Medication Reconciliation:

Between Hospital and Home

Jasneet Parmar, MBBS, Dip.COE

Associate Professor
Division of Care of the Elderly
Department of Family Medicine, University of Alberta

Medical Director,
CH Network of Excellence in Seniors' Health and Wellness

Medical Lead,
AHS Edmonton Zone Home Living and Transitions

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Learning Objectives

Participants will be able to:

- Learn about the issues of medication management in seniors at transitions of care
- Consider medication reconciliation as a strategy in a family physician's clinic
- Become familiar and use the resources for medication reconciliation

Cynthia

Cynthia, an 80-year-old lady, visits you, her family physician, for follow-up after discharge from hospital, accompanied by her daughter. She has recently been discharged after a four week stay in hospital for complications from coronary artery disease and congestive heart failure. She also suffers from diabetes, hypertension, and osteoporosis. Her discharge diagnosis includes mild cognitive impairment. Towards the end of the 15-minute visit, you review her medications and count 12 of them!

Issues of Medication Management

The family physician has limited time to address all the patient's concerns, including optimizing medications

Issues of Medication Management

The older adult with multiple co-morbidities will typically have a have a long list of medications. Seniors with 3 or more chronic conditions are taking an average of six prescription medications (CIHI, 2011).

Photo from: https://upload.wikimedia.org/wikipedia/commons/1/10/Mediciner_(Small).jpg

Issues of Medication Management

Polypharmacy, particularly >5 medications, is associated with increased incidence of drug-related adverse events. In 2010-2011, 1 in 200 Canadian seniors (more than 27,000 seniors) had hospitalizations related to adverse drug reactions (CIHI, 2013).

Issues of Medication Management

Adverse events including medication errors are common in the post-discharge period.

The health system currently has significant deficiencies in safety at discharge (Snow, 2009).

Medication errors tend to occur in transitions of care (Desai, 2013).

Strategies for Medication Management

Medication management in family physician's offices are being done through a variety of interventions (Kucukarslan, 2011) that may include:

a. Collaboration among healthcare providers – physicians or prescribers, pharmacists, nurses or care coordinators, and case workers

b. Telephone or face-to-face follow-ups

c. Creation of algorithms and treatment plans

MedRec as a Strategy

Definition: “Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate & comprehensive medication information is communicated consistently across transitions of care.”
(Institute of Safe Medication Practices in Canada: ISMP)

MedRec as a Strategy

- It has been identified by the W.H.O., as part of their High 5s project, highlighting the top 5 safety priorities internationally.
- MedRec is an Accreditation Canada Required Organizational Practice (Accreditation Canada, 2012)
- It is a major safety initiative to improve communication about medications as patients' transition through healthcare settings.

MedRec as a Strategy

- It is a fundamental to medication management and builds on the medication ‘history- taking’ physicians have been using for years.

- It helps the physicians make the appropriate (de)prescribing decisions for their patients and is an opportunity to encourage patients to be involved in the medication safety (Frank,2014).

