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Automated Medication Reconciliation Part II
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Physician's Role in Medication Reconciliation

In 2007, the American Medical Association published its 37-page monograph entitled, *The Physician's Role in Medication Reconciliation: Issues, Strategies and Safety Principles*. The very length of this monograph lets you know how complex and challenging this task really is. The preface gives this warning to physicians:

> "Medication Reconciliation is essential to optimize the safe and effective use of medications. It is one element in the process of therapeutic use of medications and medication management for which physicians are ultimately held legally accountable...".

The AMA documented that between 2004 and 2005, "in the United States 701,547 patients were treated for an adverse drug event (ADE) in emergency departments and 117,318 patients were hospitalized for injuries caused by an ADE. Insulin, warfarin (Coumadin) and other drugs that require monitoring to prevent overdose or toxicity were implicated in one of every seven ADEs treated in emergency departments." The report stated, "Interactions between prescription medications and over-the-counter (OTC) drugs, herbal preparations or supplements are a growing concern, as concurrent use can lead to serious adverse reactions." And, "in all settings of care, drug-drug interactions are significant but undetected causes of ADEs."

Steps and Principles of Medication Reconciliation -- Steps:

1. Assembling the lists of medications - notice the word is "lists," not list. In a recent meeting about a regional health information exchange (HIE) an alarm was raised by the potential need to reconcile medication lists from five to ten locations. The response was that the good news was that for the first time, all providers would know that patients were getting medication from multiple sources and providers would have access to the "real" lists for medication reconciliation.
2. Ascertaining accuracy (review and compare prior and new lists)
3. Reconciling medications and resolving discrepancies

4. Formulating a decision, i.e., making a medical judgment, with respect to the patient's condition and medications.
5. Optimizing care to best meet the patient's needs with this information.
6. Checking the patient's (and/or caretaker's) understanding of their medications
7. Documenting changes and providing the patient with a copy of his or her current medication list.

Principles

1. Medication reconciliation is a necessary component of safe medication management. The process is ongoing and dynamic, which means it is constantly changing.
2. The medication reconciliation process should be patient-centered.
3. Shared accountability between healthcare professionals and patients is essential to successful medication reconciliation outcomes.
4. All patients should have an accurate medication list for use across sites of care and over time.
5. The medication list should not be limited to prescription drugs.
6. Within all settings, the medication reconciliation process should happen at every medication encounter, regardless of the care location.
7. Across all settings, the medication reconciliation process must happen at every transition in the patient's care, regardless of the care transition.
8. The process of medication reconciliation is interdisciplinary and interdependent and reliant on a team approach.
9. Physicians are ultimately responsible both ethically and legally for the medication reconciliations process.
10. Some medication information may be emotionally or legally charged, but nevertheless significant. It may be added at the discretion of the patient or prescribing health care professional by mutual consent.

Questions which will help with Medication Reconciliation

1. What medications do you take? Can you tell me the names of all your medications, including vitamins, OTC drugs, supplements and nutraceuticals?
2. What is it important to take your medications?
3. When do you take this medication? How long have you been taking this medication? Do you have a medical condition? What medical condition(s) do you have? What did your doctor say to you about this medication?
4. How do you take your medications (e.g., time of day, with food)?
5. Are you taking your medications the way the doctor told you to? When was the last time you took it? When was the time before that?
6. What do you do when you make a mistake? Do you every skip medication or take two when you miss a dose?
7. Is your medication making you feel better or worse or no change?
8. What other medications, herbals, supplement, nutraceuticals, drops or sprays are you taking? Do you take other drugs that a physician has not prescribed?
9. From where do you get your medications? A local pharmacy? Mail order? The Internet? From another country? Other?

10. Who buys the medications in your family? Should we talk to him or her to make sure we have a complete list of all the medicines you take?

Reconciled Medication lists should be given to all patients at every point of transitioning of care and should include the following:

- A Reconciled List of Medications including Over the Counter, Herbal and Supplements
- Instructions in English (not Latin) for dosage, directions and timing of prescription
- A list of the patients allergies
- The date and time of the Reconciliation
- The person who did the reconciliation
- The contact information for the Reconciliation

Strategies to Assist Patient Understanding

1. Use plain, nonmedical language.
2. Slow down
3. Break information down, use short statements.
4. Organize information into two or three key concepts, then check for understanding. Aim for a fifth to sixth grade reading level on all written information.
5. Use communication aids to assist in conversations, discussions or education sessions with patients, families and care givers.

    a. Offer to read materials aloud and explain
    b. Underline, highlight or circle key points.
    c. Provide a trained interpreter, when appropriate.
    d. Use visual aids to help patients navigate the health care system and understand health information.

6. Ask patients to teach-back what they were told:

    a. We have gone over a lot of information. In your own words, can you review for me what we have discussed? How will you make it work at home?
    b. Sometimes I give a lot of information. Can you let me know what you heard me say? This helps me make sure I gave you the information you want and need/

Conclusion

Medication Reconciliation is hard and it is critical. The dynamic nature of medications being taken creates the complexity of maintaining and accurate lists as does the fact that most patients on multiple medications are being seen by two to seven providers annually. The probability for medication reconciliation to result in accuracy in medication administration is increased by the frequency of reconciliation being completed, particularly when each reconciliation is thorough. If a patient has ten to fifteen medication reconciliations or more per year, adverse medication

events will decline and hopefully disappear. Such reconciliations are time consuming and require perseverance, but the result will be increased safety and improved care with decreased cost.

SETMA's Medication Reconciliation Policy – Adopted by Governing Body 2010 and Renewed Annually

1. Medications will be reconciled at the following times.

    a. Hospital admission
    b. Hospital discharge
    c. Care Coordination call post hospitalization care coaching calls
    d. Hospital Follow-up clinic visits
    e. Post office Care Coordination calls
    f. Clinic Visits
    g. Nursing Home Visits
    h. Emergency Department Visits which are not admitted to hospital

2. When performing the reconciliation, staff will ensure no medications are duplicated, outdated, or omitted.
3. When medications are prescribed by physicians outside SETMA, these shall be so noted on the medication template by indicating ''prescribed elsewhere'.
4. Over the counter medications are to be marked "prescribed elsewhere". This makes the medications current instead of listing them by provider and having a start date of 2008 and never being updated giving the impression it is not updated.
5. Patients should be given a copy of the reconciled medication list when leaving the clinic or upon hospital discharge.