Medication Reconciliation Throughout the Continuum of Care

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Disclosure

No conflicts of interest to report.
Learning Objectives: Pharmacist

- Explain the differences between a patient medication list or medication history, medication reconciliation, and transitions of care.
- Identify the various transitions of care locations within and outside the acute care hospital setting and the potential gaps in the transfer of information.
- Describe the differences between obtaining an accurate medication list and performing medication reconciliation.
- Identify the challenges in obtaining an accurate medication list in both inpatient and outpatient care and the implications on population health management.
- Compare the various levels of pharmacist involvement in medication reconciliation and transition of care activities.
- Explain why a comprehensive medication reconciliation program should be a top tier patient safety initiative.
Learning Objectives: Technician

• Explain the differences between a patient medication list or medication history, medication reconciliation, and transitions of care.

• Describe the challenges in obtaining an accurate medication list.

• Explain the goal of performing an accurate medication reconciliation.

• Explain the impact an inaccurate medication list has on population health management.

• Identify other healthcare disciplines that are involved with obtaining patient medication lists or medication histories.

• Explain why a comprehensive medication reconciliation program should be a top tier patient safety initiative.
Desired Outcomes

• Recognize medication reconciliation as a top priority patient safety initiative.

• Increase the implementation of comprehensive medication reconciliation programs which extend beyond inpatient acute care.

• Promote systematic data collection to more accurately define the positive impact of pharmacist activities in medication reconciliation and transitions in care.
The Continuum of Care

AGE 0-4
AMOXICILLIN

4-12
RITALIN

12-18
APPETITE SUPPRESSANTS

18-24
NO-DOZ

24-38
PROZAC

38-65
ZANAC

65+
EVERYTHING ELSE
Prescription Drug Use: Adults aged 55–64

NOTES: Use is for the past 30 days. Prescription drug classes shown were based on the Multum Lexicon Plus therapeutic drug class. Antidepressant drugs can be prescribed for a wide variety of clinical reasons.

SOURCE: CDC/NCHS, Health, United States, 2014, Figure 28. Data from the National Health and Nutrition Examination Survey (NHANES).
Chronic Conditions: Adults aged 55–64

Medication Reconciliation Throughout the Continuum of Care

Defined as respondent report of physician-diagnosed diabetes or undiagnosed diabetes (measured fasting plasma glucose of at least 126 mg/dL or a hemoglobin A1c of at least 6.5%).

Defined as body mass index greater than or equal to 30.

Defined as reporting taking cholesterol-lowering medication or having a measured serum total cholesterol level of at least 240 mg/dL.

Defined as reporting taking antihypertensive medication or having a measured systolic blood pressure of at least 140 mm Hg or a measured diastolic blood pressure of at least 90 mm Hg.

SOURCE: CDC/NCHS, Health, United States, 2014, Figure 21. Data from the National Health and Nutrition Examination Survey (NHANES).
Could these scenarios happen at YOUR hospital?²

• **Patient Case #1**
  
  – A patient was readmitted two days after discharge with hypoglycemia.
  
  – The patient was discharged on a new insulin regimen without the healthcare providers knowing the patient also had insulin 30/70 at home.
  
  – The patient continued to take her previous regimen as well as the new regimen and was found unresponsive by her husband.

• **Patient Case #2**
  
  – A patient was discharged from a hospital without restarting Coumadin for outpatient anticoagulation and was readmitted after experiencing a stroke.
Failure of our Systems – Not Simply a Failure of People

James Reason’s “Swiss Cheese Model” of System Failure

- Each layer or slice of cheese is an opportunity to stop an error.
- An error occurs after all defenses are defeated or when the holes align for each step in the process.
- If the layers are set up with all the holes lined up, this is an inherently flawed system.

http://patientsafetyed.duhs.duke.edu/module_e/swiss_cheese.html
How do we define medication reconciliation?

Inpatient Perspective

- The process of comparing a patient's medication orders to the medications they were previously taking (e.g., on admission their home medication list) at every transition of care in which new medications are ordered or existing orders are rewritten.

- Actually, much more than comparing!

- A decision must be for each medication as to whether therapy should be continued, discontinued, or modified at every transition point.
How do we define medication reconciliation?