MedRec as a Strategy

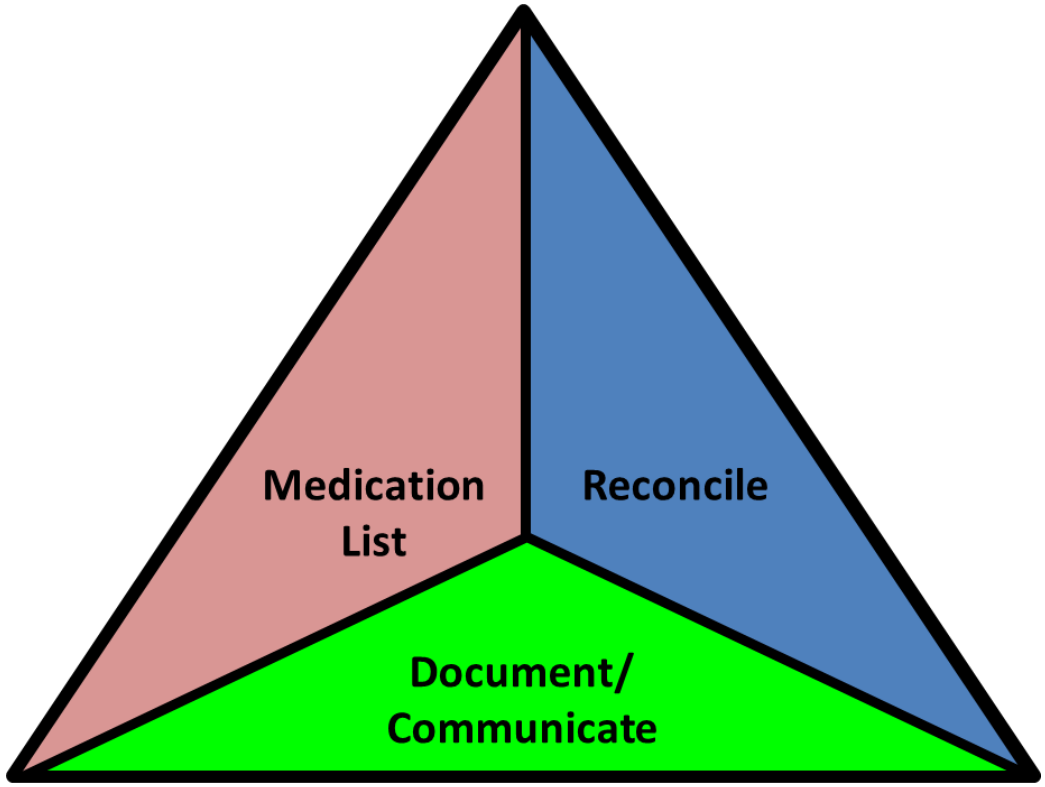
It requires:

a. Best Possible Medication History(BPMH): Generation of a complete and up to date medication list including drug name, dosage, route and frequency

