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Medication Reconciliation: Defining the Standard of Care

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Medication Reconciliation

Defining the standard of practice

PHYSICIAN EXECUTIVE LEADERSHIP

Definitions

- **Medication Reconciliation (MR)**
  Process of obtaining the most accurate list of a patient's current medications and comparing this to an external record

- **Transition of care**
  Movement of patient from one care setting to another

- **Adverse Drug Event (ADE)**
  Injury related to a drug

Why it Matters

Patient Harm

Patients may experience preventable adverse drug events

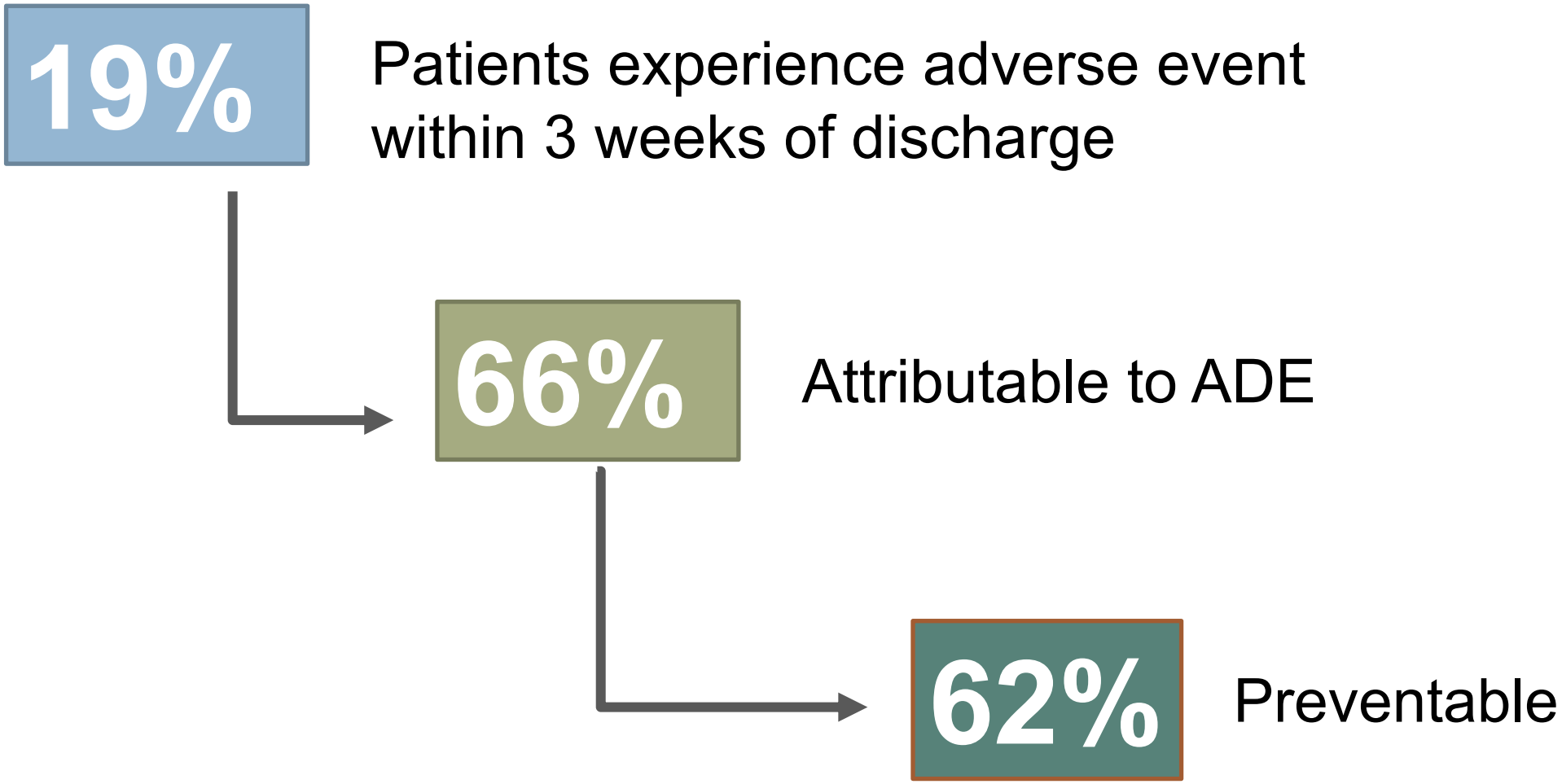
Prolonged Length of Stay

Can result in admission, transfer, and discharge delays if not completed timely

Increased Readmission

Patients may be discharged on inappropriate medication, resulting in increased 30-day readmission

