Department of Veterans Affairs **VHA DIRECTIVE 2011-012**
Veterans Health Administration
Washington, DC 20420 **March 9, 2011**

MEDICATION RECONCILIATION

1. PURPOSE. This Veterans Health Administration (VHA) Directive establishes the VHA National Medication Reconciliation Policy which delineates a system-wide approach to managing patient medication information by reconciling medications across the continuum of care.

2. BACKGROUND

a. The Medication Reconciliation process seeks to maintain and communicate accurate patient medication information. It entails identifying, addressing, and documenting medication discrepancies found in the VA electronic medical record as compared with the medication information supplied by the patient. This information, along with any changes made during the episode of care, is communicated to the patient, caregiver or family member, and appropriate members of the health care team.

b. Adverse drug events harm more than 1.5 million individuals and kill several thousand individuals annually. Many of these events occur at transitions in levels of care or as a result of clinical management by multiple independent health care providers. The Department of Veterans Affairs (VA) recognizes the impact that accurate medication information has along the medication management continuum and its role in safe-guarding the health of our Veterans. The Joint Commission (TJC) also recognizes the importance of successfully managing a patient's medication information and has defined minimum standards under their National Patient Safety Goals. Effective medication information management serves to ensure that the health care team recommends a treatment plan based on accurate patient medication information which in turn helps to mitigate the risk of certain adverse drug events (ADEs).

c. This Medication Reconciliation Directive serves to provide guidance to the VA community on effective strategies for managing Veterans' medication information, investing in continuous quality improvement strategies, and demonstrating stewardship for medication information management within the greater health care community.

d. **Definitions**

(1) **Adverse Drug Event (ADE).** An ADE is an injury from the use of a drug. Under this definition, the term ADE includes harm caused by the drug (adverse drug reactions and overdoses) and harm from the use of the drug including dose reductions and discontinuation of drug therapy.

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(2) **Adverse Event and Close Call Reporting.** Adverse event and close call reporting is the reporting, review, or analysis of incidents involving patients that cause harm or have the potential for causing harm.

(3) **Adverse Drug Reaction (ADR).** ADR is a response to a drug which is noxious and unintended and which occurs at doses normally used in people for prophylaxis, diagnosis, or therapy of disease or for the modification of physiologic function. ADRs can be mild, moderate, or serious in nature; likewise, they can be observed or historical.

(4) **Brown Bag Inventory.** Brown Bag Inventory is a term coined by the action of a patient bringing his or her medication containers, often in a brown paper bag, to an episode of care whereby the clinician reviews the patient's medication containers with the patient in an effort to compile an accurate list of the medications the patient is currently taking.

(5) **Local VA Medications.** Local VA medications are medications ordered at the treating VA facility.

(6) **Medication Adherence.** Medication adherence refers to the extent to which the use of a medication by a patient aligns with the stated medication use instructions.

(7) **Medication Discrepancy.** Medication discrepancies are unintentional differences found in the patient's medication information when compared to the medication information available on the electronic health record. These discrepancies may be omissions, commissions, inappropriate duplications, changes, and/or additions. These discrepancies may be generated from the patient or the health care system.

(8) **Medication Reconciliation.** Medication Reconciliation is a process to ensure maintenance of accurate, safe, effective, and, above all, patient centered medication information by:

(a) Obtaining medication information from the patient, caregiver, or family members.

(b) Comparing the information obtained from the patient, caregiver, or family member to the medication information available in the VA electronic medical record, including active medications, recently expired medications, medications given at other VA facilities (via remote data view), and non-VA medications, in order to identify and address discrepancies.

(c) Assembling and documenting the medication information in the VA electronic medical record.

(d) Communicating with and providing education to the patient, caregiver, or family members regarding updated medication information.

(e) Communicating relevant medication information to and between the appropriate members of the VA and non-VA health care team.

(9) **Non-VA Medications.** Non-VA medications are non-VA provider prescribed medications filled at non-VA pharmacies, VA provider prescribed medication filled at non-VA pharmacies, herbals, over-the counter-medications, nutraceuticals**,** and alternative medications.