b. Reconciliation of the medication list and identification of discrepancies

c. Documentation and communication

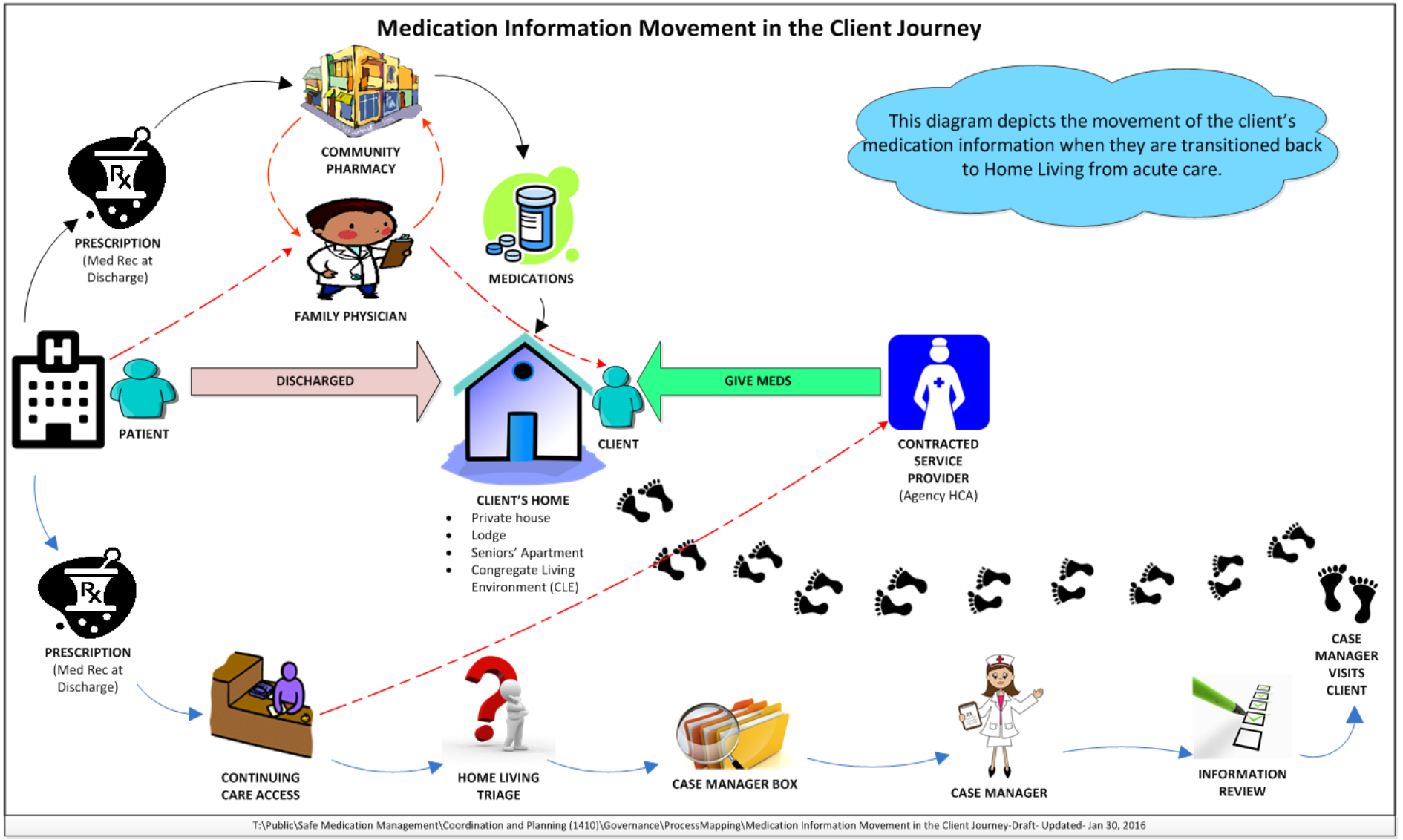
MedRec as a Strategy



MedRec as a Strategy

- It is done during admission and discharge from hospital. http://insite.albertahealthservices.ca/assets/acrd/tms-acrd-medrec-strategic-priority.pdf
- It is being done across Alberta Health Services and Covenant Health as patients' transition between care settings.

Medication Information Movement in the Client Journey



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MedRec as a Strategy

- Case managers are responsible for MedRec at admission for clients on homecare in the community. They are expected to provide the same when their clients are being discharged home from hospital.

Alberta Health Services

Home Living/Supportive Living – Edmonton Zone

Medication Record (Medication Reconciliation)

(AFFIX CLIENT LABEL OR ADDRESSOGRAPH)

Prescriber Guidelines

- The following Medications are currently being taken by the client.
- If any medications are to be discontinued or changed, notify the pharmacy by sending in a prescription.

Allergies:

Best Possible Medication History (BPMH)			**Comparison**		
Medications that client is currently taking: include insulin, over the counter (OTC), drops, patches, creams, injections, inhalers, sprays, vitamins and herbals **Dose/Route/Frequency**	Prescriber	Pharmacy	**Comments** (include any discrpancies identified between BPMH and other sources and any pertinent start/stop dates)	Discrepancy Code	Discrepancy Info Source

Prescriber:	a.	ph#		Information Source	Discrepancy Codes
	b.	ph#		☐ A – Client	1. No discrepancy
	c.	ph#		☐ B – Caregiver	2. Med not currently prescribed
	d.	ph#		☐ C – Medication vials	3. Client not taking med
	e.	ph#		☐ D – Client's own med list	4. Different frequency
Pharmacy:	1.	ph#		☐ E – Bubblepack/Dosette	5. Different route
	2.	ph#		☐ F – NetCare PIN Profile	6. Different dose
	3.	ph#		☐ G – Discharge info from Facility	7. OTC not taken as directed
	4.	ph#		☐ H – Other _____	8. Other _____

Medication Record sent to Prescriber	
☐ Yes Prescriber: ☐ a. ☐ b. ☐ c.	☐ No ☐ Client managing medication ☐ Client refused ☐ Client following up with prescriber ☐ Other _____

Assessor Name	Assessor Signature	Date

MedRec for Home Care

Alberta Health Services

1. Identify the Client
   - Ensure MedRec is completed.
2. Create the Best Possible Medication History and Identify the Differences
   - Minimum of 2 sources
   - Establish what medication the client is actually taking
   - Identify and document differences

MedRec for Home Care

Alberta Health Services

3. Resolve and Communicate Differences
   - Identify differences that require resolution by a prescriber
   - Work with client to initiate resolution of differences
   - Document actions taken
4. Close the Medication Reconciliation Loop
   - Confirm that resolution of differences has occurred
   - Educate the client and/or caregivers
   - Document actions taken

MedRec in Primary Care:
Environmental scan

Primary Care Networks (PCNs) in Alberta have started to use the materials offered though the online portal for resources and tools:

1. Bow Valley PCN – is using public materials to encourage and support patients in creating and maintaining their own medication list.
2. Kalyna County PCN – currently doing medication reviews with their geriatric population.
3. Peaks to Prairies PCN –have identified MedRec as a possibility and plan to examine the materials that are available and support mechanisms.
4. Red Deer PCN – will do MedRec/medication review if it is requested by a physician for a particular patient.

