

**ASHP – APhA Medication Reconciliation
Initiative Workgroup Meeting
February 12, 2007**

Summary and Recommendations



American Pharmacists Association[®]
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**American Society of
Health-System Pharmacists[®]**

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Summary and Recommendations of the ASHP/APhA Medication Reconciliation Initiative Workgroup Meeting February 12, 2007

On February 12, 2007 the American Society of Health-System Pharmacists and the American Pharmacists Association conducted a workgroup meeting at the Hyatt Hotel in Bethesda, Maryland to address medication reconciliation and the relationship and role of pharmacists in various practice settings. The objectives of this meeting were to:

- Develop a shared workgroup vision about medication reconciliation as a responsibility of pharmacists caring for patients who transition from one sector of health care to another.
- Develop a workgroup definition of medication reconciliation that clarifies the responsibilities of pharmacists for ensuring that an accurate record of a patient's medication regimen exists.
- Develop recommendations for actions by APhA and ASHP that will foster effective medication reconciliation processes.
- Advise APhA and ASHP about potential enduring "deliverables" that could be developed from the subsequent work (e.g., a white paper, a model.)

Each organization selected three members from their respective organizations that were experts in medication reconciliation and represented multiple aspects of pharmacy practice, including hospital, home care, community pharmacy, ambulatory care clinic, and long term care (appendix A). These members were joined by staff from each organization (appendix B). These practitioners spent a day of facilitated discussion that was led by staff members from ASHP and APhA. It was recognized in preparation for this meeting that, in not having other pharmacy organizations participate in the discussion, some perspectives might not be included.

In preparation for this workgroup, each of the participants was provided a number of existing definitions/ descriptions of medication reconciliation, the policy statements of both organizations on medication reconciliation (appendix C), and key publications on pertinent initiatives in the United States and Canada.

The workgroup participants shared their own perspectives and experiences about medication reconciliation and the role of pharmacists. This resulted in the development of a list of "lessons learned." The highest degree of consensus on impact of these lessons learned were (1) the need for a standard patient-centered approach and expectations across the continuum on how to conduct medication reconciliation (2) the need for pharmacy to be reliant on other professions for data, (3) the fact that medication reconciliation is as much about compliance, adherence, and medication appropriateness

as it is about obtaining an accurate list (4) the need for patients to understand the importance of a consistent pharmacy provider, and (5) the need to appreciate the patient care environments of our pharmacist and multi-disciplinary peers.

These discussions and lessons learned served the purpose of establishing a common framework for the group to work from for the subsequent objectives of the meeting.

Shared Workgroup Vision:

A key activity for this workgroup and its participants was to establish a shared vision on the role of the pharmacist in the medication reconciliation process. This was accomplished by identifying the key elements of such desired vision statement and then through a modified Delphi process achieving consensus among the participants. The goal of this activity was to establish a framework from which ASHP and APhA could communicate with a common language when working together, with peer organizations, and interdisciplinary groups.

Shared Medication Reconciliation Vision:

Patients and healthcare professionals will rely on pharmacists to provide leadership in designing and managing optimal patient-centered medication reconciliation systems. Pharmacists have distinct knowledge, skills, and position in the medication use process to facilitate and implement effective medication reconciliation tools for patient and interdisciplinary use.

Pharmacists will lead change in achieving safer and more effective medication use by educating patients and healthcare professionals regarding the benefits and limitations of the medication reconciliation process.

Pharmacists will serve as patient advocates throughout transitions in the healthcare continuum. This advocacy shall include, but is not limited to:

- *Promoting understanding that patient safety demands a continuous medication reconciliation process across all points of patient contact within the healthcare system;*
- *Ensuring that medication-related problems are resolved promptly and appropriately;*
- *Emphasizing collegial communication among pharmacists and other healthcare providers when serving as the patient's interdisciplinary problem solver;*
- *Performing medication reconciliation as part of the healthcare continuum or upon request by the patient, care provider, or member of the interdisciplinary team*
- *Providing comprehensive medication therapy management when medication reconciliation suggests medication related issues exist for the patient; and*
- *Ensuring continued research and education necessary to improve the medication reconciliation process.*

Shared Workgroup Definition

The participants and APhA and ASHP staff also developed a shared definition of medication reconciliation. This too was accomplished by identifying the key elements of such desired shared definition and then through a modified Delphi process achieving consensus among the participants. It was recognized among the participants that there were already a number of definitions for medication reconciliation in the health care market place. The purpose of this exercise was to create a definition that captured the unique role that pharmacists play in managing medications in our health care system and to focus on medication reconciliation for its benefits in improving patient safety not just the creation of a medication list. Therefore recognizing that it may have similar components to other definitions, the goal was that this definition would be one that the two organizations could use in discussions with interdisciplinary groups as well as among its peer groups.

