Medication Reconciliation

Medication reconciliation is a comprehensive evaluation of a patient's medication regimen to improve patient safety. The goal of medication reconciliation is to help the provider and patient understand the medication regimen and resolve conflicting information to maximize the therapeutic effects while minimizing harm. When patients transition across different levels of care or patient care settings, they are more vulnerable to potential medication errors. A lack of consistency in documenting medication histories can lead to a variety of medication-related problems.

Medication Reconciliation Tips

- Medications should be reconciled following hospitalizations, ER visits, specialist appointments, long gaps in time between patient encounters or other reasons deemed appropriate.
- Medication reconciliation step-by-step:
  1. Assemble the medication lists (physician's chart, patient's medication list, discharge medication list, prescription bottles, samples, etc).
  2. Review and compare the previous lists and new lists against the physician's orders. Remember to validate how the patient is actually taking a medication. It could be different than prescribed.
  3. Identify, clarify and document medication discrepancies. Check for:
     - Drug-duplications
     - Drug omissions
     - Drug-drug interactions
     - Drug-disease contraindications
     - Changes in dose or directions
     - Patient taking differently then prescribed or not taking at all
  4. After an accurate medication list has been gathered and any discrepancies are identified, clinical decision making can then take place with respect to a patient's conditions and medications.
  5. Communicate and share the reconciled medication list with patients, caregivers and any other specialty physicians.
- For meaningful medication reconciliation, ask your patients to bring in their medication list and all of their medications to their appointments, including medications they stopped taking. This should include prescription and over-the-counter, samples, respiratory medications, patches, creams, etc.
- Detailed medication reconciliation helps to better understand drug adherence and identify non-adherent individuals, which can impact treatment decisions. It provides the opportunity to assess barriers and improve medication adherence.
- Encourage patients to keep an accurate list of medications and provide them with a medication list prior to leaving the office.
- Get the patients involved with their health care. Educate patients on their medications and ensure understanding and ability to take the medication as prescribed.

References:

American Medical Association. The physician's role in medication reconciliation. Issues, Strategies and Safety Principles. 2007. Available at www.ama-assn.org/resources/doc/cqi/med-rec-monograph.pdf. Accessed June 27, 2013

American Pharmacists Association, American Society Health System Pharmacists. Improving Care Transitions. Optimizing Medication Reconciliation. March 2012. Available at www.ashp.org/DocLibrary/Policy/PatientSafety/Optimizing-Med-Reconciliation.aspx. Accessed on December 17, 2012.

Agency for Healthcare Research and Quality. Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation. August 2012. Available at www.ahrq.gov/qual/match/match.pdf. Accessed on December 17, 2012.

Centers for Medicare and Medicaid Services. EHR Incentive Program available at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/7_Medication_Reconciliation.pdf Accessed on May 13, 2013.

Anthem

Updated 10/20/18