(10) **Non-VA Providers.** Non-VA providers are community providers including physicians, advanced practice nurses, physician assistants, and other health care professionals who provide health care to Veteran patients outside of VA. This includes services reimbursed by Fee-Basis, Department of Defense, Tri-Care, Medicare, private pay, and health insurance. Methods to communicate with non-VA providers include phone conversations, FAX, and correspondence by mail after compliance with patient privacy regulations.

(11) **Patient-focused Local Metrics.** Patient-focused local metrics are metrics established at the local level. For example, discrepancy rates, the rates of unintentional differences found in the patients' medication information when compared to the medication information available on the VA electronic medical record, may be used.

(12) **Patient Medication Information.** Patient medication information is information on all the medications taken by the patient, how they are taking it, any problems they may be having and/or have had in the past. This may be obtained by brown bag inventory, verbal history, or patient, caregiver or family member-furnished medication list.

(13) **Remote VA Medications.** Remote VA medications means medications ordered at any other VA facilities (viewed or imported via remote data view).

(14) **VA Medication Reconciliation External Review Process (EPRP).** EPRP is the process for chart review, including the minimum documentation requirements that provide evidence that Medication Reconciliation was performed at this episode of care.

(15) **VA Medication Reconciliation Performance Monitor.** A VA Medication Reconciliation Performance Monitor includes two questions at the post discharge call process: "Did you receive an updated medication list when leaving this VA medical facility?" and "Do you know where to go to ask questions?"

(16) **VA Providers.** VA providers are physicians, medical trainees, advanced practice nurses, physician assistants, and other health care professionals who provide primary care or specialty care within the limitations of their individual VA privileges or scopes of practice.

(17) **Veterans Receiving Dual Care.** Veterans receiving dual care refers to Veterans who receive ongoing health care in both VA and non-VA health care settings.

3. POLICY. It is VHA policy that all eligible Veterans cared for within the VA system receive well coordinated, safe, appropriate, and patient-centered medical care at all levels and transitions of the health care continuum as it pertains to the management of patient medication information.

4. ACTION

a. **Chief Patient Care Services Officer.** The Chief Patient Care Services Officer is responsible for providing national direction and education to support implementation of this Directive.

b. **VA Medication Reconciliation Initiative Task Force Director.** The Director of the VA Medication Reconciliation Initiative Task Force works under the direction of the Chief Patient Care Services Officer to provide national direction and education to support implementation of this policy, and is responsible for ensuring that any changes to this policy are made in a timely fashion.

c. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for assigning a VISN Medication Reconciliation Point-of-Contact (POC), who can receive information and help disseminate new knowledge of Medication Reconciliation to Facility Medication Reconciliation POCs within the VISN.

d. **Facility Director.** The facility Director is responsible for:

(1) Assigning a Facility Medication Reconciliation POC who can receive information and help disseminate new knowledge of Medication Reconciliation transferred from the VISN Medication Reconciliation POC as it is made available.

(2) Ensuring that local policies conform to the following critical quality and safety elements:

(a) Defines the roles, tasks, and steps of the Medication Reconciliation process;

(b) Defines that Medication Reconciliation is initiated at every episode or transition in level of care where medications will be administered, prescribed, modified, or may influence the care given;

(c) Outlines how care is coordinated with the appropriate members of the health care team, including non-VA providers, through effective communication mechanisms and in conformity with the most recent revision of VHA's National Dual Care Policy.

(d) Defines the processes to be used when medications are outside of the scope of the health care team member performing components of Medication Reconciliation, such that the member has access to necessary resources and communication strategies to refer the patient to the appropriate provider in outpatient and inpatient settings;

(e) Outlines strategies that enable adherence to minimum documentation requirements in the VA electronic medical record including:

1. Patient, caregiver, or family member-provided medication information obtained at the episode of care is represented in the VA electronic medical record.

2. Comparison of this patient, caregiver, or family member-provided medication information to the medication information available in the VA electronic medical record. This documentation includes active medications, recently expired medications, non-VA medications, and medications given at other VA facilities (remote medications) highlighting the discrepancies identified and addressed.

3. Updated medication information at the end of the episode of care is represented in the VA electronic medical record (including changes relevant to the episode of care).

