MEDICATION RECONCILIATION CURRENT PRACTICE: CLEVELAND VA MEDICAL CENTER

1. Protocol for medication reconciliation upon admission AND at discharge
    - Patients admitted to our medical center will receive med rec from medicine, nursing, and pharmacy services. Patients that have been admitted via our Emergency Department will see a Clinical Pharmacy Specialist who will do a detailed med rec and history at bedside. Results of this visit will then be sent via electronic notification to the Clinical Pharmacy Specialist whom will follow this patients admission and ultimately provide addition med rec and review upon discharge.
    - Discharge protocol involves nursing notification to assigned pharmacy staff of pending discharge. Pharmacist will then med rec inpatient vs outpatient medication profiles, assess pharmacotherapy, facilitate timely and accurate dispensing of medications and ultimately counsel patient at bedside. In certain situations, specifically cardiac services patients will have medications delivered by pharmacist who takes opportunity to do detailed education and Q&A.
2. Identification of patient barriers (barrier assessments, questions asked upon admission to id barriers)
    - Patient does not bring medications to hospital
    - Patient unaware of medications taken, or caregiver or family member assists
    - Patient receives medications from multiple facilities
    - Patient is unable to see Pharmacist during admission to adequately med rec and correct identified issues.
    - Polypharmacy
    - Inadequate home support systems. Access to home health aides, community nursing, family support education and counseling.
3. Solutions/strategies to overcome patient barriers (i.e. transportation vouchers, providing discounted drug options)
    - Medication counseling at bedside allowing for sufficient time, privacy
    - Medications delivered to patient before discharge
    - Discharge planning nurses tasked with coordinating medical, social and personal issues. Identifies issues prior to discharge.
    - Pill boxes, tablet cutters issued to all patients in need at no cost to them
4. Patient handouts to help patients/caregivers understand their prescriptions (dose, type, frequency)
    - Written list of discharge medications, which includes instructions for which medications were stopped, started, and changed during admission
    - Medication education guides received with all prescription items
    - Additional FDA or manufacturer education handouts included for high risk medications
    - Education material on diagnosis. Especially diabetes, heart failure, coronary artery disease, and dyslipidemia.
5. Process for communicating to the patient/caregiver about their ongoing medication regimen
    - Counseling directly with pharmacist at bedside often in conjunction with family or caregivers. Clinical pharmacist explains both medication specific information as well as diagnosis specific items.
6. Materials/strategies used to improve medication management and engaging the patient/caregiver in their medication plan
    - Repeated and timely pharmacotherapy review by multiple highly trained Pharmacist specialists, often board certified, at admission, during hospital stay and at discharge.
    - Emphasis on medication education as well as transition to home and follow up planning.
    - Pill box utilization as mentioned above and identification of additions that may improve compliance
    - Patients admitted with decompensated heart failure, or patients requiring rapid f/u (those at high risk for medication errors, requiring rapid medication titration) may be referred to post-discharge medication reconciliation clinic within 1-2 weeks post discharge.