General Population Health Perspective

- A process of identifying the most accurate list of all medications a patient is currently taking, and using this list to provide correct medications for the patient in all care settings within the healthcare system. [IHI – 2008]

- Further broadened to consist of three steps:
  - Verification (collection of the medication history)
  - Clarification (ensuring medications and dosages are appropriate)
  - Reconciliation (documentation of changes in the orders)
How do we define medication reconciliation?

General Population Health Perspective

- **Identification and resolution of discrepancies** at each stage of the care process.

- In pharmacy speak – opportunities for interventions to prevent adverse drug effects and/or cost avoidance.
How do we define medication reconciliation?

The Goal: TJC NPSG #3 (03.06.01)\(^5\) – January 1, 2015

- The goal of medication reconciliation is to identify and resolve discrepancies with the intent to reduce adverse drug events (ADEs) during transitions of care (e.g., changes in setting, service, practitioner or level of care). [TJC – 2006, 2015]

- A clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies.

- A good faith effort to collect this information is recognized as meeting the intent of the requirement.

http://www.jointcommission.org/assets/1/6/2015_NPSG_HAP.pdf
# Federal Government Perspective: EHR Incentive Program

## Eligible Hospital and Critical Access Hospital

**EHR Incentive Program**

**Objectives and Measures for 2016**

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Date updated: February 4, 2016

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<td>The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.</td>
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<td>Measure</td>
<td>The eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23).</td>
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Definition of Terms
- **Medication reconciliation** – The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider.
- **Transition of Care** – The movement of a patient from one setting of care (for example, a hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Federal Government Perspective: EHR Incentive Program

- **Objective**
  - The eligible professional or eligible hospital that receives a patient from another setting of care or provider of care or believes an encounter is relevant **performs medication reconciliation**.

- **Measure**
  - The eligible professional or eligible hospital performs medication reconciliation for **more than 50 percent of transitions of care** in which the patient is transitioned into the care of the eligible professional or admitted to the eligible hospital's inpatient or emergency department.

How do we define transitions of care?

- Transitions of care (TOC) is defined as a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location.\textsuperscript{8,9}

- Representative locations include, but are not limited to:
  - Hospitals
  - Sub-acute and Post-acute nursing facilities
  - The patient’s home
  - Primary care offices
  - Specialty care offices
  - Assisted living facilities
  - Long-term care facilities
Are we really only being asked to:

• **Just create** and **update** a medication list?

• **Just compare** a patient’s current medication list to any other medications that are ordered for their care **wherever** they are receiving care?
How difficult a task can this really be?

• **Creating** and/or **updating** a medication list.

• **Comparing** a patient’s current medication list to any other medications that are ordered for their care *wherever* they are receiving care.
Extremely Difficult!

• The ultimate success of the process is based on the identification and resolution of ALL discrepancies.
Extremely Difficult!
A Multi-Step Complex Cognitive Process

• **Create** and **update** a medication list.

• **Compare** a patient’s current medication list to any **new** medication orders or **changes** in medication orders for their care **wherever** they are receiving care.

• **Decide** for each medication as to whether therapy should be **continued**, **discontinued**, or **modified** at every transition point.
A Multi-Step Complex Cognitive Process

• **Evaluate the appropriateness** of each medication order or change in medication order with respect to previous orders, current orders, patient’s medical history, and patient’s laboratory and diagnostic test results.

• **Identify and Resolve any discrepancies** between each medication order or change in medication order with respect to all other previous medication orders.

• **Identify any Resolve any discrepancies** between the patient’s medical history and their medication history (= medical history/medication history mismatch).
How difficult a task can this really be?

• Current evidence reflects this is an extremely difficult task regardless of EMR.

• Medication reconciliation has been redefined outside of the contemporary medical literature as:

  Med Rec  ➔  Med Wreck
What is the impact on Patient Safety when Med Rec → Med Wreck?

**On Hospital Admission**

- 54% of patients had at least one medication discrepancy on admission.\(^{10}\)
- Errors in prescription medication histories occurred in up to 67% of cases reviewed.\(^{11}\)
- 85% of patients had errors in their medication histories and over one-third (36%) experienced a medication order error on admission.\(^{12}\)
- At least one medication history error was identified on admission in 47% of patients while 24% of all patients had two or more errors.\(^{13}\)
- 86% of patients experienced one or more discrepancy in their ED medication history with approximately 3.3 discrepancies per patient.\(^{14}\)
What is the impact on Patient Safety when Med Rec → Med Wreck?

