

UPDATE: COMPLETING THE MIF

TABLE OF CONTENTS

1. Background and rationale2

2. Equipment and supplies2

3. Detailed measurement procedures2

3.1 Drug definition guidelines2

3.2 Medication reception3

3.3 Recording prescription medication4

4. Medication coding.....5

5. Duration of use.....5

6. Frequency of use5

7. Quality assurance5

7.1 Quality assurance checklist.....6

8. Data collection form7

1. Background and rationale

A complete and accurate list of current prescription medication use is essential for several reasons: Some medications affect body composition and bone mass, medication use increases with increasing disability, and a number of ancillary studies require complete medication lists.

We are specifically interested in how individual medications have been actually taken (during the preceding 30 days) rather than how they were prescribed or intended to be taken.

2. Equipment and supplies

- Medication Inventory Form (MIF) (section 8.)
- Black ball-point pen
- Plastic bag for medications
- Prescription medications participant has been taking in the last 30 days

3. Detailed measurement procedures

- The participant will have been instructed to bring all prescription and non-prescription medications used in the preceding 30 days with them to the Year 8 clinic visit.
- The examiner will review all prescription medications and transcribe the name, duration of use, and frequency that the medication is taken and mark the responses on the Medication Inventory Form (MIF).

3.1 Drug definition guidelines

For the purposes of Health ABC, use the following definition guidelines:

- 1) **Current use:** All prescription medication taken within the last 30 days prior to the Year 8 clinic visit. Do not include immunizations (e.g., flu shot) or medications received during an overnight hospitalization, unless they are continued after discharge.
- 2) **Prescription medications:** A medication for which a prescription was written by a physician, dispensed by a pharmacist or physician, and taken by the participant during the 30 days prior to the visit. Prescription medications may include eye drops, pills or tablets, solutions, creams/salves, dermal patches, and injections. It also includes prescriptions written for another person (usually the participant's spouse) in cases where a participant regularly takes the medication. This practice is not uncommon as a way of controlling medical costs.

Some non-prescription medications may also be obtained with a prescription. For example, coated aspirin may be bought over-the-counter, but many physicians write a prescription for it. If a prescription was written for the medication and it was dispensed

by a pharmacist, even if it is available without a prescription, it should be considered a prescription medication.

3.2 Medication reception

Collect all of the medications the participant has brought with them and put these in a container or plastic bag (if not already in the bag provided).

Ask the participant if they brought in ALL prescription medications that they took during the last 30 days.

- Fill in the “**All**” bubble, if all medications (or a comprehensive list) were brought in to clinic and record the number of medications in the given box.
- Fill in the “**Some**” bubble, if one or more medications were not brought in, and one or more medications were brought in. **When a participant forgets to bring in one or more medications that they have taken in the last 30 days, each site is responsible for developing a mechanism to gather the missing information via telephone. (Occasionally a participant will have brought in an accurate list of the other medications and a follow-up call will not be necessary.)** If you need to contact a participant at a later time because they cannot give you all of the necessary information while in the clinic, leave the “Total number recorded” blank and fill in the total number when the medication list is complete. You will need to change the “**Some**” response to “**All**” after the follow-up telephone call with the participant if all other medications are added. It is recommended that the participant be called 1 to 2 days after the visit to obtain the missing information.

DO NOT transmit the data to the Coordinating Center until after you have collected all of the medication information from the participant over the phone. After you have collected all medication information, put a line through the ‘Some’ bubble and fill in the ‘All’ bubble, circle the answer, and initial and date the correction. Write in the box the total number of medications recorded on the form. Send all pages of the Medication Inventory Form at the same time.

- Fill in the “**None**” bubble if the participant took medication, but did not bring the medication(s) with them to the Year 8 clinic visit. Arrange for a telephone call to complete the MIF. It is recommended that the participant be called 1 to 2 days after the visit to obtain the missing information.
- Fill in the “**Took None**” bubble, if the participant took no prescription medication in the past 30 days. Self explanatory, but ask:

Script: *"Are you sure you took no prescription medications over the last 30 days?"*

The Medication Inventory form can be seen in section 8 of this manual. There is room for nine medications on this two-page form. If a participant is taking more than nine prescription medications, print extra copies of the second page as needed to have room to record all

medications. For your convenience there is a separate PDF on the website containing just this one page. Be sure to write the participant's ID# and acrostic on the top of each additional page. Always record the number of pages used, and number the pages 1 of __, 2 of __, etc. If only the first page is used, record 1 of 1 and discard the second page; a blank second page should not be entered into the data system. After the medication names are recorded, the participant should be questioned regarding duration and frequency of use for each medication.

