Implementing a Proven Program to Take the Best Possible Medication History: How to Run “Medication Reconciliation Practitioner (MRP) University” at Your Institution – Part 2

Jeffrey L. Schnipper, M.D., M.P.H.
Stephanie Labonville, Pharm.D.
Becky Largen, Pharm.D.
Amy Aylor, Pharm.D.

Day 2 Learning Objectives: Implementing MRP University

Workshop Attendees will become the trainers
❖ Articulate the most common barriers and facilitators to implementing medication reconciliation QI programs in general and BPMH training programs specifically.
❖ Make the case for change and return on investment (ROI) for designated resources committed to medication reconciliation support, including hiring/training staff in taking a BPMH.
❖ Compare and contrast the current state of practice as it pertains to medication reconciliation and the ideal state of practice.
❖ Demonstrate ability to translate key components of the taking a BPMH from day one into training others in these skills at home institutions.
❖ Demonstrate knowledge and skills to provide feedback and assess competency among trainees.

Learning Objectives
❖ Through practice we will:
  • Identify barriers to giving feedback
  • Identify components of effective feedback
  • Review techniques to giving “positive feedback”

Objectives
❖ Define medication reconciliation and articulate the importance of performing an accurate medication history as a key component of medication safety.
❖ Explain the steps for conducting and completing a best-possible medication history (BPMH) and the process for verifying its accuracy.
❖ Demonstrate key BPMH competencies and evaluate trainees’ ability to demonstrate these competencies.
❖ Demonstrate how key skills taught during the workshop may be taught to others locally to train them to take a BPMH and certify their competency.
❖ Identify and demonstrate the appropriate mechanisms for providing feedback to trainees to facilitate improvement in their ability to conduct a BPMH.

Agenda
❖ Skills Development
  • Observation, Feedback
  • Resources
❖ Small group simulation
  • This time focus is on the observer
❖ How to sell this to your organization
  • Make the case to your C-suite
  • Final wrap-up
  • What are you going to do Monday morning?

Giving and Receiving Feedback

Special thanks to Pazo Valeria, M.D. - Brigham and Women’s Hospital
## Why Giving Feedback is Hard

- Lack of training, practice
- Culture of not giving feedback
- Safe environment?
- Perception of time
- Commitment
- Skepticism re: change
- Behavior
- Underestimation of importance
- Want to retain “good guy” status

## We can change the culture

**Be an active learner.**
**Do you care about me?**
- Do you want to help me succeed, or are you more interested in identifying my failures?
- Will you take the time to communicate with me and let me know how I am doing?

## Feedback FRAME-BASED APPROACH

- Similar to diagnostic approach in medicine
  - Listen to the “patient” (learner)
  - Make observations
  - Gather data
  - Formulate diagnosis
  - Make a Plan

## 12 Tips for Giving Feedback

1. Establish a respectful learning environment.
2. Communicate goals and objectives for feedback.
3. Base feedback on direct observation.
4. Make feedback timely and a regular occurrence.
5. Begin the session with the learner’s self-assessment.
6. Reinforce and correct observed behaviors.
7. Use specific, neutral language to focus on performance.
8. Confirm the learner’s understanding and facilitate acceptance.
10. Reflect on your feedback skills.
11. Create staff development opportunities.
12. Make feedback part of institutional culture.


## Characteristics Associated with Proficiency in Feedback Skills

- Frequently attempting to detect and discuss the emotional responses of learners
- Proficiency in handling conflict
- Frequently asking learners what they desire from the interaction
- Having written down or reviewed professional goals in the prior year
- Frequently working with learners to establish mutually agreed-upon goals, objectives, and ground rules
- Frequently letting learners figure things out themselves, even if they struggle


## Other Advice

- Distinguish feedback from evaluation
- Focus on observable behaviors rather than on the trainees themselves
- Teacher and trainee should be working as allies, with common goals
- Feedback should be regulated in quantity and limited to behaviors that are remediable
- Feedback should be phrased in descriptive, non-evaluative language
- Feedback should deal with decisions and actions rather than assumed intentions or interpretations

Principles of Positive Technique

- Encourage self-assessment and emphasize the positive
- Ask the trainee what went well
- List the tasks you thought the trainee did well
- Ask the trainee what could be improved
- Add any other things you think could be improved