**On Hospital Discharge**

- A total of 14.1% of patients experienced 1 or more medication discrepancies at discharge.\textsuperscript{15}

- 71% of patients had at least one medication discrepancy at hospital discharge.\textsuperscript{16}
How did Med Rec → Med Wreck?

- Doing the bare minimum or just putting in place enough of a process to meet accreditation standards, which even on a superficial level will still consume substantial time and resources.²

- As a profession of health care providers, both in the in-patient and out-patient environments of care, not accepting first-line responsibility for the accuracy and appropriateness of the medication record for each patient under our care at every encounter.
How did Med Rec → Med Wreck?

• By not effectively articulating the true challenges and problems in providing our patients with an accurate medication list.

• By not successfully demonstrating the potential harm produced by medication management gaps in the transitions of care.

• By not forcefully and convincingly establishing a culture where medication reconciliation is unequivocally accepted as a top priority patient safety initiative.
The Problem/Challenges: Simplified In-Patient Process Flow Model

Patient presents to the ED: with or without family, meds, med list.

RN creates home med list: priority CC, Dx, ED throughput, disposition.

Patient discharged home, SNF, etc. for follow-up with PCP.

Patient admitted to hospital with orders written by hospitalist.

Hospitalist Inpt Care: focus on adm dx, LOS, med rec?, talk to PCP?

Hospitalist writes discharge orders: focus on adm dx, new dx’s.

Discharge by RN: focus on nursing instructions, med education, TAT.

D/C Med Rec? Compare inpt to discharge orders to home med list?

Patient discharged to follow-up by PCP and/or other specialties.
The Problem/Challenges: Simplified Out-Patient Care Model

Our Patient requiring continued care

PCP
Internist/FP
Captain of Ship

Cardiologist

Nephrologist

Ophthalmologist

Optometrist

Endocrinologist

Gastroenterologist

Neurologist
What is the Recommended Standard of Practice?

- **Identified 34 safe practices** that have demonstrated effectiveness in reducing the occurrence of adverse healthcare events.
- These safe practices represent the harmonization of practices and specifications with accrediting and certifying organizations, as well as major national safety initiatives.
- They serve as a call to action for healthcare organization leaders and governance boards to proactively assess the safety of their organizations and to continually improve the quality of the care they provide.

<table>
<thead>
<tr>
<th>SAFE PRACTICES</th>
<th>AHRQ</th>
<th>CMS</th>
<th>IHI</th>
<th>LFG</th>
<th>NQF</th>
<th>TJC</th>
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<td><strong>Medication Reconciliation</strong></td>
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AHRQ - Agency for Healthcare Research and Quality  
CMS - Centers for Medicare & Medicaid Services  
IHI - Institute for Healthcare Improvement  
LFG - The Leapfrog Group  
NQF - National Quality Forum  
TJC - The Joint Commission

What is the Recommended Standard of Practice?

Pharmacy Practice Model Summit: November 7-9, 2010

• In an article entitled, “Critical requirements for health-system pharmacy practice models that achieve optimal use of medicines”\(^1\), Dr. Shane highlights:

  — Identification of priorities for patient-centered medication management based on the evidence supporting the role of pharmacists in improving patient care is essential.

  — Essential pharmacist-provided services include medication reconciliation.
What is the Recommended Standard of Practice?

Pharmacy Practice Model Summit: November 7-9, 2010

• In an article entitled, “Critical requirements for health-system pharmacy practice models that achieve optimal use of medicines”¹⁷, Dr. Shane highlights:

  — Given the evidence supporting pharmacist’s value across the continuum of care, and the fact that patients spend most of their lives outside the confines of a health system, the design of a pharmacy practice model should ensure that the role of the health-system pharmacist extends beyond acute care.
What is the Recommended Standard of Practice?

Pharmacy Practice Model Summit: November 7-9, 2010

- Pharmacy Practice Model Summit Consensus (or Vision)\(^1\)
  - B20: Pharmacists should facilitate medication-related continuity of care \((\textit{recommendation})\).
  - B23k: Medication reconciliation in the emergency department; upon admission, interhospital transfer, and discharge; and in the ambulatory care setting \((\textit{essential})\).
  - B23l: Establishment of processes to ensure medication related continuity of care for discharged patients \((\textit{essential})\).
  - B23m: Provision of at discharge education to patients \((\textit{essential})\).

