Medication Reconciliation:
Using Pharmacy Technicians to Improve Care

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Objectives

- Evaluate the medication reconciliation process and evidence for using technicians to facilitate that process.
- Describe current utilization of pharmacy technicians in the process at Salina Regional Health Center.
- Identify barriers in the current medication reconciliation process and give examples of resources to use moving forward.
THE BASICS AND USING TECHNICIANS

Megan Ohrlund, PharmD
Background

- Constantly evolving medication lists

- Medication Reconciliation (Med Rec):
  - Reduce adverse drug events (ADE)
  - Decrease medication related errors
Background

- 2005 Study on Medication Discrepancies at Hospital Admission
- In patients with >4 medications
  - 54% of admissions had ≥ 1 medication discrepancy
  - 39% of those errors had potential to cause moderate to severe harm
Medication Reconciliation

- Comparing medications the patient has been taking (and should be taking) with newly ordered medications

- Done to avoid errors:
  - Omissions
  - Duplications
  - Dosing errors
  - Drug interaction
Joint Commission

- National Patient Safety Goal #3 for 2017

- Includes:
  - Obtain a list in a routine manner
  - Within 24 hours
  - Provide patient with list on discharge
  - Explain importance of managing medication information with patient
Patient-Centered

- Focus should always be patient safety
- Patient participation is essential
- Improves relationship with patient
- Empowers patients to be more accountable

J Am Pharm Assoc. 2012; 52
Interdisciplinary

- Collaborative approach with other health care workers and facilities
- Sites should have policies about individual responsibilities
- Engage administration

*J Am Pharm Assoc. 2012; 52*
Accountability

- All members, including patient, are accountable
- Review roles and expectations regularly to ensure common goals
- Develop procedures that outline specific roles
Standardization

- Increased uniformity
- Can lead to adoption of procedures by other workers and possibly patients
- Many resources available to outline how reconciliation should be completed

J Am Pharm Assoc. 2012; 52
Continuous Improvement

- Adapt process over time to meet needs of staff and patients
- Assess barriers and potential for errors

J Am Pharm Assoc. 2012; 52
Preventing Errors

- Errors typically occur when a patient is transferred, admitted, or discharged

- JC sentinel event database:
  - > 350 medication errors resulting in death or major injury
  - About half could have been avoided with appropriate Med Rec

The Joint Commission: Sentinel Event Alert 1/25/06
Why Use Technicians?

- Limiting the responsibility to one role:
  - Fewer redundancies
  - Optimized resources

- Pharmacists:
  - Effective
  - Limited resources
  - Expensive
Why Use Technicians?

Many studies show pharmacy technicians can:

- Effectively document medication history
- Provide the best possible medication history

*Am J Health-Syst Pharm 2014; 71*
Using Technicians

➢ The Hospital of Central Connecticut:
  • 96% accuracy by pharmacy technician vs. 66% by all others combined in ED

➢ St. Vincent’s Medical Center, FL:
  • Pharmacy technicians avoided almost $1 million in ADE related to Med Rec compared to nursing staff

Pharmacy Practice News 2014; 41
Using Technicians

Morton Plant Hospital, FL:

- **High-risk antiplatelet and anticoagulant medications:**
  - Last taken times were accurate 13% of time with nursing staff vs. 76% with pharmacy technicians (p>0.001)
  - Pharmacy technicians had more complicated patients and still had better accuracy

*Pharmacy Practice News 2014; 41*
Using Technicians

2013 Study continued:

Hosp Pharm 2013;48(2)
Using Technicians

- Average 33 minutes per patient by technicians
- Average 5 minutes per patient for pharmacists to review
- Average of 14 Reconciliations per technician per day

_Hosp Pharm 2013;48(2)_
CURRENT PROCESS

Salina Regional Health Center
Salina, KS

Becky Johnson, CPhT
SRHC Med Rec Program

- Started January 2015
  - 2 Technicians
  - 0900 to 1930 Mon thru Fri and every other weekend
- Units covered: ICU, Cardiac Unit, General Medicine, Surgical, Rehab
- Start up funding provided by Nursing Units donating FTE hours
Growing Pains

- Resistance from some nursing staff
- Many lists hadn’t been updated in several years
- Physicians continue meds before Med Rec is finished
- Initially started seeing patients that had been there the “longest”, changed process to see the most recent admissions first
Which Patients to See?

- New Admissions monitored via Sentri7
- Phone calls from nursing staff
- Admissions from the ER
Gathering Information

Introduce yourself and the purpose of completing the medication reconciliation

“Hello, Mr./Mrs./Ms./Miss ________________ (patient’s name). My name is ________________ and I am a pharmacy technician. I would like to take some time to review your allergies and the medications you take at home.”
Gathering Information

- If others are in room, ask patient if it’s okay to continue
- Verify pharmacy, ask patient if they use multiple pharmacies and/or mail order
- Verify with patient about any allergies or reactions to medications/foods and update information
Gathering Information

- Obtain list of their medications or med bottles
- Clarify with patient:
  - Medication
  - Strength and formulation (XL, SR)
  - Dose
  - Route
  - Directions and last dose was taken.
Gathering Information

