Medication Reconciliation Post-Discharge

Medication Reconciliation Post-Discharge (MRP) is a review in which discharge medications are reconciled with the most recent medication list in the outpatient medical record.[1] Studies have shown that implementation of a medication reconciliation program reduces medication discrepancies as well as potential and actual adverse drug events (ADEs).[2] One qualitative study reported that most medication reconciliation failures at discharge were due to not resuming medications that were held during the hospital stay.[2] Upon discharge, about 42% of patients have at least one medication discrepancy that may lead to ADEs.[3]

An important HEDIS measure examines the percentage of discharges for Medicare members age 18 years and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days). It includes members discharged from an acute or nonacute inpatient setting and excludes members in hospice or receiving hospice care. The measure assesses discharges, not unique members.

How do I conduct an MRP?[4,5]
An MRP can be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse. Consider the following tips to conduct an MRP and reduce medication errors

Compile	a comprehensive list of medications the patient is currently taking
Clarify	name, dosage, route, frequency, and indication of each drug
Compare	current medications with medication changes at discharge
Correct	discrepancies* and document changes
Communicate	accurate medication information to physician, patient, and caregiver

* Drug omissions, therapy duplications, dosing errors, drug-drug and/or drug-disease interactions, etc.

How do I document an MRP?[1]
Acceptable forms of documentation include:

- Discharge summary with documentation that discharge medications were reconciled with the most recent medication list in the outpatient medical record, *or*
- Notation that no medications were prescribed or ordered upon discharge, *or*
- Record of current medications and any notation of the following:
  - member was seen for post-discharge hospital follow-up and medications were reviewed
  - current medications have been reconciled with discharge medications
  - discharge medications were reviewed or referenced
    (e.g. same medications at discharge, discontinue all discharge medications)

References

1. HEDIS 2018, Volume 2. National Committee for Quality Assurance (NCQA) *Medication Reconciliation Post-Discharge (MRP).*
2. Barnsteiner JH. Chapter 38 Medication Reconciliation. Patient Safety and Quality: An Evidence-Based Handbook for Nurses: Vol. 2. April 2008.
3. Moore C, Wisnivesky J, et. Al. Medical Errors Related to Discontinuity of Care from an Inpatient to an Outpatient Setting. J Gen Intern Med. 2003 Aug; 18(8): 646–651.
4. Action of patient Safety (High5s)- Medication Reconciliation SOP. The High5s Project- Standard Operating Protocol of Medication Reconciliation. Version 3, September 2014.
5. Lutz R. How Pharmacists Can prevent Medication Errors in Transitions of Care. Pharmacy Times. June 12, 2015. Accessed April 10, 2018.