What is the Recommended Standard of Practice?

ASHP Statement on the Pharmacist’s Role in Medication Reconciliation

• Pharmacists, because of their distinct knowledge, skills, and abilities, are uniquely qualified to lead interdisciplinary efforts to establish and maintain an effective medication reconciliation process in hospitals and across health systems.

• Pharmacists share accountability with other hospital and health-system leaders for the ongoing success of medication reconciliation processes across the continuum of care.
What is the Forecasted Standard of Practice?

Pharmacy Forecast 2016-2020: Strategic Planning Advice for Pharmacy Departments in Hospitals and Health Systems

• Population Health Management: Aligning Incentives to Transform Care Delivery
  - 75% of health systems will consider medication-use issues in strategic planning for population health.
  - 75% of health systems will have a formal program for rigorously coordinating post-acute-care services.
  - 50% of health systems will actively include pharmacists in their community-wide programs that are focused on improving the health status of the population.

http://www.ashpfoundation.org/PharmacyForecast2016
What is the Forecasted Standard of Practice?

Pharmacy Forecast 2016-2020: Strategic Planning Advice for Pharmacy Departments in Hospitals and Health Systems

- Population health management is defined as the explicit efforts of health systems to improve the health status of the population of patients they serve (not simply to provide sickness care).

http://www.ashpfoundation.org/PharmacyForecast2016
What is the Current Standard of Practice?

- In a 2014 national survey to transition-of-care activities, “Variations in pharmacy-based transitions-of-care activities in the United States: a national survey”\textsuperscript{22}, the following trends were identified:
  - Medication histories completed on admission: 31%
    - by Nurses – 56%
  - Admission medication reconciliation in the ED: 12%
  - Medication reconciliation at discharge: 22%
  - Review discharge medication lists: 27%
  - Discharge counseling: 24%
  - Post-discharge telephone calls: 9%
  - Reported barriers: resources, insufficient recognition of value, low priority
Do Med Rec/TOC Activities by Pharmacists Improve Patient Care?

• Pharmacist Case Managers\textsuperscript{23}

  – Pharmacist case managers \textit{reduced the number of medication discrepancies of high significance} at 30 days in the enhanced intervention group.

  – \textit{A trend of decreasing discrepancy rates was seen} with increased pharmacist intervention (control \textgreater{} minimal pharmacist intervention \textgreater{} enhanced pharmacist intervention).

  – Of note, the mean number of medication discrepancies per patient for high level discrepancies for both the minimal and enhanced pharmacist intervention were below the mean for the control group at 90 days in the physician record, although this did not reach statistical significance.
Do Med Rec/TOC Activities by Pharmacists Improve Patient Care?

- IPITCH Study\textsuperscript{24}
  - Demonstrated that Pharmacist involvement in hospital discharge transitions of care had a positive impact on decreasing composite inpatient readmissions and ED visits within 30 days postdischarge.

  - Hospital discharge in transitions of care activities included:
    - face-to-face medication reconciliation
    - a patient-specific pharmaceutical care plan
    - discharge counseling
    - multiple post-discharge phone calls
Do Med Rec/TOC Activities by Pharmacists Improve Patient Care?

• IPITCH Study\textsuperscript{24}
  
  – Statistically significant differences in medication-related events were not observed.

  – Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores showed a 9% improvement which was not a statistically significant improvement.
Do Med Rec/TOC Activities by Pharmacists Improve Patient Care?

• A systematic review of hospital-based medication reconciliation practices over 26 controlled studies consistently demonstrated a reduction in medication discrepancies, potential adverse drug events, but showed mixed effects on healthcare utilization (ED visits/readmission).25

— Key aspects of successful interventions included:
  
  o Targeting a “high-risk” patient population.
  
  o Pharmacy staff involvement in medication history-taking on admission and medication reconciliation on admission, during hospitalization, and at hospital discharge.
  
  o Communication with the primary care physician.
  
  o Telephone follow-up after discharge.
Do Med Rec/TOC Activities by Pharmacists Improve Patient Care?