Three-pronged Approach

- Simulated cases
  - Good for standardization, certification of competency, specificity of feedback
- Direct observation of actual cases
  - Best for ongoing assessments, realistic cases and systems, focus on behavior
- Measurement of medication discrepancies
  - Most relevant for patient care, allows for comparisons with usual care

Applying This to History-Taking

- Set expectations up front, make clear this is for self-improvement, establish goals together
- Directly observe, do this regularly
- Focus on observed behaviors, compare to checklist
- Focus on accuracy of history
- First ask what went well, list tasks they did well
- Then ask what could be improved, then add as needed
- Avoid ad-hominem criticisms, be sensitive to their reactions, use neutral language, regulate quantity of feedback
- Make a plan for improvement with their involvement
- Have them identify best practices, then share with others
- Take the time to show you’re invested in their improvement

Measurement of Discrepancies

- Used in MARQUIS study (and several others)
- New NQF-endorsed measure

- Procedure
  - Take gold-standard medication history
  - Compare to admission and discharge orders
  - If discrepancies in orders
    - If order is discrepant because history is wrong, that’s a history error
    - If order is discrepant and history is right, it’s either a reconciliation error or it’s intentional – review chart +/- talk to the team if has potential for serious harm

Measurement of Discrepancies

- Outcome: number of discrepancies per patient
  
- Can also track type of discrepancies (omission, dose, etc.) and reason (history vs. reconciliation error)
- Even with a small sample of patients, can learn a lot of information
- Resources for measurement
  - Protocol, Paper Form, RedCap Form, SAS code

Medication Discrepancies
Other Resources
- 6 cases
- 3 from yesterday, 3 more from today
- Observation checklists
- Didactic slide decks
- Videos of taking a BPMH
- MARQUIS materials

Handoff Simulations
- Split into groups of three.
- Play the role – patient, clinician, observer – listed on the packet you receive.
- Each packet has specific instructions + supporting materials as needed
- 10 minutes to take the history
- 5 minutes for observer to give feedback
- 5 minutes for us to debrief as a group

Handoff Simulations – Day 2

Handoff Simulations: Case 1
- Patty Beaumont, 59-year-old female
- Admitted for chest pain, neck pain, and dyspnea while lying down during lumbar MRI
- PMHx: type 2 diabetes, anxiety, hypertension
- Occasional chest pain and leg swelling
- Last hospitalized 3 months ago
### Handoff Simulations: Case 1 Debrief

**Uses medications:**
- Asks the patient open-ended questions about what medications she or he is taking (i.e., doesn’t read the list and ask if it is correct).
- Does probing questions to elicit additional information: non-oral meds, non-daily meds, PRN medications, non-precription meds (Doesn’t ask about OTC or PRN meds).
- Does other probes to elicit additional medications: common reasons for PRNs, meds for problems in the problem list, meds prescribed by specialists (Doesn’t ask about common reasons for PRNs).
- Ask about adherence (but doesn’t ask about side effects).
- Does ask if at least two sources of medications, clearly one provided by the patient and one from another “objective” source (e.g., patient’s own list and ambulatory EHR med list).
- Really have just one list, from the pharmacy, since doesn’t list meds in pill box and clinician’s list is 5 years old.
- Does elicit when to stop getting additional sources (e.g., if patient has a list or pill bottle and names completely reliable and data are not at that dissimilar from the other sources, and/or the difference can be explained).
- Does elicit when to get additional sources if available (e.g., if patient is not sure, relying on memory only or it can’t resolve discrepancies among the various sources of medication information).
- Other additional sources are needed, uses available sources first (e.g., pill bottles present). Then obtains pharmacy data. If the medication history is still not clear, obtains outpatient provider lists, all bottles from home and/or other sources.
- Does review the things used to identify these medications (e.g., for a bag of medications, not in their bottles, provided by a patient).
- Does help from other team members when needed.
- Educates the patient and/or caregiver of the importance of carrying an accurate and up to date medication list with them.