MedRec in Primary Care:
Environmental scan

5.Oliver PCN – has a MedRec process where high risk patients discharged from hospital are identified for medication review with the pharmacist. Other patients get flagged based on set criteria regarding risk.

6. Calgary Rural PCN – has had success in partnering with the hospital in Strathmore project on seamless discharge, as well have a team of pharmacists that support medication reviews within the PCN.

7.Heartland PCN is examining medrec possibility within smaller communities (e.g. Redwater) and hope to build off the success there.

MedRec in Primary Care:
Environmental scan

8. Edmonton Southside PCN – conducting research regarding the information coming from hospitals, partnering with AHS & CH, including med management.
9. Edmonton West PCN – have a similar program to Oliver PCN for targeted patients. As well, have tried to establish links with pharmacists within the hospital.
10. Calgary Foothills PCN –Have a MedRec form that is used within the PCN for new patients; it's done as needed.
11. Westview PCN – Pharmacists supporting physician offices will reconcile medications for patients once a discharge summary arrives from the hospital (if needed), additionally pharmacists support complex care plans and medical assessments with medication reviews if needed.

The Journey to Appropriate Medication Management

Patient in the Hospital

Patient at Home

Patient in clinic

MedRec at Admission

MedRec at Discharge

MedRec Support at Home

MedRec in Community

MedRec Online Resources

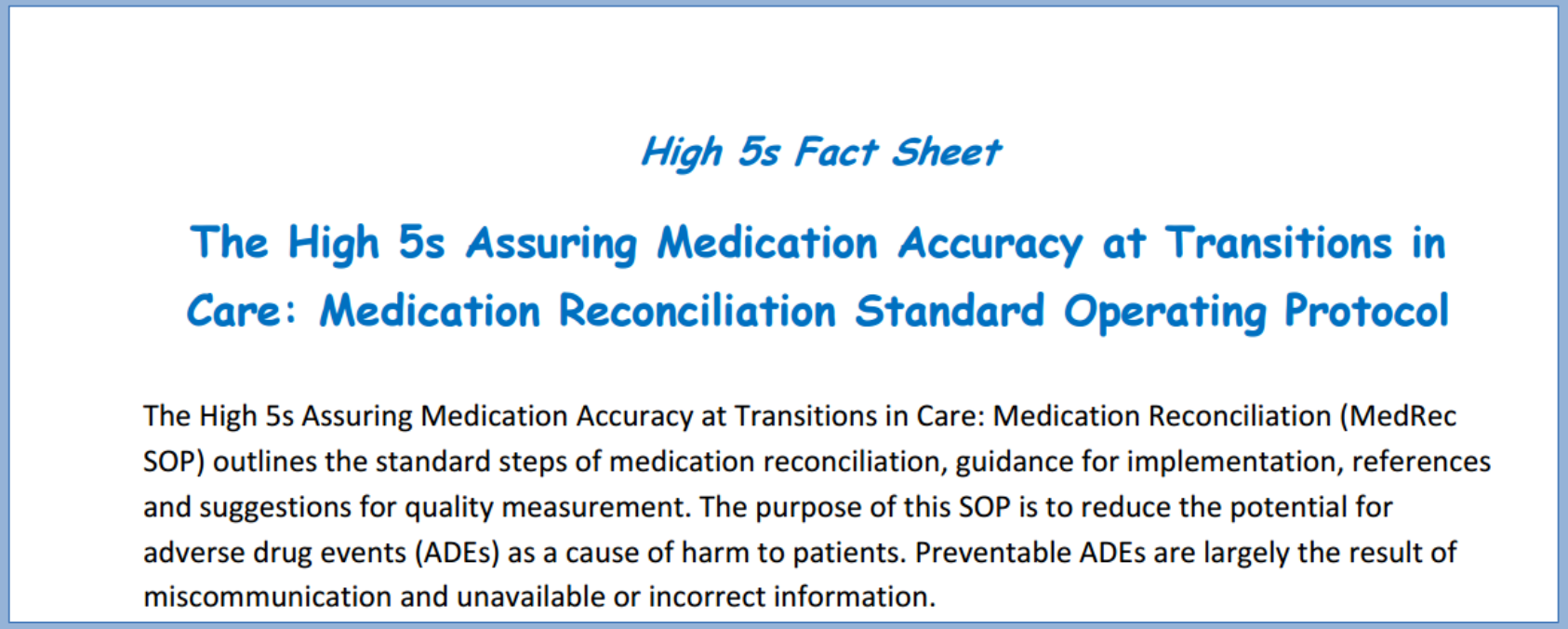
Institute of Safe Medication Practices in Canada

