Time to Get Serious

About Medication Reconciliation

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The Centers for Disease Control and Prevention estimates that each year in the United States:

- 82% of American adults take at least one medication and 29% take five or more;
- 700,000 emergency department visits and 120,000 hospitalizations are due to Adverse Drug Events (ADEs) annually;
- $3.5 billion is spent on extra medical costs of ADEs annually;
- At least 40% of costs of ambulatory (non-hospital settings) ADEs are estimated to be preventable.

The prevention of ADEs was the incentive behind creating medication reconciliation. Medication reconciliation is the act of obtaining a list of medications taken prior to the hospital or provider visit and comparing that to any new medications that are prescribed. If performed well, medication reconciliation, which is far from a new concept, can prevent errors and ADEs. Yet many hospitals still struggle to perform these processes effectively. Now the Center for Medicare & Medicaid Services (CMS) is upping the game with financial incentives and penalties. Two new regulations could change how seriously providers and hospitals focus on this difficult task.

1) Starting in 2014, Stage 2 Meaningful Use demands that providers and hospitals no longer just document the patient’s home medications. They must also perform medication reconciliation as a CORE requirement. For eligible hospitals, this could represent anywhere from $2 million up to $6.3 million in incentive money based on the number of patient discharges within the reporting year. Starting in 2015, a Medicare payment penalty will be imposed for hospitals and providers not performing medication reconciliation.

2) Not as widely discussed, the Hospital Readmissions Reduction Program, which started in October 2012, dings a hospital 1% of its Medicare payments if it has excessive readmissions to its own facility or any like hospital within 30 days of discharge. The penalty increases to 2% in October 2013, and again to 3% in October 2014.

Because medication mistakes can lead to readmission, these penalties provide an incentive to improve medication reconciliation and decrease ADEs. Following a hospital stay, patients are often sent home with new or changed medications. Hospitals must give patients a list of all their new medications at the time of discharge. There is a risk that incorrect information given to the hospital at the time of the initial interview with the patient goes uncorrected throughout the entire hospital stay. Consequently, the medication list the patient takes home likely contains errors that are confusing to the patient. That confusion could become exacerbated by the patient possibly not being...
able to see their primary care physician right away after they are discharged. With no assistance to clear up the confusion, a patient could inadvertently take the wrong medication, wrong dose, or experience an undesired reaction with another medication, which could lead to an ADE and a potential readmission.

Why is medication reconciliation so difficult? It starts with the patient. A typical person taking more than a few medications will likely be unable to correctly recite all their medications, the correct strength or dose, and for what reason they are taking the medication in the first place. It gets even more complicated if the patient has medications prescribed by more than one doctor or gets prescriptions filled by more than one pharmacy.

The difficulties continue if a patient is unable to communicate upon presentation to the emergency room or admission to a hospital. When that happens, nurses and doctors often rely on family members to provide information about the patient – a practice supported by The Joint Commission:

“When the patient is unable to actively or fully participate in the medication reconciliation process and has requested assistance from another person(s) (e.g., family member, significant other, surrogate decision maker), involve the authorized person(s) in the medication reconciliation process. This involvement should occur at all interfaces of care, and on admission to and discharge from the facility.”

As a test, I asked my family and friends to name all the medications their loved ones were taking. “I couldn’t even begin to tell you” was a common response.

Another barrier to getting an accurate medication list from the start is under-trained non-pharmacy staff members failing to obtain an accurate, detailed medication history. I witnessed an admission nurse struggle for well over an hour trying to find the correct medications in the electronic health record she was using. She explained to me that she was taught to pick a generic medication on the list when she was unable to find an exact match. The expectation was that someone who had more time would correct it later.

Unfortunately, time also seems to be a contributing factor. A busy ED or a nurse with several admissions during the day may be unable to dedicate the time to obtain a full, accurate medication history on the patient.

So, short of providers asking their patients to walk around with their pill bottles at all times, what can be practically done to help solve this problem?