**Uses other resources:**
- For final list, clinician likely:
  - Doesn’t identify acetaminophen since doesn’t ask about PRNs or OTCs.
  - Does realize patient is on lisinopril/HCTZ since doesn’t use pill identifier on meds in pill box.
  - Doesn’t know patient is having muscle aches on rosuvastatin.

### Handoff Simulations: Case 2 Debrief

**Uses medications:**
- Harry Vicente, 48-year-old male.
- Chronic lymphedema, frequent admissions for diuresis and leg pain.
- Admitted for increased left lower extremity edema and pain.
- PMHx: asthma, depression, type 2 diabetes, hypertension, chronic pain, gout.

**Uses other resources:**
- Relate the process issues to the inaccuracies in the final list, likely leaving off acetaminophen, missing non-adherence with lisinopril/HCTZ, missing side effect to rosuvastatin.
- Focus on remediable observable behaviors rather than personality traits or intentions.
- Use neutral language.
- Act sensitively to the clinician’s reactions.
- Regulate the quantity of feedback.
- Make a plan for improvement with clinician’s involvement.
- Finish with encouragement, take the time to show he/she is invested in the clinician’s improvement.

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Handoff Simulations: Case 2 Debrief

- For final list, clinician likely:
  - Only catches ipratropium bromide/albuterol 3 mL neb q6h prn SOR/wheezing by calling the pharmacy, but doesn’t know how often patient uses it (uses a few times a week) for asthma
  - Thinks patient is taking: potassium chloride extended-release 20 meq (#2 10 meq tablets) by mouth daily but is not
  - Misses acetaminophen 500 mg [1 tablet] by mouth every eight hours for pain
  - Misses patient recently went a few days without a few of his medications including amlopidine and metformin due to pharmacy not being able to deliver meds

Did the Observer?

- Put the clinician at ease
- Set expectations up front
- Ask the clinician what went well
- Note what the clinician did well, e.g., knew to get additional sources, including pharmacy, loose meds, knew to use a pill identifier or to get help, educated the patient about keeping a lit
- Ask the clinician what they thought could have been improved
- Note what the clinician could have done better, especially start with an open-ended question rather than reading off a list (even if have one), ask about OTCs, PRNs, common reasons for PRNs, non-oral meds, non-daily meds, meds for problems on the problem list, meds prescribed by specialists.

Did the Observer? (cont’d.)

- Relate the process issues to the inaccuracies in the final list, likely leaving off acetaminophen, thinking patient is still on potassium, not knowing how often patient takes ipratropium/albuterol, missing non-adherence with amlopidine and metformin (note that the inaccuracies could have been worse)
- Focus on remediable observable behaviors rather than personality traits or intentions
- Use neutral language
- Act sensitively to the clinician’s reactions
- Regulate the quantity of feedback
- Make a plan for improvement with clinician’s involvement
- Finish with encouragement, take the time to show he/she is invested in the clinician’s improvement

Handoff Simulations: Case 3

- Cynthia Tucker, 68-year-old female
- Admitted for likely GI bleed
- PMHx: hypertension, stroke, hypothyroidism, seizure disorder, knee pain
- New to this hospital

Handoff Simulations: Case 3 Debrief

- For final list, clinician likely:
  - Doesn’t know about ibuprofen, baby ASA, MVI, and albuterol
Did the Observer?
- Put the clinician at ease
- Set expectations up front
- Ask the clinician what went well
- Note what the clinician did well, e.g., knew to get additional sources, including pharmacy, loose meds, knew to use a pill identifier or to get help, educated the patient about keeping a list
- Ask the clinician what they thought could have been improved
- Note what the clinician could have done better, especially start with an open-ended question rather than reading off a list (even if have one), ask about OTCs, PRNs, common reasons for PRNs, non-oral meds, non-daily meds, meds for problems on the problem list, meds prescribed by specialists.

Did the Observer? (cont’d.)
- Relate the process issues to the inaccuracies in the final list, likely leaving off acetaminophen, thinking patient is still on potassium, not knowing how often patient takes ipratropium/albuterol, missing non-adherence withamlodipine and metformin (note that the inaccuracies could have been worse)
- Focus on remediable observable behaviors rather than personality traits or intentions
- Use neutral language
- Act sensitively to the clinician’s reactions
- Regulate the quantity of feedback
- Make a plan for improvement with clinician’s involvement
- Finish with encouragement, take the time to show he/she is invested in the clinician’s improvement

Discussion
- Can you see doing this at your own institutions?
- What barriers do you see?
- What about observing clinicians interviewing “real” patients?

