Rapid Discharge Medication Reconciliation - A Targeted Approach for Pharmacists

FSHP Best Practices Submission

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Break Through Branch Out

Disclosure

The speakers have nothing to disclose concerning possible financial or personal relationships with commercial entities (or their competitors) that may be referenced in this presentation.

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Objectives

1. Discuss the impact of discharge medication reconciliation on medication error reduction
2. Describe the potential role of the pharmacist in discharge medication reconciliation in a setting with limited resources
3. Evaluate the benefits of a targeted approach to pharmacist provided medication reconciliation at discharge

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Medication Reconciliation

Joint Commission National Patient Safety Goal 8
- "accurately and completely reconcile medications across the continuum of care"

Schnipper et al. (2006)
- Discharge pharmacist counseling decreased ADEs from 11% to 1%

Kilcup et al. (2013)
- Pharmacist medication reconciliation post-discharge decreased 7 and 14 day readmission rates (0.8% vs. 4%, p=0.01 and 5% vs. 9%, p=0.04, respectively)

ADE's: adverse drug events

Challenges

- Limited resources
- Increased workload burden
- Identification of patients
- Provider acceptance

Process Goals

- Develop process to identify patients at greatest risk for ADEs post-discharge
- Identify patients for whom pharmacists would have most direct impact
- Maximize pharmacist contribution to successful discharges
- Develop tools within EMR to increase efficiency in providing care

EMR: electronic medical record

Slide 1

KD1 Moved my name to 3rd
Kelley, Denise, 5/25/2018

Slide 3

KD2 Spaced out the objectives a little bit
Kelley, Denise, 5/25/2018

Slide 4

KD3 Increased smart art and font size in the red ovals
Kelley, Denise, 5/25/2018

Slide 5

KD4 Took away Med Rec so heading would fit on one line - feel free to change if you wish
Kelley, Denise, 5/25/2018

High-risk Patient Identification

Inclusion Criteria:

High-risk medication	Anti-infective medication	High risk diagnosis
Anticoagulant Antiplatelet Antiepileptic Antidiabetic Immunosuppressive		Heart failure, MI COPD, asthma Malignancy Diabetes mellitus Liver or Kidney failure HIV

High-risk Patient Identification

Exclusion Criteria:

Admission to psychiatry or critical care unit
Gabapentin orders
Parenteral anticoagulation for VTE prophylaxis

Integration into Workflow

Notification in EMR Patient List

Integration into Workflow

Notification in EMR In-Basket Messages

Reconciliation Process

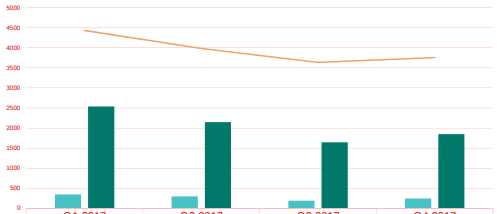
- Compare discharge med list with home med list and inpatient orders
- Note duplications, omissions, dose corrections, etc
- Clarify with prescriber
- Provide patient education and document findings

Project Development Timeline

Aug 15, 2016	Initial team meeting
Aug 22 – Sep 2, 2016	Tool created in EMR
Sep 12 – 23, 2016	Two week feasibility study
Oct 2016	Pharmacy resident analysis
Nov 28, 2016	Implementation

Results

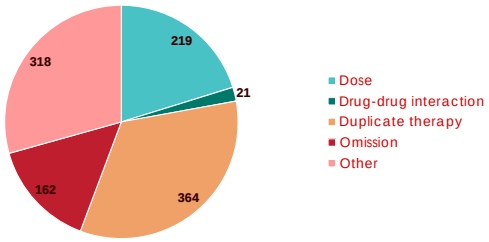
Overall findings



	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Total discrepancies	347	300	192	245
Total Completed	2536	2147	1642	1848
Total high risk patients	4429	3980	3634	3752

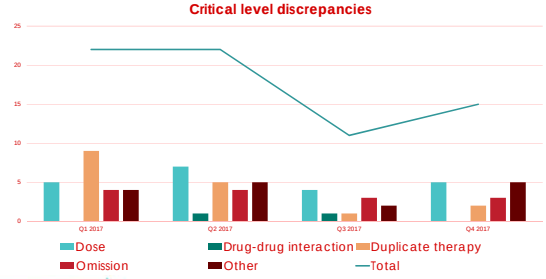
Results

Discrepancy distribution
n = 1084



Results

Critical level discrepancies

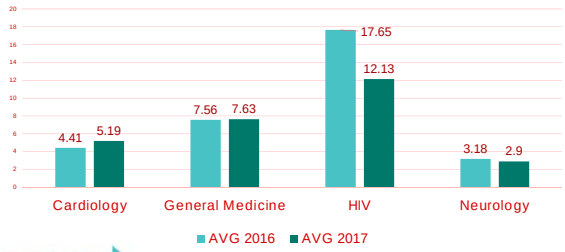


Common Critical Issues

- Problems from the admission med list continued at discharge
- Inpatient formulary substitutions and previous medications both ordered at discharge
- Continuation of previous therapy despite changes in patient status

Results

Average 30-day Readmission Rate (%)



Challenges

- Inadequate staff to perform 24/7
- Some patients discharged prior to assessment
- Med list not updated
- "Order all" and Prescribe all" buttons

Opportunities

Medication reconciliation improvement project

- Organize list by pharm class vs. alpha
- Make pertinent data more visible
- Sequence of steps more intuitive
- Improve discharge preference list

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