Four solutions:

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1 The Joint Commission, Issue 35: Using medication reconciliation to prevent errors, Available at: http://www.jointcommission.org/assets/1/18/SEA_35.pdf
1. Form a multi-disciplinary team, which includes strong support from the Pharmacy department, to tackle the problem. Focus on high-risk patients and use pharmacists to assist in the medication reconciliation process. Develop detailed questionnaires to query patients on the medications they are taking, including herbs and supplements. A good questionnaire utilizes multiple ways to get the patient to think about what medications they may be taking. It also asks questions in a manner that solicits more than a yes/no response to engage the patient to be more thoughtful about their response. For example:
   - What medications do you take every day?
   - What other medications do you take or only take occasionally?
   - What over-the-counter medicines do you take?
   - What medications do you take for allergies, such as pet allergies or hay fever?
   - What medications do you take that help with breathing, such as an inhaler?
   - What medications do you take that help with joint pain?
   - What multivitamins or herbal supplements do you take?
   - Have you taken any antibiotics within the last 2-3 weeks?
   - Are you wearing any medication patches?
   - What medications are you taking in a way that is different from how you were told to take them?
   - What medications are you supposed to be taking and aren’t?
   - Are there any medications that you stopped taking because they caused an allergic reaction, such as a rash?
   - Is there anything else you take that has not been mentioned?

2. Establish a process to validate the Best Possible Medication History (BPMH) with at least one other source such as the patient’s PCP or local pharmacist. You may also want to establish procedures to recheck the medication list at multiple points during the hospital stay. For example, once in the Emergency Department, then again when the patient is admitted, and then again a day or two into the hospital stay. Create some sort of indication in the electronic health record that medication reconciliation was completed and to what confidence level. For example:
   - “Completed and verified with PCP/Pharmacy”
   - “Completed and verified with pill bottles”
   - “Completed and verified with patient written list”
   - “Completed and verified with patient’s family member”
   - “In progress, waiting for additional information”
   - “Not completed”

3. Utilize functionality within the electronic health record to retrieve medication information from multiple sources, including pharmacies and other hospitals.

4. Provide patients and family members education on the importance of maintaining an accurate medication list and carrying it with them at all times. There are even free
applications patients can install on their smartphones to help with this. Review discharge medication lists in detail with patients before they are discharged to make sure they understand the new medications they should be taking and any changes to medications they were taking before their hospitalization.

Attention to improving medication reconciliation will continue to grow. Stage 2 Meaningful Use requirements and reduced CMS payments may make this even more important to providers and hospitals. It is easy to identify barriers for performing medication reconciliation. Identifying practical solutions for performing effective medication reconciliation will require increased coordination, communication, education, and use of technology.
13) Medication Question Dos and Don’ts, Available at: 
   http://www.charlydmiller.com/COMM/medquestions.html

14) Centers for Disease Control and Prevention, Medication Safety – Basics, Available at: 
   http://www.cdc.gov/MedicationSafety/basics.html#ref

15) Medication Reconciliation, A Program that Provides Good Medicine for Patients and Care Givers, 
    Available at: http://i.dell.com/sites/content/public/solutions/healthcare/en/Documents/medi-
    reconciliation-patients.pdf

16) Collaborative Medication Reconciliation Significantly Reduces Errors and Readmissions in 
    Patients Discharged to Nursing Homes, Available at: 
    http://www.innovations.ahrq.gov/content.aspx?id=3111&tab=1

17) University of Wisconsin Hospital and Clinics Medication Reconciliation Education Packet. 
    Available at: 

18) A Health Care Provider’s Guide to the HIPAA Privacy Rule: Communicating with a Patient’s 
    Family, Friends, or Others Involved in the Patient’s Care, Available at: 

19) The Joint Commission, Issue 35: Using medication reconciliation to prevent errors, Available at: 
    http://www.jointcommission.org/assets/1/18/SEA_35.pdf