Implementing Medication Reconciliation Practitioner (MRP) University at Your Institution

Logistics
- Personnel
  - Are personnel already doing this job?
  - If not, are personnel available who could be re-allocated to this job?
  - If not, can you hire new personnel?
  - If not, how can you get the resources to do this?
- Hiring
  - Pharmacy staff vs. residents vs. students vs. techs
  - Qualifications
    - Know medications cold
    - Competency in top 200 med list
  - Social “people people”
  - Passionate about this work
  - Service-minded
  - Community pharmacy experience often helpful
Logistics

- Training
  - Didactic lecture (we will give you)
  - Videos of medication history-taking (ditto)
  - Simulated cases (ditto) with feedback
  - Watch an expert do this (either you or personnel already doing it)
  - Certification of competency
    - Direct observation of 3 cases
    - Simulated case

Training

- Will likely need local modification
  - How to use the local EHR to gather information, document histories
  - Details of local issues (community pharmacies, affiliated practice groups, local regulations, etc.)
  - Additional points you want to emphasize, e.g.
    - Interviewer is audible, uses patient-friendly language, shows respect, adapts positioning to engage the patient, maintains eye contact, maintains control of the interview, maintains organization, uses appropriate pace, etc.

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- Interviewer is audible, uses patient-friendly language, shows respect, adapts positioning to engage the patient, maintains eye contact, maintains control of the interview, maintains organization, uses appropriate pace, etc.

Logistics

- Interviewer is audible, uses patient-friendly language, shows respect, adapts positioning to engage the patient, maintains eye contact, maintains control of the interview, maintains organization, uses appropriate pace, etc.

Ongoing Assessment

- Periodic check-in meetings
- Sharing of best practices
  - Living document
- Ongoing direct observation of actual cases
- Competency in documentation within EHR
- Measurement of medication discrepancies
  - Most relevant for patient care, allows for comparisons with usual care, helps prove ROI
  - Alleviates concerns that errors are increasing

Measurement of Discrepancies

- Used in MARQUIS study (and several others)
- New NQF-endorsed measure
- Procedure
  - Take gold-standard medication history
  - Compare to admission and discharge orders
  - If discrepancies in orders
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Measurement of Discrepancies

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- Even with a small sample of patients, can learn a lot of information
- Resources for measurement
  - Protocol, Paper Form, RedCap Form, SAS code

Measurement of Discrepancies
Summary of Resources
- 6 cases
  - 3 from yesterday, 3 more from today (re-written to be used to evaluate clinicians)
- Observation checklists
- Didactic slide decks
- Videos of taking a BPMH
- Materials for measuring discrepancies
- MARQUIS materials, including pocket cards

Barriers to Implementation

Barriers
- SEIPS Model of Work System and Patient Safety

Barriers
- Task
  - Too complex
- Organization
  - Lack of institutional commitment, leadership, QI experience; competing priorities, financial problems
- Hospital/Unit
  - Insufficient training, problems with policies/procedures, unclear goals/expectations, lack of authority given to front-line leadership, lack of feedback, culture that inhibits interdisciplinary teamwork, lack of commitment to safety
- Staff and patients
  - Required help from others not available, not valued by other clinicians, staff burnout, difficult patient population
- Technology/Tools (like computer systems, templates)
  - Inadequate materials, supplies, tools, technology, information to do the job

Barriers
- This is what you’ve said so far this conference:

Barriers
- Which of these barriers do you see as the biggest ones?
- What other barriers do you see?
Overcoming Barriers

Let’s start with resources
- Do you have them?
- Can you get them?
- Who do you need to convince?

