Medication Reconciliation

What You Are Missing BENEATH the Surface

Medication reconciliation is not a new concept, yet most hospitals and health systems struggle to get it right. The average medication list has between one and seven errors, and an estimated 30% of those errors could result in harm if not addressed. These errors can spring up anywhere, but are more likely to occur when nurses, physicians, and other caregivers are inadequately trained or pressed for time.

Fortunately, there are individuals specifically trained to identify and correct medication errors and optimize medication regimens: pharmacists and pharmacy technicians. But data suggests that most organizations aren't leveraging these individuals when it comes to medication reconciliation. Those institutions miss opportunities to reduce readmission rates and length of stay, improve margins, and boost patient and provider satisfaction. Here's how to take advantage of the specialized expertise of pharmacists and pharmacy technicians and address common "med rec" missteps.

A More **Complicated Process** Than Commonly Thought

1.	2.	3.	4.	5.
Interview the Patient	**Check Against Other Sources**	**Document Changes and Notes**	**Review List Against Orders**	**Locate Provider to Discuss**
Average Time Required **13 minutes**	**13 minutes**	**9 minutes**	**8 minutes**	**12 minutes**

What Could Go **Wrong**

Asking only surface-level questions, missing opportunities to identify discrepancies and missing medications	Accepting one source of data without confirming accuracy	Transcribing incorrectly or failing to complete all required fields per medication	Using an incomplete or inaccurate medication list when reconciling	Failing to relay medication-related updates to next provider

How **Pharmacy** Can Help

Applying medication knowledge and training to ask in-depth, open-ended questions; reminding patients to consider over-the-counter medications, nutritional supplements, and herbals	Taking a best possible medication history (BPMH) and checking at least two sources to confirm medication information	Documenting detailed medication information, including name, dose, route, and frequency; flagging instances where a patient may deviate from prescription instructions	Catching errors during comprehensive medication review; optimizing medication regimen	Dedicating time to flag issues for next provider; discussing any concerns in person or by phone

Pharmacy-Led Medication Reconciliation Leads to Positive Clinical and Financial Outcomes

11%
reduction in median **length of stay** after pharmacist-led BPMH and admission medication review

25%
reduction in **readmissions** from 8 SNFs partnering with Cedars Sinai Medical Center on transitions of care

$4,036
average **increase in margin** at Yale New Haven Health for patients without a medication-related event compared to patients with a medication-related event within the same DRG

124%
increase in **nurse satisfaction** at Legacy Health due to pharmacist-led BPMH in the ED

Sources: "The Alarming Reality of Medication Error: A Patient Case and Review of Pennsylvania and National Data," *J Community Hosp Intern Med Perspect*, 2016; 6(4), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5016741/; "The Importance of Medication Reconciliation for Patients and Practitioners," *Australian Prescriber*, 2012, https://www.nps.org.au/australian-prescriber/articles/the-importance-of-medication-reconciliation-for-patients-and-practitioners#r3; Hohl CM, et al., "Impact of Early in-Hospital Medication Review by Clinical Pharmacists on Health Services Utilization," Ed. Alessandra Marengoni. PLoS ONE 12.2 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5305222/; 2017 Pharmacy Executive Forum Medication Reconciliation Survey; Pharmacy Executive Forum interviews and analysis.

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