Patient Harm is Preventable



The Problem

- No standardized protocol for Medication Reconciliation despite acknowledgement from TJC, IHI and CMS
- Resources vary within the Jefferson Health Network
- No robust process of MR for admission, transfer, or discharge

TJC The Joint Commission; IHI Institute for Healthcare Improvement, CMS Center for Medicare & Medicaid Services

Objectives

- Reduce patient harm and healthcare expense
- Develop a standard protocol for medication reconciliation for Jefferson-owned Hospitals
- Implement protocol and follow outcomes

Current Workflow at TJUH

1

Admission

Provider gets complete med list
Enters into Epic EMR

2

Update medication list

Prescriber marks each medication as to be ordered, not ordered, replaced
Update status to '**Provider Complete'**

3

Pharmacist verification

Pharmacist reconciles then marks as '**Pharmacist complete'**

Jefferson Affiliate Resources

Hospital	Med Rec Personnel	Epic EMR Used (Y/N)
Abington Memorial	2 pharmacy technicians	Y
Abington Landsdale	Hospitalists Pharmacists – on admission per request	--
Einstein	Physicians – admission & discharge Pharmacists on med surge units	NA – no epic
Jefferson NJ	Medical staff	--
Jefferson Northeast	Nursing/physicians – no true program	--

Suggested Workflow Components

1. Acquire best possible medication history (BPMH)
2. Specify roles and responsibilities for staff
3. Stratify patients by risk (ie more meds = higher risk)
4. Use standardized medication history notes
5. Enable access to pre-admission documents and patient medication lists (via EMR)
6. Community collaboration (with other hospitals, provider networks, pharmacies)
7. Deploy pharmacy-led MR teams

Methods for Accurate Reconciliation

Start Early

- Remind patients to bring a medication list or photo of labels
- Telehealth review of medications
- Save time and resources during admission

Electronic Medication Reconciliation

- Utilize uniform software for accurate and transferable medication lists
- automated reconciliation for home and inpatient medications
- Reduced medical staff burden

Take-Home Medication Lists & Community Education

- Always discharge with medication forms
- Create option to store medication lists as photos
- Community education at the point of care and at home

Resources and Recommendations

Pharmacist – led teams

Pharmacist – physician collaboration at transitions of care is critical

Educational training program

Based on **Model for improvement framework** train pharmacists; initiate protocol guided by experienced mentors

Plan Do Study Act

Focus on iterative process improvement with interim data readout; make improvements as needed

Standard Data Collection/Software

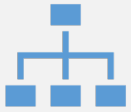
EMR use shown to be effective in reduce MR related ADE

Transitions of Care Matter

Transition points present higher risks of error in medical reconciliation

KPIs should highlight stress points - staff limitations, admissions, high-risk patients

Data obtained from Epic charts – self-reported attestations, automated data points



Clear definition of roles & responsibilities is most important factor

KPI Metric	Goal	Data Capture
Pharmacist reviews 100% ICU/step-down patient meds w/in 24 hours of admission	Capture all inflow into the hospital (ED and non-ED) and perform timely med rec	Standardized admission form
Medication verification from at least two sources	Assure accuracy of patient medications.	Report created daily to identify success rate.
100% of discharge medication reconciliations reviewed for patients directly discharged from the ICU	ICU discharge identified as high incidence for medication error. These metrics will show missed opportunities due to time of transfer/workflow constraints	Report created and run daily
90% of transfer medication reconciliations reviewed for internal transfers		Report created and run daily
Discharge reconciliation verified with follow up provider via verbal sign out	Discharging physician reconciles the medications for discharge and verbally verifies with the follow up provider (PCP or otherwise).	Self-reported (Y/N)

Projected Timeline

NOTE: Detailed timelines for other key activities are TBD

	Tasks	Responsible Party
Admissions	Best Possible Medication History	Nurse/ pharm tech/ provider/ ER tech
	Enter into EMR using standardized med hx list	EMR
	Flag high risk patients	Provider / pharmacist
	Provider approves reconciled medication list	
Transfer	Communicate changes between providers	Prescribing Physician
	Update medication list from time of admission	Provider/nurse/pharmacist
	Dual approval for transfer	Provider and pharmacist
Discharge	Ensure medication list in EMR is updated and accurate	Provider / pharmacist
	Patient education on medication changes	Medical staff
	Provider gives hand-off to follow-up provider	Provider

Short term, low resource plan:

- Establish point person/ team at each Jefferson Hospital
- Specify responsible party for MR at transitions of care
- Flag high risk patients – pharmacist integration here
- Need more information on EMR integration

Long term, high resource:

- See Suggested Workflow components (slide 9)
- Educational & training components
- Longitudinal study; IRB approval

Other thoughts*:* Physician input

- Can we create a temporary team of Providers & pharmacists to discuss how we can best execute these plans at TJUH?