3.3 Recording prescription medication

Record only prescription medications used in the 30 days prior to the Year 8 clinic visit. Medications administered in the previous 30 days during surgery or hospitalization will not be recorded on the MIF unless they are continued after discharge. Medications that were prescribed but not taken, or those taken more than 30 days ago, are not recorded.

Copy the name directly onto the MIF from the medication container, using capital letters. Write clearly! Record the complete drug name exactly as written on the container. It is not necessary to record the name of the store or pharmacy where the medication was obtained.

Some combination medications contain two or more drugs in a single pill or tablet, and the trade name should be recorded (for example, Dyazide is a combination of hydrochlorothiazide and triamterene).

If a single trade name is not present, record the components separated by a slash (for example, hydrochlorothiazide/triamterene). Combination medications with more than two or three components should be listed by the generic or trade name, as there are only 27 character spaces available to record the medication name. Common abbreviations can be used, such as HCTZ for hydrochlorothiazide, susp for suspension, etc.

If a medication is not taken orally, include the route of administration or include the word "cream" or "ointment" in the name. Some common examples where the route of administration should be listed include:

- suppositories (e.g., "compazine suppository")
- eye drops (e.g., "timolol eye drops")
- injections - This includes medications administered by injection or intravenously (e.g., "vitamin B12 injection," "allergy injections," "intravenous pamidronate")
- inhalers (e.g., "proventil inhaler")
- topical preparations (e.g., "hydrocortisone ointment" or "Premarin vaginal cream")
- patches (e.g., "testosterone patch")

In addition, the formulation code (indicating route of administration, e.g., oral, topical, etc) must be recorded in the Form Code boxes. A complete list of formulation codes can be found at the bottom of the medication inventory form page.

4. Medication coding

Most medications listed in the Health ABC MIF database will be automatically matched to an existing medication in the on-line medication dictionary by the data system. Those that cannot be matched will appear as edits that can be resolved by choosing the matching medication from an on-line medication dictionary. Medications or formulations not found in the Health ABC medication dictionary will be identified and coded by the Coordinating Center. Medication edits for the field centers will be periodically generated for medications that seem incorrect or cannot be coded.

5. Duration of use

We are only interested in collecting the most recent duration of use. If the participant took the medication sometime in the past, discontinued it for more than 8 weeks, and then restarted it more recently, we only want the duration of use since they last started the medication. Ask the participant *“How long have you taken the medication since you most recently started it?”* Do not confuse this with frequency of use. For example, a participant may take a medication only once a week or once a month, but has done so for 7 years and has taken it within the last 30 days – in this case, the ‘> 5 years’ response bubble should be filled in.

In the past 30 days, it is possible that a medication may have been discontinued or another medication substituted. To distinguish simultaneous from serial use of similar medications, please ask the participant whether they are still using each medication or have now discontinued use. Complete the “Still using?” (Y/N) question for each medication.

6. Frequency of use

We want to record whether the medication is taken on a regular basis or taken on an as needed basis, but not on a regular schedule. For example, someone may have taken Naprosyn or Celebrex within the last 30 days but only takes it when they have joint pain. This would be recorded as “As needed.” Any medication that has been prescribed to be taken daily or on a set schedule would be recorded as “Regular” Medications may be taken on a regular basis only 1 or 2 days a week (some may even be once a month, but they take the medication or receive a therapy on a predetermined schedule). Any medication that the participant takes on a regular basis as part of a predetermined schedule should be coded as ‘Regular.’ That is, daily use is not the only use that should be recorded as regular. If the participant occasionally forgets to take the medication, but normally takes it on a regular basis, this is also considered regular use.

7. Quality assurance

- Read and study manual
- Practice looking up medication codes in the Health ABC website

7.1 Quality assurance checklist

- Participant asked if they brought in all prescription medications used in the past 30 days
- If no medications taken, participant asked “Are you sure you took no prescription medications over the last 30 days?”
- Records only prescription medications on the MIF
- Records only medications used in the past 30 days
- Properly records name of medication
- Properly records route of administration of medication, if route is not oral
- Correctly enters appropriate formulation code
- Correctly codes "as needed" and “regular”
- Accurately records participant's responses on data collection form
- Reviews form for completeness
- Correctly completes form

