MiCMRC Self-Study Module

Medication Reconciliation

The Michigan Care Management Resource Center

Medication Reconciliation Objectives

- Define the purpose of medication reconciliation
- Describe steps to conduct a medication reconciliation
- Address barriers that may influence medication reconciliation

Introduction

- Over one third of adults take five or more medicines. In addition to prescribed meds many take over- the- counter drugs, vitamins, herbs, and supplements
- Medication reconciliation is a complex set of steps that involves multiple individuals, including providers, nurses, pharmacists, patients and their family.
- Older adults are at risk for errors because of their rate of poly-pharmacy, co-morbidities and multiple providers

Definition

- Medication reconciliation is the process of comparing a patient's medication list to all of the medications that the patient has been taking.

- It's a National Patient safety goal (NPSG) from the Joint Commission (TJC) that entails reviewing all medications a patient takes after a health care transition.

Purpose

- It is conducted to avoid medications errors such as omissions, duplications, dosing errors or drug interactions.

Medication Errors

- Given the complexity of medication reconciliation, errors can occur at many steps such as prescribing, dispensing, and administration
- May also occur between settings, i.e. when a patient moves from home to the hospital, hospital back home or from hospital to nursing facility to back home

When to do Medication Reconciliation

- The Joint Commission defines the implementation expectations for medication reconciliation:

  Obtain the patient's medication information at the beginning of an episode of care and updated when medications change

- The goal is to provide patient safety across the continuum of care, regardless of location or providers involved with their care

Benefits for the Patients

- Reduces their risk from medication errors
- Become more engaged participants in their own healthcare
- Improved clinical outcomes
- Gain knowledge regarding safe medication management
- Have effective communication with their healthcare providers

Benefits for Providers

- Improve the safety and quality of the medication process
- Realize the enormity, complexity and importance of medication reconciliation
- Appreciate the influences and non-medical factors that affect patients ability to manage medications
- Develop a more comprehensive medication list, including OTCs, vitamins, herbals and nutritional supplements
- Comply with recommended clinical practices

Comments From Patients

- “What are all the medicines I take? I don’t know but my doctor does”
- “Doctors need to learn how we think. We are speaking different languages”
- “I turn my pill bottle upside down after I take my pills so I know I have taken them. Sometimes the bottle tips over and then I try and remember”

A Three Step Process

According to the Institute for Health Improvement medication reconciliation is a three step process.

Verification

- Collecting an accurate medication history

Clarification

- Ensuring that the medication and doses are appropriate

Reconciliation

- Documenting every single change
- Making sure it “squares” with all the medication history

Verification

- Involves collecting a medication history and creating a medication list. The challenge is:
  - Patients may not be able to provide an accurate history of medication use, nor maintain a documented list of their medicines

  - Healthcare providers may not obtain a complete medication history with every patient encounter
- This breakdown in communication between patients and providers regarding medications leads to error and adverse events.

Clarification

- A Key goal in clarification is to identify any duplicative medication use as well as inappropriate medication use in the older adult
- Below are tools to help the care manger when clarifying patient medications:
  - Review the drugs for appropriate use:
    - 2015 Updated Beers Criteria
    - List of *confused* drug names
  - Reference Clinical Guidelines:
    - Designing the Medication Reconciliation Process

Reconciliation

- The patient is the one source of truth when conducting medication reconciliation. If patient is unable then refer to the caregiver
- Provide education for patient/caregiver and document in the patient's medical record

Ask to See All the Medications

- When patients are scheduled to meet with their physician ask that they bring their medications, including supplements and OTCs.
- Reviewing the medications the patient brings to the visit is an essential step in gathering information.
- Viewing the medication with the patient helps the patient and health care professional discuss each medication *and how the patient takes the medication*"
  - Identification of the bottle
  - Reviewing labels
  - Refills left

