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Medication Reconciliation

In the recent FY 2024 SNF PPS Proposed Rule, CMS proposed implementing the Transfer of Health Information Measure as soon as possible, which includes a percentage of residents that had a reconciled medication list provided to the subsequent provider. In addition, Appendix PP under F661 states that nursing homes must reconcile all pre-discharge medications with the resident's post-discharge medications both prescribed and over the counter. The interpretative guidelines define reconciliation of medications as a process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over-the-counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care.

The interpretative guidance provides additional information including identifying medications that the resident was receiving in the nursing home that will not be required to continue post-discharge such as antibiotics. Any discrepancies or differences found during the reconciliation must be assessed and resolved including documenting the resolution in the discharge summary along with the clinical rationale for changes.

According to a study published on April 30, 2019 in the National Library of Medicine, adverse drug events are common and costly in health care systems across the world. In a 2007 seminal report on Preventing Medication Errors, the U.S. Health System approximately $3.5 billion dollars per year, result in 1.3 million emergency department visits and 350,000 hospitalizations annually.

This study emphasized the importance of the pharmacist's impact on medication reconciliation during care transitions. While this study focused on hospital discharges, it likely is applicable to long-term care services as well. The study called out the importance of a team-based approach in collaboration with the resident and does not rely solely on the primary care provider. The study reviewed readmissions for 10,621 Medicare FFS patients and the evaluation found that readmission reduction was 9.3% among the population when implementing personalized transitional care which included education, medication reconciliation, follow up telephone calls, and linkage to community resources.

What is a best practice when completing a medication reconciliation?

A best practice according to the American Society of Health System Pharmacists includes:

- Patient medication interview and obtaining an accurate list of all current medications from the resident or their caregiver. This could include review of the resident's medication bottles, insurance filing claims, information from the prescribing pharmacy, and past medical records.
- Directed questions could include asking the resident or caregiver what prescription, over-the-counter, vitamins, herbals, nutraceuticals/health supplements. Including:
- Name
- Strength
- Formulation (extended-release, cream, aerosol, etc).
- Dose
- Route
- Frequency and time of administration
- Duration, if applicable
- Time of last dose
- Directed questions could also include asking the resident what they take for specific illnesses, such as "What do you take when you get a headache?"
- You could also ask the resident questions such as "Do you use any creams or eye drops?"
- Ask the resident about specialists that may prescribe medications such as "Does your cardiologist want you to take any medications?"
- Once the medication list is established all providers and clinical staff administering medications should reference that list, regardless of the format.
- An assessment for interactions or contraindications should be completed. This could be completed by establishing a protocol for having the pharmacy complete a medication regimen review following admission and readmission in addition to the monthly requirements.
- The prescriber or primary care physician should be consulted for resolution and the resulting changes should be clearly documented in the resident's record.

In addition, a best practice prior to the resident discharging home is to request a resident representative to obtain the resident's medication bottles from their home (including routine over the counter medications). The nurse should then review the current medication list compared to the medication bottles to determine if medications were added, changed, or discontinued to accurately educate the resident and/or their representative upon discharge on what the resident should and should not be taking. These changes could be included on the resident's discharge form.