http://www.ismp-canada.org/medrec/

MedRec Online Resources

W.H.O. Collaborating Centre for Patient Safety in Support

http://www.who.int/patientsafety/implementation/solutions/high5s/h5s-fact-sheet.pdf



High 5s Fact Sheet

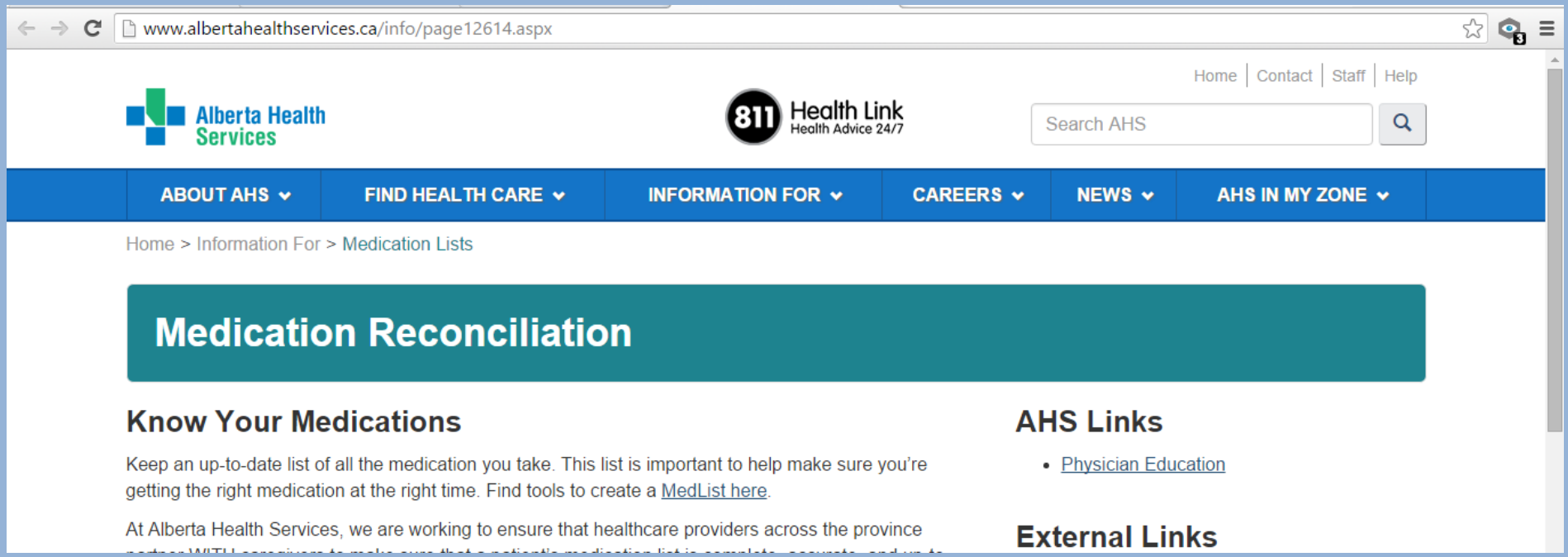
The High 5s Assuring Medication Accuracy at Transitions in Care: Medication Reconciliation Standard Operating Protocol

The High 5s Assuring Medication Accuracy at Transitions in Care: Medication Reconciliation (MedRec SOP) outlines the standard steps of medication reconciliation, guidance for implementation, references and suggestions for quality measurement. The purpose of this SOP is to reduce the potential for adverse drug events (ADEs) as a cause of harm to patients. Preventable ADEs are largely the result of miscommunication and unavailable or incorrect information.