- OTC meds, including pain relievers
- Vitamins, supplements, herbals
- Eye drops, ear drops, inhalers
- Nebulizer meds
- Anything for allergies, heartburn, to help them sleep
- Any stool softeners, laxatives, fiber supplements
- Patches, creams, ointments, lotions (other than hand/body lotion)
Gathering Information

- Meds they might only take weekly, bi-weekly, monthly, every 6 months, once a year. (i.e.: Fosamax, B12 injections, Humira, etc)

- Any meds through their Dr. office (samples, medication assistance program)

- Have they recently been started on any meds that may not be on their medication list?
Potential Barriers

- Patient not able to participate in the Med Rec process
- Pt not available for interview
- Patient and/or caregiver frustrated with having to provide a list or go over meds multiple times
Potential Barriers

- Language barrier or hearing impaired patients
- No medication list, med bottles available for review
- No family caregivers available for interview
Solutions for Barriers

- Interpreter services available via IPads
- Contact PCP office for med list
- Contact Pharmacy for information
- Contact Home Health Agency for med list
- Contact VA for med list
- Contact family member or caregiver via phone to obtain information
Documenting Information

- Input patient pharmacy, if pt is in a nursing home that is listed as the pharmacy
- Make appropriate changes to medications
- Always document how patient states they take the meds
  - If patient says “It says I should take this 2 times a day, but I only take it 1 time a day” document as such
- Make note of this for pharmacist/physician review
Documenting Information

- All prescription medications need two sources of verification (i.e.: patient, patient med list, med bottles, pharmacy, Dr office med list, VA med list, Home Health med list)

- If the patient is a resident of a Nursing Home then the MAR is the only source needed

- Enter intervention that Med Rec has been completed and list sources
Documenting Information

- All Med Recs are reviewed by the clinical pharmacist for that unit
- If no meds have been continued prior to the Med Rec intervention no further action is taken.
- If changes have been made after meds continued the pharmacist will contact the provider regarding the changes
Moving Forward

- 2017 expanded to 4 Med Rec Techs.
- Day shift Med Rec coverage from 0700 to 1930
- Evening Med Rec now covers ER from 1200 to 2230 (ER Med Recs previously done by the ER Pharmacist from 1230 to 2100)
- Weekend coverage 0900 to 1930
Moving Forward

- Both techs will work to cover direct admits and catch up on patients admitted when no Med Rec coverage available

- Working to expand units
  - Pre Admission Services
  - Ambulatory Services
BARRIERS AND HOW TO DEVELOP A PROGRAM

Steve Finch, RPh
Pharmacy involvement in Med Rec has improved outcomes and reduced in healthcare costs

- 36% patients had med errors at admissions of which 85% originated from the patient’s medication history
- Strategies show to reduce medication errors at discharge when a pharmacist reviews the medications
Justifying Medication Reconciliation Cont.

- **Reductions in:**
  - Physicians visits
  - ED visits
  - Hospital days
  - Overall health care costs

- **Med Rec reduced discharge med errors from:**
  - 90% to 47% on Surgical Floor
  - 57% to 33% on Medical Floor
Common Barriers

- **Insufficient Standardization of Data in Med Lists**
  
  - ASHP defines: “a record of current medications that an individual carries across the continuum of care to stimulate conversation between the patient and his/her health care providers regarding their current medications.”
  
  - Medication lists serve as a tool
Common Barriers

- Working with community pharmacies, ambulatory care centers, hospitals, physician offices/clinics and other patient care settings to gather information to establish a current Med List

- Resource:
  “ASHP My Medication List”
  www.ashp.org/MyMedicationList
Common Barriers

**GOAL:**

Standardized format that meets the needs of both patients and providers.
Common Barriers

- Sharing of the appropriate information by both patients and healthcare providers
  - Value
  - Usability
  - Portability of the Med List
Common Barriers

- **Value** -
  
  Healthcare providers need to educate patients on the importance of the med list

- **Usability** -
  
  Patient’s vision, literacy level, language spoken, cognitive ability, and assistance of a provider or caregiver

- **Portability** -
  
  Size and medium used for ALL patient settings
Common Barriers

- Lack of established best practices—
  - WORK IN PROGRESS

- Other Barriers—
  - Duplication and additive workflow
  - Low reliability of the current healthcare system
  - Lack of evidence to validate the importance
  - Failure for the public to adopt the list

Improving Care Transitions: Optimizing Medication Reconciliation: March 2012
Common Barriers

- Resolutions to the barriers-
  - Incorporate the med list into the patient’s health record
  - Develop accountability
  - Conduct research that will validate the use of the med list
Role of the Pharmacist

- Commitment to continue care on behalf of the patient
  - Assure continuity of care is maintained
  - Collaborate among healthcare providers to ensure the Med Rec is accurate and in place
  - Provide leadership in the design and management of the Med Rec
  - Educate providers
  - Serve as the patient’s advocate

Improving Care Transitions: Optimizing Medication Reconciliation: March 2012
Role of the Pharmacist

- ASHP statement (development in October, 2011) –
  “the pharmacist should take leadership in the system based Medication Reconciliation activities”

- Development of policies/procedures
- Implement P/I systems
- Training of the personnel performing Med Recs
- Develop HER application
- Profession and community advocate

Improving Care Transitions: Optimizing Medication Reconciliation: March 2012
Resources

- http://www.ihi.org/topics/adesmedicationreconciliation/Pages/default.aspx
QUESTIONS?