Shared Medication Reconciliation Definition:

Medication reconciliation is the comprehensive evaluation of a patient's medication regimen any time there is a change in therapy in an effort to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions, as well as to observe compliance and adherence patterns. This process should include a comparison of the existing and previous medication regimens and should occur at every transition of care (1) in which new medications are ordered, existing orders are rewritten or adjusted, or if the patient has added non-prescription medications to their self-care.

Medication reconciliation should be a patient-centered process, taking into account the patient's level of health literacy, cognitive and physical ability, and willingness to engage in his or /her personal health care. The goal of medication reconciliation is improvement in patient well-being through education, empowerment, and active involvement in the accurate transfer of medication information throughout transitions along the healthcare continuum. By promoting communication among patients and healthcare providers, medication reconciliation can resolve discrepancies in medication regimens and improve patient safety.

Medication reconciliation should be standardized across the continuum with a common set of data elements; such as prescriber, drug name, regimen, and allergies; that facilitate the efficient transfer of information among providers and patients. This data set should be established by an interdisciplinary group of practitioners, with the pharmacist serving as a key contributor in implementing medication reconciliation in the healthcare system.

Aspects of this definition were inspired by definitions published by The Joint Commission and the Agency for Healthcare Research and Quality.

(1) The Joint Commission Home care Standards Manual Glossary; Definition of transfer: The formal shifting of responsibility for the care of an individual (1) from one care unit to another, (2) from one clinical service to another, (3) from one licensed independent practitioner to another, or (4) from one organization to another.

Recommendations:

The workgroup created recommendations that ASHP and APhA staff could use in setting priorities and direction when working with members, peer organizations, and interdisciplinary groups on medication reconciliation. These recommendations are outlined below and cover the realm of information, education, advocacy, publishing, research, and recognition awards. The workgroup encouraged APhA and ASHP to consider sharing the thoughts of this workgroup with other pharmacy organizations and stakeholders in medication reconciliation.

Workgroup recommendations to ASHP and APhA:

- Stimulate standardized medication reconciliation and the pharmacist's role as a leader in this, evidence-based information related to medication reconciliation should be used
- Disseminate information to health care providers as well as patients and their families
- Educate pharmacists about the need to take a leadership role with respect to medication reconciliation
- Develop tool kits and demonstration projects to promote going beyond minimal regulatory compliance
- Establish a presence at various quality and information technology organizations focused on continuity of care
- Serve as leaders in generating an interdisciplinary expectation and processes for medication reconciliation that includes pharmacists as facilitators for resolving medication reconciliation inconsistencies.
- Document the work of pharmacists in the evolution of medication reconciliation in peer-reviewed literature.
- Develop best practices and tools to help pharmacists apply medication reconciliation consistently
- Support research on the benefits of medication reconciliation and the pharmacist's role
- Establish a recognition program to honor those that engage in best practices and research with respect to medication reconciliation.

Summary:

This workgroup was a first step toward collaborative actions between ASHP and APhA on the subject of medication reconciliation. Next steps should include exploration of collaborative action on the recommendations.

Appendix A

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Appendix B

Association Staff:

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Appendix C

APhA Policy:

Medication Reconciliation the Pharmacists' Responsibility -

APhA recognizes pharmacists as the health care team member responsible for the medication reconciliation process when patients move between practice settings within the continuum of care.

ASHP Policy:

0620: PHARMACISTS' ROLE IN MEDICATION RECONCILIATION

Source: Council on Professional Affairs

To ensure that pharmacists are responsible for coordination of interdisciplinary efforts to develop, implement, maintain, and monitor the effectiveness of the medication reconciliation process; further, To advocate that pharmacists, because of their distinct knowledge, skills, and abilities, should provide the leadership of an interdisciplinary effort to establish systems for ensuring the accuracy and completeness of all medication lists taken at admission and for communication of a reconciled list of medications at any change in level of care and at discharge; further, To encourage community-based providers, hospitals, and health systems to collaborate in organized medication reconciliation programs to promote overall continuity of patient care; further, To declare that pharmacists have a responsibility to educate patients and caregivers on their responsibility to retain an up-to-date and readily accessible list of medications the patient is taking and that pharmacists should assist patients and caregivers by assuring the provision of a personal medication list as part of patient education and counseling efforts.

0301: CONTINUITY OF CARE

Source: Section of Home, Ambulatory, and Chronic Care Practitioners

To recognize that continuity of patient care is a vital requirement in the appropriate use of medications; further, To strongly encourage pharmacists to assume professional responsibility for ensuring the continuity of pharmaceutical care as patients move from one setting to another (e.g., ambulatory care to inpatient care to home care); further, To encourage the development of strategies to address the gaps in continuity of pharmaceutical care.