE**
an initiative of the pharmacy society of wisconsin

Contents

Prep-Work/Day of Event 3
Workflow Diagram 4
Aprexis Health Solutions 5
Media Release Form 7
Adverse Drug Event/Falls Risk Assessment 8
Authorization for Comprehensive Medication Review and Assessment 8
Agreement to Receive Comprehensive Medication Review 10
Pharmacy Communication Form 11
DAPO Form 12
Pharmacy Fax Form 13

Prep-Work/Day of Event

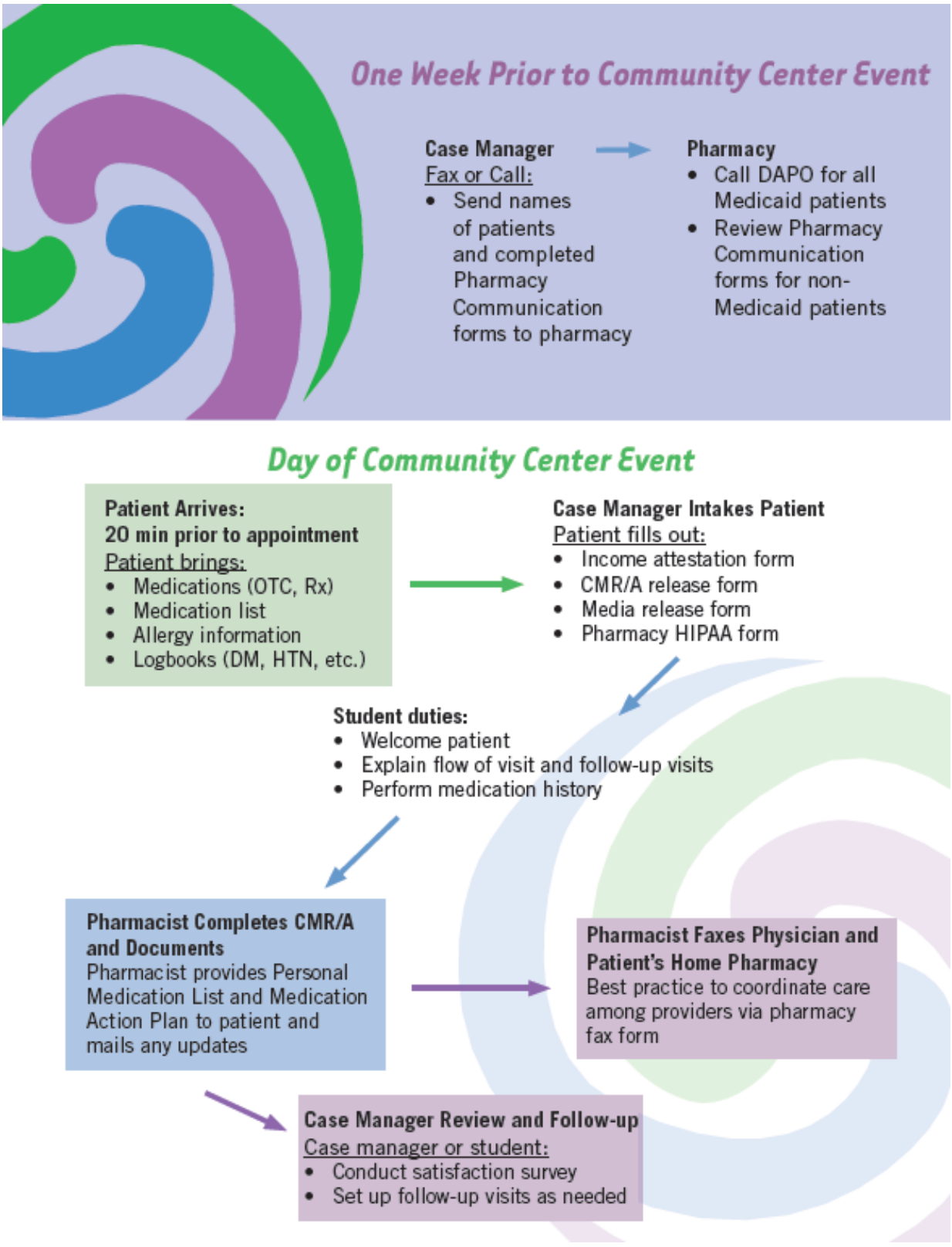
One Week Prior to Event:

1. Expect an email from United Way within one week of the event date with details
2. Read and review this User Manual and documents provided in email

Day of Event:

1. Please arrive at the time provided by United Way representative (see email)
2. Things to bring:
   - Nametag
   - Laptop with wireless access (if possible)
   - Do NOT bring lab coats (intimidating for seniors)
3. Discuss process with pharmacist
   - May work with patient alone, prior to the patient's visit with the pharmacist, or as a "team" with the pharmacist, depending on pharmacist preference
4. Patients are typically asked arrive 20 minutes prior to appointment with pharmacist
5. Patients have been asked to bring in all medications, a medication list, allergy information, and any logbooks that they might have (e.g., blood sugar logs)
   - If not, consider calling patient's pharmacy
6. Patient is required to fill out intake forms
   - Case manager and United Way representative will welcome patients and have them fill out the forms. **Student may be asked to help** complete forms if not completed prior to session.
     - Income Attestation Form
     - CMR/A Release Form
     - Falls Risk Assessment and Pharmacy Communication Form should be completed ahead of time by case manager
     - Student may also be asked to contact the DAPO center via phone to ensure patient eligibility for Medicaid patients
7. [Patient to be greeted and moved to area for medication history/intake with pharmacy student]
8. Student serves as the **medical assistant**
     - Welcome patient; review that program consists of 1 CMR (comprehensive medication review) ("medication check-up") and up to 3 follow-up visits (or in some circumstances, phone calls) over the next 12 months, the first of which must occur within 90 days.
     - Some seniors don't know what they are at the event for; try to make them comfortable and provide a brief overview of the service. Please avoid referencing "low income qualifications" for this program. You may share that one goal of this program is to help them remain independent for as long as possible.
     - Please use your motivational interviewing skills. ☺ Use open-ended questions, recognize the patient's accomplishments, and summarize the patient's thoughts in response.
     - Collect and document as much background information as possible. See "Aprexis Health Solutions" section below for more detail regarding documentation.
     - Escort the patient to the pharmacist's private consultation room/area for visit with the pharmacist (and student).

WORKFLOW


One Week Prior to Community Center Event
Case Manager
Fax or Call:
• Send names of patients and completed Pharmacy Communication forms to pharmacy
Pharmacy
• Call DAPO for all Medicaid patients
• Review Pharmacy Communication forms for non-Medicaid patients
Day of Community Center Event
Patient Arrives:
20 min prior to appointment
Patient brings:
• Medications (OTC, Rx)
• Medication list
• Allergy information
• Logbooks (DM, HTN, etc.)
Case Manager Intakes Patient
Patient fills out:
• Income attestation form
• CMR/A release form
• Media release form
• Pharmacy HIPAA form
Student duties:
• Welcome patient
• Explain flow of visit and follow-up visits
• Perform medication history
Pharmacist Completes CMR/A and Documents
Pharmacist provides Personal Medication List and Medication Action Plan to patient and mails any updates
Pharmacist Faxes Physician and Patient's Home Pharmacy
Best practice to coordinate care among providers via pharmacy fax form
Case Manager Review and Follow-up
Case manager or student:
• Conduct satisfaction survey
• Set up follow-up visits as needed

Aprexis Health Solutions (WPQC Documentation Application)

