Hospital Tip Sheet:
Medication Reconciliation
Treatment Settings: All

L.A. Care HEALTH PLAN

As a part of L.A. Care's initiative to improve the quality of care for our members and prevent potential or harmful drug events, this reference guide is designed to ensure medications are adequately communicated to the next provider, level, or setting of care following discharge or transfer.

Medication errors make up a significant portion of the adverse drug events patients may experience during the period upon admission, or discharge from the hospital to home or another facility. To prevent potential or harmful adverse drug events and reduce unplanned re-admissions, it is important that medications are reconciled at all transition of care points.

Per the Joint Commission, medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. Reconciliation is done to prevent medication errors such as omissions, duplications, dosing errors, and harmful drug interactions. Reconciliation should be done at transition of care points, whether it is a change in setting, service, practitioner or level of care. Reconciliation consists of five steps:

1. Developing a list of current medications.
2. Developing a list of medications to be prescribed.
3. Comparing the two medication lists for variances.
4. Based on the comparison, deciding which medications to add, discontinue, or modify.
5. Communicating the new list to the provider or service and to the patient or their caregiver.

UPON ADMISSION - WHAT CAN HOSPITALS DO?

- **Collect a complete list of current medications the patient is taking at home, including over-the-counter medications, vitamins, herbals, nutritional supplements, and others. Review the list with the patient or caregiver to ensure it is correct.**
- **Use electronic prescribing data sources and CURE, if indicated, to identify unreported prescriptions**
- **Obtain a list of the patient's medication allergies and drug intolerances, noting them on the medication list as an "alert."**
- **Place the medication list in a highly visible location in the patient's chart and include dosage, drug schedules, immunizations, and allergies or drug intolerances on the list.**
- **Assign a Pharmacist to compare the admission orders to the home list to identify discrepancies, and recommend changes.**

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TRANSFERS BETWEEN FACILITIES - WHAT CAN HOSPITALS DO?

- Compare the medication history (medication taken at home) and the current medication list with the physician transfer orders. If medications appear on one list and not on the other, without documented reason, they are not reconciled, and need to be clarified by the physician.
- Coordinate a review and reconciliation of the patient's medications by the Hospitalist, Discharge Planner and Pharmacist prior to discharge.
- Transmit the transfer summary sheet, and a complete medication list, to the receiving facility. Telephone the receiving facility and confirm receipt.
- Educate the patient or their caregiver. Provide them with discharge instructions (oral and written) of what to expect during transfer.
- Inform the patient's primary care physician and health plan of the member's transfer. Transmit a copy of the transfer summary to the provider's office.

PATIENT DISCHARGE HOME - WHAT CAN HOSPITALS DO?

- Coordinate a review and reconciliation of the patient's medications by the Hospitalist, Discharge Planner and Pharmacist prior to discharge.
- Educate the patient or their caregiver prior to or at discharge and provide discharge instructions (oral and written) that are simple and easy to read, and include a complete list of medications.
- Instruct the member to bring all the medications they take at home and the discharge instructions given to them by the hospital to their next doctor's visit.
- Emphasize with the patient the importance of following up visit with their doctor, ideally within 7 days after discharge.
- Transmit the summary of care document, including a complete medication list, to the patient's primary care physician. Facilitate timely completion and transmission of the discharge summary.
- If the patient is to receive home health services, communicate to the provider the patient's discharge date and fax the discharge summary, including a complete list of medications, prior to discharging the patient home. Confirm receipt by telephone.
- To access or download a copy of this reference guide and other reference materials, please visit: http://www.lacare.org/providers/provider-resources/hedis-resources.

The HEDIS Operations team is here to support quality patient care and ensure the care you provide members is reflected in your HEDIS performance. Send any email inquiries our way, along with the best time/day and phone number to reach you. We will reach out to you within 3 business days. HEDISOps@lacare.org - All emails containing member PHI MUST be securely encrypted.

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HEDIS Hospital Tips: Medication Reconciliation Post-Discharge (MRP)

Treatment Setting: Inpatient

L.A. Care HEALTH PLAN®

HEDIS® (Healthcare Effectiveness Data and Information Set) is a standardized set of performance measurements developed by the National Committee for Quality Assurance (NCQA) for measuring quality health care performance.

As a part of L. A. Care's initiative to improve quality of care for our members, this HEDIS® reference guide is designed to help achieve the best quality care, in alignment with the HEDIS® standards as well as with evidence-based clinical practice guidelines.

*Medication errors make up a significant portion of the adverse events patients may experience during the period immediately following hospital discharge. To improve continuity of care and to reduce unplanned re-admissions, it is important to reconcile discharge medications with the outpatient medications. Medication Reconciliation post-discharge can be conducted by PCP, Clinical Pharmacist, or Registered Nurse.

WHAT CAN HOSPITALS DO?

- At the time of discharge, ensure that medication reconciliation is performed by a physician, pharmacist or nurse.
- If not performed at discharge, coordinate with PCP, Pharmacist, or Home Health Agency for post discharge medication review and reconciliation.
- Ensure timely transmission of a summary of care document to the PCP, including a copy of complete medication list.
- Facilitate timely dictation and transmission of the full discharge summary to the PCP.
- Review medication list with the patient prior to discharge and scheduling of a follow-up visit with PCP, ideally within 7 days.
- Provide discharge instructions (oral and written) that are simple and easy to read to patients and caregiver(s) to ensure comprehension and avoid adverse events.
- To access or download a copy of this reference guide and other reference materials, please visit: http://www.lacare.org/providers/provider-resources/hedis-resources.

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