MedRec Online Resources

Alberta Health Services – Medication List Campaign

http://www.albertahealthservices.ca/info/page12614.aspx



MedRec Online Resources

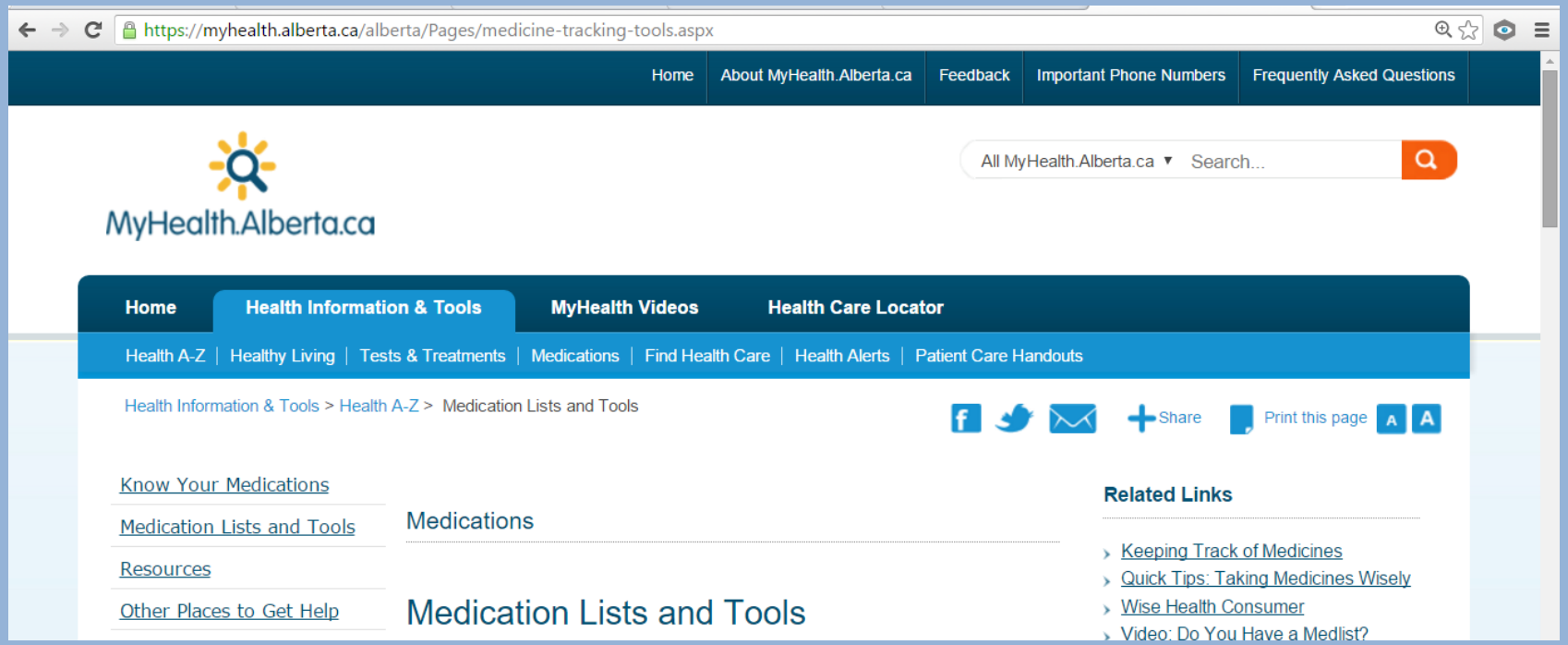
Alberta Health Services – Medication Reconciliation eLearning Module

http://www4.albertahealthservices.ca/elearning/wbt/MedRec/index.html

MedRec Online Resources

MyHealth.Alberta.ca – Medication Lists and Tools

https://myhealth.alberta.ca/alberta/Pages/medicine-tracking-tools.aspx



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Acknowledgement

Peter George Tian MD, MPH

Research Coordinator

Division of Care of the Elderly

Dept. of Family Medicine

University of Alberta

Questions:

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