1. Go to: http://portal.aprexis.com
   - Login using provided student, technician, or pharmacist log-in information
   - Please email Aprexis™ (support@aprexis.com) requesting set up of a student account. If there is an email address for student use, provide it to Aprexis at this time. Following the event, please change the password to the Aprexis technician or student account.
   - Pharmacists and students can log in and view the intake information concurrently
2. Students will complete through the patient goals and concerns in the "Interventions" tab. If pharmacist would like, students may complete social history, health conditions, lab values, immunization and medication device history as well in the "Interventions" tab.
3. Add new patient
   - Add intervention
   - Select "CMR Initial" for intervention type
4. Collect and document as much background information as possible on "Patient" tab.
   - Member Number: Enter the patient's 10-digit phone # without dashes or periods.
   - Person Code: Not required unless 2 patients have the same phone number, then please use different person codes (e.g. 00 and 01 or A and B, etc.)
5. Document patient's primary and specialty providers. Be sure to select their primary provider.
6. Enter caregiver information if applicable
   - Please also add in pharmacy information under Caregiver tab. There is currently no standard place to input this information.
7. Enter in all prescription medication information
8. Enter in all OTC/herbal medication information
   - "Non-coded OTC" means: OTC's without NDC's; this is also the place where you can free text prescription medications that you cannot find in the database.
9. Enter any relevant patient allergies or adverse drug reactions
10. Move to the "Interventions" tab
    - Enter in goals and concerns expressed by patient
    - If time permits
      i. Social history
      ii. Health conditions
      iii. Lab values
      iv. Immunizations
      v. Medical devices
11. Student may continue documenting for the pharmacist if the pharmacist prefers. Student may follow along and complete these sections as the pharmacist discusses them with the patient.

12. The pharmacist is not required to complete every section in the Interventions tab (i.e. social history, adherence, etc.) At a minimum,
    - Please complete questions related to falls, adverse drug events, potentially inappropriate medications, hospitalizations, MD visits and ER visits. United Way is counting on these data. You will find these questions within the focused condition review for patients at risk for falls.
    - Please complete recommendation information in the Aprexis Intervention tab (Intervention → Recommendations) and document (complete) the outcome of the interventions following the review. Completing the interventions will signal payment of up to 2 intervention-based services. Free text entries are not able to be captured as data.
13. There is no Aprexis time limit for submitting documentation, but payers have different requirements. Please attempt to complete documentation within 14 days of the event to ensure timely payment and data analysis.
14. Patient satisfaction surveys are built into Aprexis; pharmacy student or United Way/PSW representative should complete with the patient at the end of the visit while the pharmacist is completing documentation.
15. There may be a printer available for use, but if you don't finish your documentation, mailing a copy of the PMR and MAP to the patient and faxing the physician later is fine.

IMPORTANT BROWSER NOTES:

Optimal use of Aprexis requires your computer to have one of the following browsers as minimum requirements:

- Internet Explorer 7+
- Mozilla Firefox 4+
- Safari 4.0.5+

Media Release Form

I hereby authorize Pharmacy Society of Wisconsin, to publish photographs taken of me on _____(mm/dd/yy), for use in the Pharmacy Society of Wisconsin's print, online and video-based marketing materials, as well as other Company publications.

I hereby release and hold harmless Pharmacy Society of Wisconsin from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Pharmacy Society of Wisconsin, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Authorization

Printed Name: _____

Signature: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

United Way of Dane County

WISCONSIN PHARMACY QUALITY COLLABORATIVE
an initiative of the pharmacy society of wisconsin

Adverse Drug Event/Falls Risk Assessment

Patient Name: _____ **Gender**: Male/Female

Race: White Black/African American Latino Asian American Indian Other:_____

Patient Phone Number: _____ **Date of Assessment:** _____

Caregiver Name/Relationship: _____

Please complete based on verbal answers:

1. Do you take more than three medications? These could include prescriptions, herbals, and over-the-counter medications such as Tylenol PM, Motrin, or Advil. YES NO
2. Do you ever forget to take medications? YES NO
3. Have you fallen in the past year? YES NO
4. Do you have a fear of falling? YES NO
5. Do you ever feel dizzy? YES NO
6. Do you ever forget important dates or events? YES NO
7. Do you go to more than one pharmacy to fill your prescriptions? YES NO

****If the patient answers "yes" to any of questions 1 through 7, s/he could be at risk of experiencing ADE's and would benefit from a comprehensive medication review and assessment.**