Reminders to Patients and Caregivers When they Bring a List

- Full name of medicine including XL, CR, CD, etc.
- Strength of each medicine (mg, mcg, units, etc.)
- How much is taken (one tablet, 2 capsules)
- How the med is taken (by mouth, inhaler, SQ)
- When it is taken (morning, evening, at bedtime)
- Date and time of last dose

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Medications Include:

- Prescriptions and sample medications
- Herbal remedies and vitamins
- Over-the counter drugs
- Vaccines
- Diagnostics and contrast agents
- Radioactive materials

Medications Continued:

- Respiratory therapy treatments
- Parenteral nutrition
- Blood derivatives
- Intravenous solutions
- Any product designated by the Food and Drug Administration as a drug

Medication Prompts

- Ask about creams, ointments, lotions, patches, eye drops, ear drops, nebulizers and inhalers
- Ask about medications that may be taken for medical conditions, “What do you take for diabetes?”
- The types of physicians that prescribe the medication, “Does your heart doctor prescribe medication?”

Medication Prompts Continued

- When do they take their medications, time of day, weekly, monthly, and as needed.
- Medication recently started or stopped
- Changes to any medication
- To help determine dose, you may ask about the color, shape or directions for use

Medication History Prompts

- Incorporating “probing questions” into the patient interview may help triggers the patient’s memory of their medication.
  - Open ended questions such as, “What do you take for your high cholesterol?”
  - “Can you show me what you buy over the counter?”
  - Why questions, “Can you tell me why you take ___?”

Inquiring about OTC

- What do you take for a headache?
- What do you take for allergies?
- Do you take anything to help you sleep?
- What do you take when you have a cold?
- Do you take anything for heartburn?