Overcoming Barriers

Making the business case for medication reconciliation resources (continued)
- Increase in patient engagement
- Increase in staff satisfaction
- Increase in referring provider satisfaction → increased market share

Overcoming Barriers

Making the business case for medication reconciliation resources
- Decreased Inpatient ADEs → decreased costs, shorter LOS under prospective payment system
- Decreased readmissions → decreased financial losses due to bundled payments, capitated health plans, ACO contracts, readmission penalties
- Decrease in malpractice claims
- Increase in efficiency of other personnel

ROI Calculator: ADEs

ROI Analysis to Perform Medication Reconciliation Upon Patient Hospital Admission
Based on Inpatient ADE Reduction

ROI Calculator: Pharm Tech

ROI Analysis to Perform Medication Reconciliation Upon Patient Hospital Admission
Based on Inpatient ADE Reduction

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20th Annual ASHP Conference for Pharmacy Leaders
Implementing a Proven Program to Take the Best Possible Medication History:
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ROI Calculator: Pharm Tech

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Talking to the C-Suite

- CMO
- CNO
- CFO
- CQO

Chief Medical Officer

- Current risk to physicians, who at the end of the day are responsible for medication errors and patient harm
- Don’t currently give this the attention it deserves, too many competing priorities
- This creates role clarity, frees up their time to do other things, improves care
- Note: still have a role in this process

Chief Nursing Officer

- If don’t currently take medication histories, should be an easy sell
- Still worth getting their support
- Can talk about role clarity

Chief Quality Officer

- Should be an easy sell, but they need to become passionate about this issue
- Provide numbers on current error rates
- Ideally, provide local data
  - This usually dwarfs rates of other kinds of errors
- Supplement with local stories if possible
- Discuss evidence for benefit

ROI Calculator: Pharm Tech

Table 2: Medication Reconciliation Model ROI (1/13): numbers repeated directly from Table 1.

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#### Chief Financial Officer
- Usually the biggest critic and the one most important to the decision-making process
- Need to convince them it really saves money
- No, it really does
- Focus on inpatient ADEs – that’s the clearest angle
- The others are more subtle but can be powerful depending on your hospital’s situation

#### Addressing Other Barriers
- **Culture**
  - This one is the hardest to change but often the most important
  - In this case, staff will welcome the help
  - But they will still need to understand their role
    - Double-checking the list
    - Doing additional tasks if needed
    - Doing the entire task if not seen downstairs
  - Role clarity under different circumstance

#### Your Role as Residents
- **Look for Med Rec Support Note**
  - Take additional actions as recommended
  - If no action recommended, make sure no new medication sources have emerged since then
- **If no Med Rec Support Note**
  - Take medication history yourself
  - Document properly in EMR

#### Tasks You Might Be Asked To Do
- **Call outpatient pharmacy**
- **Ask patient’s family to bring in pill bottles from home, go over them with patient/family**
- **Contact outpatient providers**

#### Not All Patients Will Receive Med Rec Support
- Patients admitted through ED off hours
- Direct admissions
- Outside hospital transfers
- In these cases, you will have to take medication histories yourself

#### Addressing Other Barriers
- **Task**
  - Balancing quality with time/effort
  - Keeping it as simple as possible
  - Maintaining consistency and standardization over time and among personnel
Addressing Other Barriers

- **Organization**
  - Cultivating local leadership, QI experience
  - Keeping this a priority
  - Ongoing data will help
  - Avoiding staff being stolen for other priorities
  - Find clinical champions
  - Get an "executive champion"

Addressing Other Barriers

- **Unit**
  - Educating and training other personnel about their roles (have slide deck for this)
  - Making clear policies and procedures for each role
  - Setting clear goals, providing feedback, giving sufficient authority to local leadership

Addressing Other Barriers

- **Staff and Patients**
  - Creating clear lines of supervision
  - Making help available when needed
  - Debriefing difficult patient encounters

Addressing Other Barriers

- **Technology and Tools**
  - Make sure MRPs have correct permissions within the EHR to do their job
  - Creating note templates
  - Make sure their notes are recognizable to others
  - Tracking patients seen by MRPs
  - Creation of reports: who’s been seen
  - Access to pre-admission med sources: local pharmacies, local physicians, etc.

