Medication Reconciliation & Polypharmacy Work Group

June 17, 2019

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Agenda

Welcome and Call to Order	Michael Matthews	2:00 PM
Public Comment	Public	2:05 PM
Review and Approval of May 15, 2019 Meeting Minutes	Attendees	2:10 PM
Review and Finalize Recommendations Report	Attendees	2:15 PM
Next Steps and Planning for Future Meetings	Michael Matthews	3:45 PM
Next Steps and Adjournment	Michael Matthews	3:55 PM

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Public Comment

Review & Approval of:

May 15, 2019 Meeting Minutes

Review and Finalize Recommendations Report

Topics for Discussion

- New Joint Commission definition of medication reconciliation
- Literature review executive summary
- Recommendations schematic
- Final version of Recommendations Report
- Validation and Approval

New Joint Commission Definition

The Joint Commission definition of medication reconciliation and recommended process that was endorsed by the MRP Work Group has been retired. In its place is a National Patient Safety Goal, effective January 2019, related to medication reconciliation found in Ambulatory Health Care Accreditation Program (https://www.jointcommission.org/ahc_2017_npsgs/).

ORIGINAL TEXT IN RECOMMENDATIONS

As defined by the Joint Commission, medication reconciliation is "the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner or level of care." The steps involved are as follows:

- Defining "current medications";
- Developing a list of current medications;
- Developing a list of medications to be prescribed;
- Comparing the medications on the two lists;
- Making clinical decisions based on the comparison; and
- Communicating the new list to appropriate caregivers and to the patient

NEW TEXT IN RECOMMENDATIONS

As defined by the Joint Commission, medication reconciliation is "a process of comparing the medications a patient is taking (and should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose." The steps involved are as follows:

- Obtain and/or update information on the medications the patient is currently taking.
- Define the types of medication information to be collected in different settings and patient circumstances.
- Compare the medication information the patient brought to the organization with the medications ordered for the patient by the organization in order to identify and resolve discrepancies.
- Provide the patient (or family as needed) with written information on the medications the patient should be taking at the end of the episode of care (for example, name, dose, route, frequency, purpose).
- Explain the importance of managing medication information to the patient at the end of the episode of care.

Literature Review
Executive Summary

Recommendations Schematic – v1

Approach

- Patient Engagement
- Team Approach

Vision and Focus

PATIENT AS NORTH STAR

- Best Possible Medication History (BPMH)
- Med Rec Process Improvement

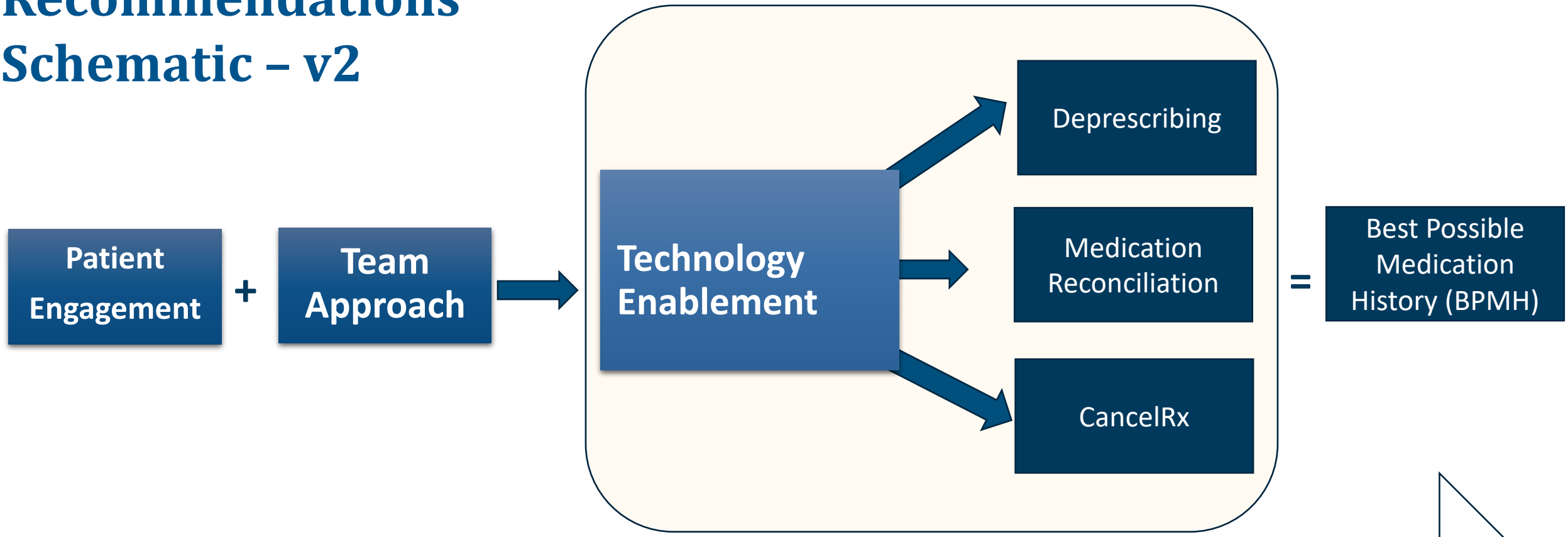
- Deprescribing
- CancelRx

Technology Enablement

Policy and Planning

- Aligned Policy
- SUPPORT Act Coordination
- Planning and Design
- MRP Work Group Continuation

Recommendations Schematic – v2



Review Final Recommendations Report

Next Steps and Planning for Future Meetings

Adjournment

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