MEDICATION RECONCILIATION

MCP 11CHIO-01

VA North Texas Health Care System
Dallas, TX 75216

Signatory Authority:
Stephen R. Holt, MD, MPH, MSNRS
Director

Responsible Owner:
Chief Health Informatics Officer

Rescinded Document:
VANTHCS Memorandum No. 11CHIO-01, Medication Reconciliation, dated July 10, 2014

Effective Date:
May 7, 2020

Recertification Date:
May 31, 2025

1. POLICY

This medical center policy (MCP) (establishes/revises) a system-wide approach to medication reconciliation across the continuum of care at VA North Texas Health Care System (VANTHCS).

2. JUSTIFICATION

This policy provides guidance to ensure all eligible Veterans cared for within our system receive well-coordinated, safe, appropriate and patient-centered medical care at all levels and transitions of the health care continuum, as it pertains to the management of patient medication information in accordance with VHA Directive 2011-012.

3. RESPONSIBILITIES

a. **Director**. The Director is responsible for:

(1) Assign a Facility Medication Reconciliation Point of Contact (POC) who can receive information and help disseminate new knowledge of medication reconciliation transferred from the VISN Medication Reconciliation POC as it is made available.

b. **Chief of Staff.** The Chief of Staff (COS) is responsible for:

(1) Ensure VA providers are adequately trained and educated on the medication reconciliation process and understand its importance in the scope of quality patient care and patient safety.

(2) Ensure VA providers are knowledgeable about their lead role and responsibilities with respect to medication reconciliation.

(3) Ensure VA providers have been provided sufficient resources for inter-provider, inter-departmental, inter-facility, and inter-system communication which conforms to all relevant VA and VHA privacy policies and Federal law.

c. **Facility Medication Reconciliation POC**. The Facility Medication Reconciliation POC is responsible for:

(1) Report to the Performance Measures Committee.

(2) Ensure the committee reviews action plans developed for measures not meeting established targets.

(3) Ensure a forum for multidisciplinary collaboration to develop tools that enhance the incorporation of performance measures/monitors into clinical practice.

4. OTHER PARAGRAPHS

a. Medication reconciliation must be initiated at every scheduled outpatient appointment with a provider who has prescriptive authority where medications will be administered, prescribed, modified or may influence the care given, and at every inpatient admission, transfer resulting in a change of primary inpatient team and inpatient discharge.

b. Providers, nurses, pharmacists and specifically trained technicians may perform and document the medication reconciliation process. Prescribing providers must use the information obtained to make clinical and shared decisions regarding medication care, perform medication counseling and document the medication treatment plan.

(1) Review: Review the medications listed in the Electronic Health Record (EHR) to ensure the list is as complete and accurate as possible compared to the medications the patient is currently taking and/or should be taking. Every reasonable effort will be made to obtain medication information from the patient/caregiver. If unable to do so, the reason will be documented in the EHR. Medications include those prescribed by VA practitioners, non-VA practitioners and over-the counter drugs/supplements, both scheduled and those taken on an as-needed basis. The medication information collected must include at least name, dose, route and frequency.

(2) Resolve: Identify and resolve any discrepancies, changes, additions and/or deletions in medications. Discrepancies include omissions, duplications, contraindications and unclear information. Non-compliance with a medication regimen should be noted as part of the encounter but does not constitute a discrepancy.

(a) In some instances, the resolution of a medication issue may need to be done by another provider. The process and method of communicating issues employed should be adapted to the level of acuity and severity associated with the particular medication and disorder being treated. This should be recognized, documented and the patient appropriately instructed. The other clinician should be notified of the issue using an appropriate communication mechanism.

(3) Document: Document the medication reconciliation using the appropriate documentation options based on patient location, which may include, but are not limited to, the following: medication reconciliation note, history and physical, discharge instructions and discharge summary, among others.

c. Notwithstanding anything to the contrary contained in sections 3.a. and 3.b. above, the following variations of the medication reconciliation process are allowed in the circumstances described below.

(1) Radiology Procedures: When any type of medication is used for a radiology procedure, the provider must verify the patient's medications focused only on medication interactions, known adverse reactions, temporary changes, potential complications (e.g., metformin if using contrast) or any other potential interactions of clinical importance during the radiology procedure. Medication dose, route and frequency may be omitted unless deemed clinically relevant.

(2) Outpatient Surgery: When a medication reconciliation has been completed as part of the presurgical evaluation within 30 days of a procedure, the EHR and patient/caregiver will be queried about any changes. If no changes have occurred, the provider may document verification of the presurgical medication reconciliation. If changes have occurred, a new medication reconciliation must be completed and documented.

(3) When a specific therapeutic course involves serial or recurrent treatments or procedures (e.g., hemodialysis), which occur more often than monthly and are rendered or overseen by the same healthcare team, it is generally not necessary to repeat the medication reconciliation for each new treatment or procedure, provided that all of the following conditions are met and documented in the EHR.

(a) A medication reconciliation is completed for the initial treatment or procedure, and at least monthly thereafter throughout the length of the therapeutic course.

(b) The EHR and patient/caregiver are queried for each new treatment or procedure, and no medication changes since the previous treatment or procedure, other than those entailed by the therapeutic course itself, are identified.

(c) There is no significant change in the patient's condition or substantial deviation from the original treatment plan.

d. Reporting: All adverse drug events (i.e., harm resulting from the use of a drug) and close calls must be entered into the VA EHR and the VA Adverse Drug Event Reporting System (ADERS).

5. DEFINITIONS

None.

6. REFERENCES

a. VHA Directive 2011-012 (Medication Reconciliation), dated March 9, 2011 https://www.va.gov/vhapublications/publications.cfm?Pub=1

b. VHA Directive 1164 (Essential Medication Information Standards), dated June 26, 2015 https://www.va.gov/vhapublications/publications.cfm?Pub=1

c. The Joint Commission National Patient Safety Goal 03.06.01
https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/npsg_chapter_hap_jan2020.pdf

7. RESCISSION

VANTHCS Memorandum No.11CHIO-01 (Medication Reconciliation), dated July 10, 2014.

8. REVIEW

This MCP should be reviewed at minimum at recertification, and in conjunction with national updates to associated VHA Directives.

9. RECERTIFICATION

This MCP is scheduled for recertification on or before the last working day of May 2025 – 5 years from effective date. This MCP will continue to serve as local policy until it is recertified or rescinded. In the event of contradiction with national policy, the national policy supersedes and controls.

10. SIGNATORY AUTHORITY

Stephen R. Holt, MD, MPH, MSNRS
VA North Texas Health Care System
Director

Date Approved: May 7, 2020

NOTE: *The signature remains valid until rescinded by an appropriate administrative action.*

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