Medication Reconciliation

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Objectives

- Describe medication reconciliation
- Identify guidelines and evidence for medication reconciliation in various practice settings
- Practice medication reconciliation through completion of a case series

The Joint Commission ®

- National Patient Safety Goal (NPSG) 3: Improve the safety of using medications.
  - NPSG.03.06.01: "Maintain and communicate accurate patient medication information"
    - "Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to brig their up-to-date list of medicines every time they visit a doctor."

      https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2022/simple_2022-ahc-npsg-goals-101921.pdf
  - NPSG.03.06.01 appears in the following standards:
    - Ambulatory Health Care, Assisted Living Communities, Behavioral Health Care and Human Services, Critical Access Hospital, Home Care, Hospital, Nursing Care Center, Office-Based Surgery

    https://www.jointcommission.org/standards/national-patient-safety-goals/-/media/131f1a35ea9743eca04b9858b73b0a93.ashx, https://www.jointcommission.org/standards/national-patient-safety-goals/

Medication Reconciliation

- "reviewing the patient's complete medication regimen at the time of admission, transfer, and discharge and comparing it with the regimen being considered for the new setting of care."

  Agency for Healthcare Research and Quality (AHRQ) Patient Safety Newtwork (PSNet) Patient Safety 101 Primer, Medication Reconciliation, September 7, 2019 https://psnet.ahrq.gov/primer/medication-reconciliation

- "identifies and resolves unintentional discrepancies between patients' medication list across transitions in care."

  Kwan JL, Lo L, Sampson M, & Shojania KG. (2013). Medication Reconciliation During Transitions of Care as a Patient Safety Strategy. Annals of Internal Medicine. doi: 10.7326/0003-4819-158-5-201303051-00006

Medication Reconciliation

- Medication reconciliation at transitions in patient care contributes to the safe use of medications, especially in older adults.

The Joint Commission, Quick Safety 26: Transitions of Care: Managing medications (Updated April 2022) https://www.jointcommission.org/resources/news-and-multimedia/newsletters/Newsletters/quick-safety/quick-safety-issue-26-transitions-of-care-managing-medications/transitions-of-care-managing-medications#.Yxd4WnbMI2x

Kwan JL, Lo L, Sampson M, & Shojania KG. (2013). Medication Reconciliation During Transitions of Care as a Patient Safety Strategy. Annals of Internal Medicine. doi: 10.7326/0003-4819-158-5-201303051-00006

Transitions of Care

- Transitions of Care
  - "The Centers for Medicare & Medicaid Services (CMS) defines a transition of care as the movement of a patient from one setting of care to another. Settings of care may include hospitals, ambulatory primary care practices, ambulatory specialty care practices, long-term care facilities, home health, and rehabilitation facilities."

Transitions of Care. Content last reviewed June 2018. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.htm

The Evidence for Medication Reconciliation in Practice

Hospital to Ambulatory Care (Home) Transition of Care

- Cassano A, Reilly C, Mehta S, Ingram JY, Scheckelhoff D, Owen JA, Burns AL. (2013). ASHP-APhA Medication Management in Care Transitions Best Practices.
  - American Society of Health System Pharmacists (ASHP) and the American Pharmacist's Association (APhA) collaboration
  - Medication Management in Care Transitions (MMCT) Project developed to identify exemplar practices involving pharmacists
    - Common features seen in exemplar programs: interprofessional team approach including pharmacy involvement, evidence of impact of interventions, access to patient medical records
    - Common barriers to implementation of processes: funding, staff, access to patient medical records, communication

Medication reconciliation at hospital admission, discharge, and after discharge

- Daliri S, Bouhnouf M, van de Meerendonk Henk, Buurman BM, Scholte op Reimer W, Kooij MJ, Karapinaar-Carkit F (2021). Longitudinal medication reconciliation at hospital admission, discharge and post-discharge. *Research in Social and Administrative Pharmacy* 17 (2021) 677-684.
  - Collaboration between hospitals and community pharmacies in the Netherlands
    - Patient demographics: Age (62-81 years), 10.3 medications at discharge
    - Admission: 66.5% of patients had one or more changes to reconcile medications
    - Discharge: 62.9% of patients had one or more change to reconcile medications
    - At home (5 days post discharge): 52.8% of patients had one or more change to reconcile medications

Ambulatory Care to Ambulatory Care Transitions of Care

- Institute for Healthcare Improvement, Reconcile Medications in Outpatient Settings (https://www.ihi.org/resources/Pages/Changes/ReconcileMedicationsinOutpatientSettings.aspx)
  - At the start of the visit, reconcile prescription medications, non-prescription medications, and dietary supplements use
    - Directions for use should be complete
    - Adherence should be noted
  - At the end of the visit, reconcile prescription medications, non prescription medications and dietary supplement use to reflect any changes made as a result of the visit

Hospital to Skilled Nursing Facility Transition of Care

- Barry K, Tyagi R, O'Brien J, & McNicoll L. Lessons Learned When Discharging Older Adults to Skilled Nursing Facilities. *Brown J Hosp Med.* 2022; 1(2). doi:10.26300/gd5k-6456
  - Completeness and accuracy are critical for patient care
    - Provide specific directions for all medications to be used in the care setting
    - Accurate and compete medication list should be in discharge summary
    - If patient is readmitted to the hospital, check for medication changes that may have occurred in the skilled nursing facility

Hospital to Skilled Nursing Facility Transition of Care

- Stratis Health (2014). White Paper. Understanding and Improving Medication Reconciliation Between Hospitals and Nursing Homes, Patient Safety Risk and Cost in Care Transitions
  - All prescribed medications should have a documented indication
  - Use an interdisciplinary healthcare team that includes pharmacists

Medication Reconciliation Mini Case Series

Medication Reconciliation Mini Case Series

Transition of Care One:

Home to Hospital

82 year old ambulatory patient admitted to the hospital following a hip fracture sustained from a fall in her home.

Transition of Care Two:

Hospital to Skilled Nursing Facility

82 year old hospitalized patient admitted to skilled nursing facility following a repaired hip fracture sustained from a fall in her home.

PMH:

Osteoporosis, Osteoarthritis, Hypothyroidism,

Labs:

Medication Reconciliation Mini Case Series
Transition One: Home to Hospital

Clinic Medication List

alendronate
Calcium Carbonate
Ferrous Sulfate
Topical Product, PRN use
ASA 81 mg
levothyroxine

Medication List from Outpatient Pharmacy

alendronate
levothyroxine

Medication List from Patient

alendronate
Calcium Citrate
Ferrous Sulfate
ASA 81 mg

Medication Reconciliation Mini Case Series
Transition One: Home to Hospital

Patient Interview

Cinnamon

Reconciled Home Medication List

Medication Reconciliation Mini Case Series
Hospital Course

Medications started while in the hospital

Anticoagulant (indication: hip replacement)

Pain medication (indication: pain)

PPI (indication: stress ulcer prophylaxis)

Medications stopped while in the hospital

ASA 81 mg

Final Hospital Medication List

Medication Reconciliation Mini Case Series
Transition Two: Hospital to Skilled Nursing Facility

Medication List : Hospital Discharge Summary

Clinic Medication List

Medication List from Outpatient Pharmacy

Medication Reconciliation Mini Case Series
Transition Two: Hospital to Skilled Nursing Facility

Medication List from Patient

Patient/Patient Family Interview

Final Skilled Nursing Facility Medication List