• A systematic review of 18 eligible studies to evaluate the effects of hospital-based medication reconciliation interventions showed most unintentional discrepancies identified had no clinical significance.\textsuperscript{26}

  — The actual effect of medication reconciliation on reducing clinically significant discrepancies in the inpatient setting remains unclear.

  — The lack of effect of medication reconciliation alone on hospital utilization within 30 days of discharge may reflect the need to consider a longer window of observation to demonstrate benefit.

  — Bundling medication reconciliation with other interventions aimed at improving care coordination at hospital discharge holds more promise, but the specific effect of medication reconciliation in such multifaceted interventions may not become apparent until much later than 30 days after discharge.
Do Med Rec/TOC Activities by Pharmacists Improve Patient Care?

• In a Cochrane systematic review of in-hospital medication reviews by a physician, pharmacist or other healthcare professional, there was no evidence that medication review reduces mortality (low-certainty evidence) or hospital readmissions (low-certainty evidence).27

— Medication reviews may have a preventive effect on reducing the number of emergency department contacts (low certainty evidence).
Do Med Rec/TOC Activities by Pharmacists Improve Patient Care?

• In a systematic review of 30 studies to identify the components of pharmacist intervention that improve clinical outcomes during care transitions, performing medication reconciliation alone is insufficient in improving post discharge clinical outcomes and should be combined with active patient counseling and a clinical medication review.²⁸

— Care continuity can be secured by integrating pharmacists across settings so they can collaborate with physicians providing them with patients’ clinical background.
Next Steps: We Need to Unequivocally Prove Med Rec/TOC Activities by Pharmacists Improve Patient Care

• Collect data which effectively describes our positive impact:
  — Clearly define and identify when readmissions or ED visits are:
    o **Unavoidable**: disease progression or a separate problem that is unrelated to the initial admission.
    o **Avoidable**: a breakdown in process such as a failure to relay important information to outpatient providers, patient is unable to fill prescriptions, etc.
Next Steps: We Need to Unequivocally Prove Med Rec/TOC Activities by Pharmacists Improve Patient Care

• Collect data which effectively describes our positive impact:
  
  — Length of Stay (LOS).

  — Medication-related problems during reconciliation which are severity indexed: place a value on the intervention.

  — Disease-specific metrics.

  — Patient Satisfaction or Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)—related metrics.
Next Steps: Implement a Change in Culture

• Accept primary responsibility for the **accuracy** and **appropriateness** of the medication record for each patient under our care at every encounter.

  — Consider adopting “Universal Precautions for Medication Lists”\(^{29}\)

  o At each healthcare encounter, medications lists should be considered contaminated or erroneous until they have been verified for accuracy, especially for high-risk medications.

  o Medications should not automatically be continued at discharge unless needed to treat the patient’s underlying conditions.
Next Steps: Implement a Change in Culture

• Accept primary responsibility for the **accuracy** and **appropriateness** of the medication record for each patient under our care at every encounter.
  
  — As a profession, we need to be “**Med-List Centric**” and own the integrity of the medication list at every episode of care for our patients.

  — Clearly understand that despite being the best trained and qualified profession, other healthcare disciplines are and will accept the challenge, e.g., nurses, nurse practitioners, physician assistants, optometrists, etc.
Next Steps: Implement a Change in Culture

• Adopt and promote a comprehensive medication reconciliation program as a top tier patient safety initiative.
  – The Agency for Healthcare Research and Quality (AHRQ) provided support for an evidence-based assessment of patient safety strategies (PSS).\(^{30}\)
    o PSSs were evaluated over a 4 year period on strength and quality of evidence, with twenty-two identified for adoption.
    o Two of the 22 PSSs recommended for adoption included: the use of clinical pharmacists to reduce adverse drug events and medication reconciliation (encouraged).
    o The research group consisted of project teams from the RAND Corporation, Stanford University, the University of California San Francisco, Johns Hopkins University, the ECRI Institute and an international panel of 21 stakeholders and evaluation methods experts.
Next Steps: Implement a Change in Culture

• Adopt and promote a comprehensive medication reconciliation program as a top tier patient safety initiative.
  
  
  o The evidence for the clinical impact of medication reconciliation exclusively involves interventions in which pharmacists play a key role.
Next Steps: Implement a Change in Culture

- Adopt and promote a comprehensive medication reconciliation program as a top tier patient safety initiative.