Med Rec Support Note: Epic

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<tr>
<th>Field</th>
<th>Required</th>
<th>Description</th>
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<td>Yes</td>
<td>Unique identifier for each patient</td>
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<tr>
<td>Race</td>
<td>Yes</td>
<td>Self-reported race of the patient</td>
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<tr>
<td>Gender</td>
<td>Yes</td>
<td>Patient's gender at birth</td>
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<tr>
<td>dob</td>
<td>Yes</td>
<td>Date of birth</td>
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<tr>
<td>Admission Date</td>
<td>Yes</td>
<td>Date the patient was admitted to the hospital</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>Yes</td>
<td>Date the patient was discharged from the hospital</td>
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<td>Admission Type</td>
<td>Yes</td>
<td>Type of admission (e.g., elective, emergency)</td>
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<tr>
<td>Discharge Status</td>
<td>Yes</td>
<td>Status of discharge (e.g., discharged, died)</td>
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<tr>
<td>Discharge Disposition</td>
<td>Yes</td>
<td>Disposition on discharge (e.g., home, skilled nursing facility)</td>
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Med Rec Support Note: Epic

- **Level of Confidence in accuracy of information:** A
- **Additional data needed to make accurate LLC:** Not applicable

The following discrepancies found today on my reconciliation:

1. Patient was found to have a drug allergy to penicillin.
2. Discharge summary indicates the patient was discharged on a new medication regimen.
3. Family history indicates the patient has a family history of diabetes.

Recommended actions that should be undertaken by the identifying team to complete the full medication reconciliation include:

- Review the patient's chart for all medications prescribed.
- Consult with the patient's primary care physician to confirm the new medication regimen.
- Update the patient's medical record to reflect the new medication regimen.
- Notify the pharmacist of the discrepancies found.

Note: The discrepancy listed is just an example for demonstration purposes. In actual practice, the discrepancy list should be customized to reflect the actual discrepancies found.
Addressing Other Barriers
- Other Barriers

Discussion
- Barriers
- Facilitators
- Customization

Small Group Exercise
- Make the case to your C-suite:
  - Groups of 4, prepare case for:
    - CMO
    - CNO
    - CQO
    - CFO
  - Give each other feedback
  - 5 minutes to prepare, each give for 2 minutes each, 7 minutes for feedback

Small Group Exercise: Debrief
- How did it go?
- What was easy? What was hard?

Group Simulation
- 3 volunteers to present their arguments to the group
  - CMO or CNO
  - CQO
  - CFO

Group Simulation
- Group Discussion
  - What did you think?
  - Were they persuasive?
  - What was good about them?
  - How could they be improved?
Which argument was most persuasive?

A. CMO/CNO  
B. CQO  
C. CFO

Success Stories
- Presbyterian
  - Initial proposal: deploy pharmacy techs to ED of all Novant hospitals to gather BPMH of all admitted patients within 24 hours
  - Rationale: improved patient safety, TJC NPSG, Novant long-term goal, known barriers to PAML accuracy
  - Pilot done at 2 facilities, 7 months of data
    - Higher % of PAMLs accurate c/w usual care
    - Potentially harmful errors reduced with pharm techs

Success Stories (continued)
- Brigham and Women’s Hospital
  - Proposed more pharmacist FTE in 2013
    - BPMH in ED
    - Discharge counseling on the floors
    - Rejected due to financial concerns but also concern about overlap with nursing role in discharge counseling
  - Tried again in 2014
    - Eliminated discharge counseling piece
    - Made it all the way to last step (CFO), who killed it along with all other proposals for new funding

Success Stories (continued)
- Brigham and Women’s Hospital
  - Tried again in 2015
    - Epic about to go live, concern for increased discrepancies during transition: dedicated proposal just for first 2 months of implementation
    - Under Department of Quality and Safety
    - Pharmacy students
    - Accepted
    - Second, long-term proposal, similar to previous years, but with pharmacy technicians
      - Also accepted

Success Stories (continued)
- Brigham and Women’s Hospital
  - Success factors
    - Epic as motivator, then didn’t want bridge to nowhere
    - Less expensive with use of techs
    - New CFO, former head of ED
    - Pharmacist staffing ratio historically low compared with other AMCs
    - Proposals available upon request
20th Annual ASHP Conference for Pharmacy Leaders
Implementing a Proven Program to Take the Best Possible Medication History:
How to Run “Medication Reconciliation Practitioner (MRP) University” at Your Institution – Part 2

Final Wrap-Up

Ideal vs. Reality

What are you going to do Monday morning?

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