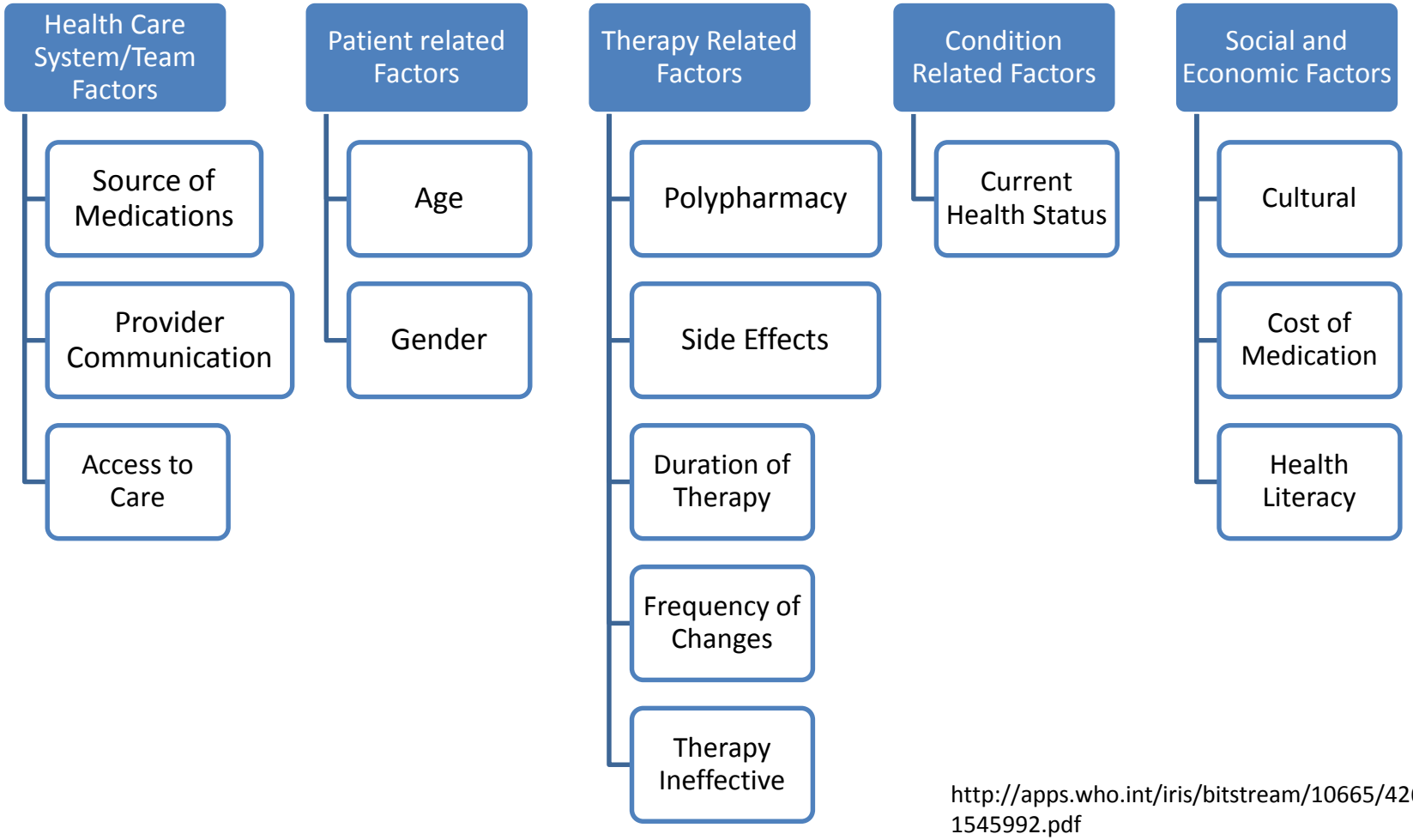
Summary of the Process

1. Developing a current medication list
2. Developing a list of medications to be prescribed
3. Comparing medications on both lists
4. Making changes and interventions accordingly
5. Communicate the newly developed list to providers, caregivers and the patient.

Medication Adherence

- **Medication Adherence:** The patient's conformance with the provider's recommendation with respect to ***timing,*** ***dosage,*** and ***frequency*** of medication-taking during the prescribed length of time