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<th>Published Examples</th>
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<td>3PMH with admission reconciliation</td>
<td>Cornish et al. 2005[^5]; Kwan et al. 2007[^3]</td>
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<tr>
<td>“Gold”</td>
<td>Silver + discharge reconciliation is interprofessional (e.g., prescribing physician and pharmacist) + Electronically generated discharge prescription</td>
<td>Cesta et al. 2006[^10]; Dedhia et al. 2009[^36]; Schnipper et al. 2009[^35]</td>
</tr>
<tr>
<td>“Platinum”</td>
<td>Gold + attention to broader medication issues, such as appropriateness of medication choices (e.g., safe prescribing in the elderly)</td>
<td>Dedhia et al. 2009[^26]; Murphy et al. 2009[^41]; Nazareth et al. 2001[^42]; Al-Rashed et al. 2002[^33]</td>
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Table 3, Chapter 25. Medication reconciliation in varying levels of intensity as seen in published studies.[^31]
Examples of Best Practice Models

The Medication Management in Care Transitions (MMCT) Project

• Developed jointly by ASHP and APhA to ascertain best practices in transitions of care by pharmacist

• Conclusions
  — Embracing comprehensive pharmacy services throughout the medication-use process can cost-effectively optimize patient outcomes.
  — Pharmacist-driven medication management in care transitions makes a significant difference in reducing overall health care spending.

Examples of Best Practice Models

The Medication Management in Care Transitions (MMCT) Project

• MMCT best practices were represented by:
  - Einstein Healthcare Network
  - Froedtert Hospital
  - Hennepin County Medical Center
  - Johns Hopkins Medicine
  - Mission Hospitals
  - Sharp HealthCare
  - University of Pittsburgh School of Pharmacy and University of Pittsburgh Medical Center
  - University of Utah Hospitals and Clinics
Available Resources

• The National Transitions of Care Coalition
  – This site offers tool and resources for both patients and providers to help improve the safety of healthcare transitions.
  – Many of the tools are offered in languages other than English.
  – http://www.ntocc.org/

• The Institute for Healthcare Improvement
  – This site contains numerous resources about care transitions, as well as other quality-related components of healthcare in the United States.
  – http://www.ihi.org
Available Resources

• Project RED (Re-Engineered Discharge)
  – Researchers at the Boston University Medical Center (BUMC) developed and tested the Re-Engineered Discharge (RED).
  – Research showed that the RED was effective at reducing readmissions and posthospital emergency department (ED) visits.
  – The Agency for Healthcare Research and Quality contracted with BUMC to develop this toolkit to assist hospitals, particularly those that serve diverse populations, to replicate the RED.
The definition of insanity is doing the same thing over and over again and expecting different results. - Albert Einstein
Self-Assessment Questions

1. There is a clear delineation of responsibility regarding which healthcare provider should create a patient medication list and perform medication reconciliation?
   A. True
   B. False

2. Which of the following are barriers to performing an effective medication reconciliation?
   A. Access to information.
   B. Accuracy of information.
   C. Insufficient resources.
   D. Lack of importance placed on the process.
   E. All of the above
Self-Assessment Questions

3. Which national organization or federal agency specifically identifies medication reconciliation supported by clinical pharmacists?
   A. The Agency for Healthcare Research and Quality (AHRQ)
   B. Centers for Medicare & Medicaid Services (CMS)
   C. Institute for Healthcare Improvement (IHI)
   D. The Leapfrog Group
   E. The Joint Commission
Self-Assessment Questions

4. Which of the following data sets would be the least important in documenting the effectiveness of pharmacist involvement in medication reconciliation and transition of care activities.
   A. Unavoidable readmissions or ED visits.
   B. Medication-related problems during reconciliation which are severity indexed.
   C. Total dollar value of each patient’s medication list.
   D. Avoidable readmissions or ED visits.
   E. Disease-specific metrics.

5. Current medical literature clearly documents the impact of medication reconciliation on improving post discharge clinical outcomes?
   A. True
   B. False
Self-Assessment Answers

1. B. False
2. E. All of the above
3. A. AHRQ
4. C. Total dollar value of each patient's medication list.
5. B. False
References


5. The Joint Commission. National Patient Safety Goals effective January 1, 2015. NPSG.03.06.01.www.jointcommission.org/assets/1/6/2015_NPSG_HAP.pdf


References


References


References


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