Chapter 3 - Patient Data Collection
From last class

- A patient presents with a new Rx for Norvasc 10 mg qd for BP of 164/102. He has never had it before. You think this is too high a dose (usual initial dose is 2.5 -5 mg qd. How you you rephrase the “dose too high” problem in words that will not offend the Doctor?
Some possible solutions - 1

- Doctor, I rarely see initial doses of Norvasc this high. Usually, I see 2.5-5 mg po qd initially. Can you please help me understand what you know about this patient that sufficiently concerned you to choose the higher dose? It will help me to educate the patient better about his drug therapy and disease if I know.
Doctor, I am concerned that the patient may be at risk for a hypotensive episode if we start with 10 mg. Would you consider 5 mg initially? For this week, I’ll have the patient come into the pharmacy and monitor his BP daily. He has agreed to this. If his diastolic isn’t less than 90 within 3 days or if he has any adverse effects, I will call you.
Some possible solutions - 3

- Doctor, the literature suggests starting Norvasc for hypertension at 2.5 mg po qd and tapering up over 7-14 days. Can we do that in this patient, or is there some particular concern you had that indicates he needs a fully therapeutic dose immediately? I don’t want to see the patient have a fall if he cannot initially tolerate 10 mg.
Who to interview?

- If there are 57 problems per 100 patients, who do I interview or ignore?
- When refilling a Rx, always ask the patient, “How is your (drug name) working for you?”
- They will answer, “OK I guess”
- This allows RPh to follow-up and inquire more deeply - “So how is your BP/blood sugar/asthma lately?”
Subjective data

- Cannot be directly measured
- May not always be accurate
- May not be reproducible
- Often supplied directly by the patient
- Generally includes PMH, CC, HPI, SH/FH, ADL
Objective data

- Can be measured
- Is observable
- Not influenced by prejudice or emotion
- Typically numerical
- Often includes vital signs, lab measures
- Often created in the pharmacy - PEFR, Lipids, BS, vitals etc
Subjective or objective? - 1

- Lab data can be either depending on the source
- If the patient tells you, it’s subjective
- If the source is verifiable it’s objective
- Verifiable sources - lab slips, doctor’s office, patient chart, diagnostic test performed by the pharmacist
Subjective or objective? - 2

- Patient home monitoring logs can be either
- If RPh is certain patient is testing and recording results correctly, it’s objective
- If RPh cannot be certain patient is testing or recording consistently and accurately, it’s subjective.
Subjective or objective? - 3

- Medication histories can be either
- A well performed drug history by a trained pharmacist is objective. Includes Rx’s, Rx’s filled elsewhere, samples, pills borrowed from family/friends, OTC’s and herbals and the outcome of therapy
- Hospital profiles/ MARS are objective
- History just taken off computer is objective but incomplete.
Subjective or objective? - 4

- Compliance histories can be either
- A true assessment of compliance (pill count, calculation of days of therapy, thorough/open-ended interview) is objective
- Partial or close-ended interview is subjective (e.g., Do you forget to take your medications very often?)
Finally....

- Gender, age/DOB, race are generally put in the subjective, even if they are sometimes objective. SOAP notes simply read better this way, e.g., Liang Yee is a 75-yr-old Asian female....

- Include the source of the information in your SOAP notes
Getting started - 1

- Interview by appointment or on the fly?
- By phone or in person?
- Is semi-private space available to conduct the interview?
- Does the pharmacy have sufficient support systems to permit you to leave the pharmacy and spend 15-30 minutes with the patient and not come back to utter chaos?
How are your communication skills?

Open- vs closed-ended questions?

Focused vs comprehensive interviews?

Logical flow to the questions you ask?

Do you present a calm, professional appearance or look flustered and nervous?

What’s your body language saying?
You do not need to ask every question of every patient every time.

You will need to learn how to judge what is absolutely necessary and what is not.

Consider gathering all the patient’s data in pieces over a series of interviews rather than all at one sitting.
Basic data to collect - 1

- Demographic data - name, address, phone (home and office), best times to call, permission to leave messages, financial and insurance information
- General data - diet, exercise, employment, height, weight
- SH/FH - smoking, EtOH, illicit drug use, caffeine, family disease history
Basic data to collect - 2

- Medical history - “What are all the things you currently see a doctor for? What complaints do you have that you don’t see a doctor for?”
- PMH - “What have you previously seen a doctor for? Did the problem get better?”
- CC- “What is your main health-related problem today?”
Basic data to collect - 3

- **HPI** - “What is currently happening with the major health-related complaint you have today?”

- Patient’s expectations of you and the rest of the system - “If I could fix one health-related problem for you, what would you like it to be? What is the one health-related issue that concerns you the most?”
Useful questions to ask - 1

- The Basic 7
  - Where is the problem/symptom?
  - What is it like?
  - How severe is it?
  - How long have you had it?
  - How did it happen?
  - What makes it better or worse?
  - What other symptoms are present?
Many of the problems that arise when pharmacists contact physicians occur because the pharmacist cannot answer the Basic 7 questions above. If the pharmacist does not have this information, the physician will nearly always ask the pharmacist to send the patient in to see the doctor.
Useful questions to ask - 3

- Three US Public Health Service questions:
  - What did the doctor tell you this medication is for?
  - How did the doctor tell you to take it?
  - What did the doctor tell you to expect?

- Answers to these questions often suggest patients at risk for a drug therapy problem.
If time is a problem

- Conduct a focused interview:
  - What are all the things you see a doctor for?
  - What are all the medications you take? (Rx, Rx’s filled elsewhere, samples, OTCs, borrowed from family/friends, herbals/nutritionals)
  - What happens when you take them?
Data collection forms - 1

- Provide space to collect the relevant data in a logical and coherent fashion
- Can be used to start a pharmacist’s patient record
- Can be filled out by the patient while waiting to speak to the pharmacist
Data collection forms - 2

- Can provide a false sense of security. What if it’s not on the form?
- Can result in a tendency to write or think ahead to the next question and not listen.
- Are popular with pharmacists just learning how to interview patients, but are generally dropped after some practice.
Sources of data

- The patient, the patient, the patient
- Family members, caregivers, providers
- Physician offices, clinical labs, hospitals etc
- Hospital charts, nursing home records, MARS
- Other pharmacies
- The patient
Possible problems

- Providers may not release information without a “Patient Information Release Form”
- Be prepared to pay for copying costs. Don’t ask the hospital for the entire chart. It might be 400 pages long and cost you $150
- Be mindful of patient confidentiality issues – e.g., asking a 17-yr-old’s mom re: oral contraceptives