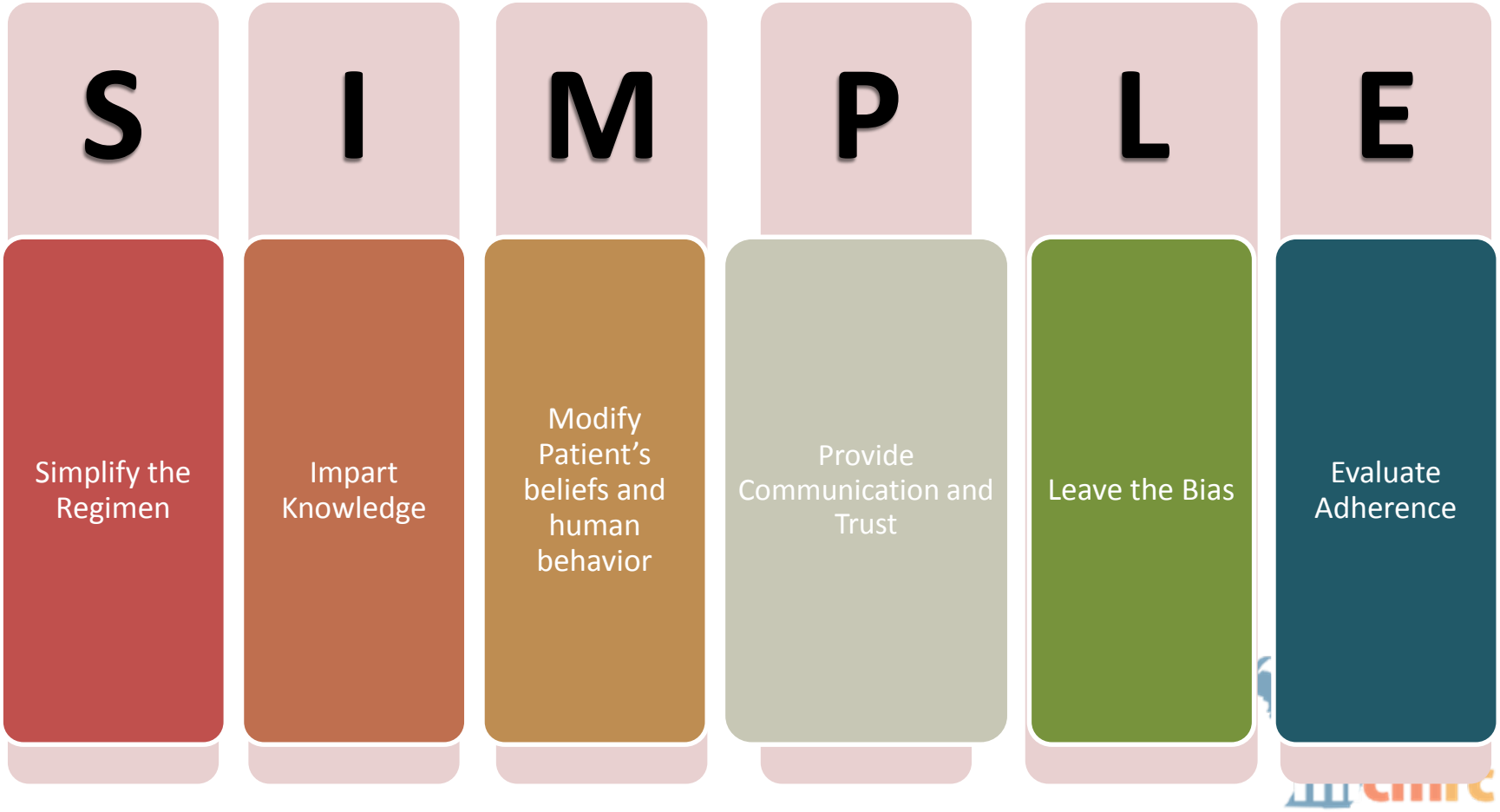
Five Interacting Dimensions of Non-Adherence and Contributing Factors



http://apps.who.int/iris/bitstream/10665/42682/1/9241545992.pdf

What Can Care Managers Do?

"SIMPLE"



http://www.acpm.org/?MedAdherTT_ClinRef

Other Sources of Information

In addition to the patient or when the patient is not able to give the information…..

- Family/Caregiver
- Patient's medication bottles (verify that the medication is taken as written on the label)
- Patient's community pharmacy- mail order
- Other providers or specialists
- Past medical records
- Contact patient's pharmacy for a medication history

No Matter What the Challenges, Medication Reconciliation….

- Is an opportunity to decrease adverse events
- Provides vital information about the patient and their understanding
- Improves the safety and quality of care

Additional Tools

- Medications at Transitions and Clinical Handoffs (MATCH) Toolkit
  - Step by step guide to improving the medication reconciliation process
- Medication reconciliation worksheet

Michigan Care Management Resource Center Website micmrc.org

Care Management 101 is a web based self study opportunity

- a suggested road map of staged content for the new Care Manager
- may be utilized to create customized curriculum for self-study based on the CM's self-assessment
  - Care managers may identify their areas of strengths and gaps
  - Review CM 101 content to select recorded webinars, tools, resources

Access Care Management 101: www.micmrc.org

Access your specific program information

View CE approved Webinars

Share your success as a care manager and practice team

View best practice stories and tools

View multiple webinars on various clinical topics

Michigan Care Management Resource Center Website micmrc.org

Topics for Care Managers Include:

- Advance Care Planning
- Palliative Care
- Pediatrics
- Medication Management
- Transitions of Care
- Patient Centered Medical Home & Team Based Care
- Chronic Conditions
- Quality and Population Health Management
- Elderly Population
- Behavioral Health

Thank You!

- Questions?
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