4. Ensure discharge information in the VA electronic medical record is consistent with discharge instructions provided to the patient, caregiver or family member at the end of the episode of care.

(f) Defines patient-focused local metrics to evaluate the quality and efficacy of the program.

(3) Ensuring processes exist which provide support to the patient, caregiver or family with being full and active partners in the Veteran's medication information management.

(4) Ensuring that the multidisciplinary health care team is knowledgeable about and accepts stewardship of the process by complying with local policies.

(5) Ensuring that local policy conforms with guidance from accreditation organizations where applicable.

(6) Ensuring that the facility monitors compliance as appropriate. ***NOTE:*** *Resources for monitoring are VA Medication Reconciliation EPRP and the VA Medication Reconciliation Performance Monitor (IPEC).*

e. **Facility Chief of Staff (COS).** The Facility COS is responsible for ensuring:

(1) VA providers are adequately trained and educated on the Medication Reconciliation process and understand its importance in the scope of quality patient care and patient safety.

(2) VA providers are knowledgeable about their lead role and responsibilities with respect to Medication Reconciliation.

(3) VA providers have been provided sufficient resources for inter-provider, inter-departmental, inter-facility, and inter-system communication which conforms to all relevant VA and VHA privacy policies and Federal law.

f. **VA Provider.** The VA provider is responsible for:

(1) Completing Medication Reconciliation in accordance with local policy including medications prescribed by, or secured outside of, the VA system to diminish the potential safety risk for the dual care patient.

(2) Documenting a plan to address medication discrepancies that is commensurate with the severity of the discrepancy and the risk of patient harm. ***NOTE:*** *Addressing a discrepancy does not always require managing a medication or changing the medication order.*

(3) Educating patients identified as dual care users as per VHA's National Dual Care Policy.

(4) Documenting and reporting adverse events and close calls and reporting. All adverse drug events must be entered into the Computerized Patient Record System (CPRS) and the VA Adverse Drug Event Reporting System (ADERS) as defined by VHA policy regarding Adverse Drug Event Reporting and Monitoring**.** ***NOTE:*** *Employees becoming aware of adverse events or close calls report them to the medical center via VA Form 10-2633 Report of Special Incident Involving a Beneficiary or other locally approved channels. Current examples of adverse events, which require review and reporting, are included in VHA Handbook 1050.01*.

(5) Assisting the Veteran patient, caregiver, or family member to maintain, update, and take ownership of the patient's medication information. Patients need to be encouraged to be active participants in the decision making of their treatment plan. As such, the patient, caregiver or family member should share with the patient's health care team:

(a) The Veteran patient's goals of care;

(b) Personal medication utilization;

(c) Problems which affect medication adherence, such as:

1. Allergies and/or ADRs,

2. Difficulties with access to health care,

3. Financial hardship,

4. Recommended medication treatment plan declined, or

5. Other health-system, condition, or therapy-related factors

(6) Non-VA medication and provider information;

(7) Any medication and provider information from other VAMC facilities; and

(8) The patient's health care proxy, if there is one.

5. REFERENCES

a. Joint Commission National Patient Safety Goals, April 2010; available at: http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/.

b. National Patient Safety Goal on Reconciling Medication Information (NPSG.3.06.01).

c. Preventing Medication Errors, Committee on Identifying and Preventing Medication Errors, Philip Aspden [et al.], editors, 2006.

d. Adherence to long-term therapies: evidence for action. World Health Organization 2003. http://www.who.int/chp/knowledge/publications/adherence_full_report.pdf

e. PBM Web site Standardized Definitions of ADE's and ADRs: http://vaww.national.cmop.va.gov/PBM/default.aspx. ***NOTE:*** *This is an internal VA Web site not available to the public.*

f. VHA Handbook 1050.01. VHA National Patient Safety Improvement Handbook.

6. FOLLOW-UP RESPONSIBILITY: The Chief Patient Care Services Officer (11) is responsible for the contents of this Directive. Questions may be referred to (202) 461-7326.

7. RESCISSIONS: None. This VHA Directive expires March 31, 2016.

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