8. Is your annual income < $47,080 (per one-person household) or < $63,720 (per two-person or more household)? YES NO

United Way of Dane County will cover the cost of the Comprehensive Medication Review service to seniors who meet the following criteria:

1. **Over 65 years old**
2. **Live in Dane County, Wisconsin**
3. **Annual income does not exceed $47,080 per one-person household, or $63,720 per two-person (or more) household.**
4. **Answer 'Yes' to at least one question (#1-7) in the above risk assessment**

Please complete (and file) the following documents with the patient prior to providing the United Way CMR/A:

1. Income Assessment Form
2. CMR/A Release Form
3. Your pharmacy's HIPAA Form

Initial Review by: _____

Date:_____

Authorization for Comprehensive Medication Review and Assessment

Patient Initials	
_____	I hereby authorize _____ Pharmacy to review my medications. I understand that any changes to my medications will not be made without the permission of my physician(s).
_____	By signing below, I give _____ Pharmacy permission to contact my physician(s), if necessary, about medication-related issues that were discussed during the appointment.
_____	I understand that I can withdraw this consent at any time by contacting _____ Pharmacy except for when the medication-related issues have already been discussed with my physician(s).
_____	I authorize _____ Pharmacy to keep a copy of my health profile and medication-related recommendations for the purpose of follow-up and monitoring.
_____	I authorize _____ Pharmacy to send a copy of their report and recommendations to the case manager so that he or she can be a source of support to me in making the changes approved by my physician.
_____	Some of the information collected in this review may be used by United Way or Pharmacy Society of Wisconsin for reporting or publication purposes. Any data from my visit that will be used for this program will be de-identified so it cannot be linked to my personal health information. I understand that every effort will be made to keep my personal health information private and confidential.

Signature of Patient:	Date:
Print Patient Name:	
Patient Address and Phone Number:	
Pharmacist Name and Signature:	Date:

Agreement to Receive Comprehensive Medication Review through United Way of Dane County Funds

- I understand that Wisconsin Pharmacy Quality Collaborative (WPQC) participating pharmacies are offering Comprehensive Medication Review & Assessment services to seniors who meet the following criteria ***without any charge****.*

    - Seniors over 65 years old
    - Seniors living in Dane County, Wisconsin
    - Seniors whose annual income does not exceed $47,080 per one-person house hold, or $63,720 per two-person (or more) household.
    - Seniors who answer 'Yes' to at least one question on the program's *Adverse Drug Event/Falls Risk Assessment* questionnaire

- I understand that United Way of Dane County is covering the cost of this first Comprehensive Medication Review & Assessment service and follow-up visits.

- I understand that I am eligible to receive up to three follow-up visits (either in person or by phone) with the pharmacist.

- I certify that I meet all the criteria listed above and agree to give proof if I am asked to verify any of the criteria.

_____ _____

Print Name (patient) Date

_____

Signature (patient)

Pharmacy Communication Form

WPQC Comprehensive Medication Review
Pharmacy Communication Form

Attn (Pharmacist): _____

Case Manager: _____

Patient Name: _____ DOB: _____

Member ID: _____ ☐Medicare Part D (Company: _____)

Reason for Level II Service

- ❑ 4+ RX for 2+ chronic disease States (below)
- ❑ Diabetes
- ❑ Coordination of care due to multiple providers
- ❑ Discharged from hospital or LTCF within 14 days
- ❑ Health literacy
- ❑ Provider referral

Disease States

- ❑ Hypertension
- ❑ Asthma
- ❑ Chronic Kidney Disease
- ❑ Congestive Heart Failure
- ❑ Dyslipidemia (Cholesterol)
- ❑ COPD
- ❑ Depression

*This patient will be seen at _____ on ____/____/____

Pharmacist - if Medicaid patient, please call DAPO Center for PA at 800-947-9627 (3)

Date of Call: _____ **Date of Approval:** _____

Pharmacist: _____

Notes:

WPQC Medicaid Level II Intervention Request Form

Patient Name:____________________DOB:________

Member ID: ____________________ ☐ Medicare Part D

Reason for Level II Service

- ☐ 4+ RX for 2+ chronic disease States (below)
- ☐ Discharged from hospital or LTCF within 14 days
- ☐ Diabetes
- ☐ Health literacy
- ☐ Coordination of care due to multiple providers
- ☐ Provider referral

Disease States/ Medications Need to include medications used to tx

•Hypertension:____________________

•Asthma:____________________

•CKD: ____________________

•CHF: ____________________

•Dyslipidemia: ____________________

•COPD: ____________________

•Depression: ____________________

Pharmacist NPI: ____________________

Pharmacy NPI: ____________________

Call DAPO Center at 800-947-9627 (3)

Date of Call:__________ **Date of Approval:**__________

WPQC Medicaid Level II Intervention Request Form

Patient Name:____________________DOB:________

Member ID: ____________________ ☐ Medicare Part D

Reason for Level II Service

☐ 4+ RX for 2+ chronic disease States (below)
☐ Discharged from hospital or LTCF within 14 days
☐ Diabetes
☐ Health literacy
☐ Coordination of care due to multiple providers
☐ Provider referral

Disease States/ Medications Need to include medications used to tx

•Hypertension:____________________
•Asthma:____________________
•CKD: ____________________
•CHF: ____________________
•Dyslipidemia: ____________________
•COPD: ____________________
•Depression: ____________________

Pharmacist NPI: ____________________
Pharmacy NPI: ____________________

Call DAPO Center at 800-947-9627 (3)

Date of Call:__________ Date of Approval:__________

WPQC Medicaid Level II Intervention Request Form

Patient Name:____________________DOB:________

Member ID: ____________________ ☐ Medicare Part D

Reason for Level II Service

☐ 4+ RX for 2+ chronic disease States (below)
☐ Discharged from hospital or LTCF within 14 days
☐ Diabetes
☐ Health literacy
☐ Coordination of care due to multiple providers
☐ Provider referral

Disease States/ Medications Need to include medications used to tx

•Hypertension:____________________
•Asthma:____________________
•CKD: ____________________
•CHF: ____________________
•Dyslipidemia: ____________________
•COPD: ____________________
•Depression: ____________________

Pharmacist NPI: ____________________
Pharmacy NPI: ____________________

Call DAPO Center at 800-947-9627 (3)

Date of Call:__________ Date of Approval:__________

WPQC Medicaid Level II Intervention Request Form

Patient Name:____________________DOB:________

Member ID: ____________________ ☐ Medicare Part D

Reason for Level II Service

☐ 4+ RX for 2+ chronic disease States (below)
☐ Discharged from hospital or LTCF within 14 days
☐ Diabetes
☐ Health literacy
☐ Coordination of care due to multiple providers
☐ Provider referral

Disease States/ Medications Need to include medications used to tx

•Hypertension:____________________
•Asthma:____________________
•CKD: ____________________
•CHF: ____________________
•Dyslipidemia: ____________________
•COPD: ____________________
•Depression: ____________________

Pharmacist NPI: ____________________
Pharmacy NPI: ____________________

Call DAPO Center at 800-947-9627 (3)

Date of Call:__________ Date of Approval:__________

United Way
United Way of Dane County

WISCONSIN PHARMACY QUALITY COLLABORATIVE
an initiative of the pharmacy society of wisconsin

Pharmacist: _____
Home Pharmacy: _____
Address: _____
Telephone: _____ | Fax: _____

Fax

TO: FROM:

FAX: PAGES:

PHONE: DATE:

RE:

☐ For review ☐ Please reply

One of your patients recently completed a comprehensive medication review and assessment provided by the United Way of Dane County and the Wisconsin Pharmacy Quality Collaborative. The purpose of this document is to make you aware of the recommendations faxed to the patient's physician. Please contact me with any concerns. I am also including a summary of the visit for your records.

☐ No follow up needed.

☐ Please contact me when the physician approves/denies the recommendations. Knowing the outcome of the recommendation will help the WPQC in proving the value of pharmacist.

☐ Other:

Thank you for your time,

_____
Signature of Pharmacist providing CMR/A