**Medication Reconciliation Quality Improvement Project**

**Authors**:

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**Practice Site:**

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**Background**:

 Medication use in the United States is widespread. In a national survey conducted between 1998-2000,
 approximately 80% of participants reported using at least 1 medication in the week preceding the survey,
 with 50% reporting use of at least 1 prescription medication. Medication prescribing has only increased
 since that time. The medication reconciliation process aims to accurately identify medications that the
 patient is actively taking, resolve any discrepancies, and document any changes during transitions of
 care. This process has been shown to improve patient outcomes, reduce the incidence of adverse drug
 events, and improve patient satisfaction.

**Objective:**

 The objective of this quality-improvement project was to evaluate the accuracy of medication lists in both
 inpatient and outpatient settings.

**Methods**:

 This was a retrospective, single-center, continuous quality improvement (CQI) project. The current
 medication history and reconciliation process was reviewed in both inpatient and outpatient settings to
 identify areas at high risk for potential medication list discrepancies. A random sample of 125 veterans
 were selected after receiving care at HAMVAMC between January 1, 2022 – March 15, 2022.
 Medication lists were assessed for accuracy with the use of CPRS (Computerized Patient Record
 System) and JLV (Joint Longitudinal Viewer) progress notes and medication records. This data was
 collected to utilize process mapping to identify inconsistencies, gaps, and overlaps in the current
 medication reconciliation process.

**Preliminary Results:**

 Across all settings, 4 general themes were identified: lack of use of all resources available (i.e. JLV,
 Remote Data within CPRS), infrequent evaluation of Non-VA medication lists within CPRS, lack of
 documentation of medication history/reconciliation within the chart, and lack of a standardized medication
 reconciliation process (admission, transition of care, discharge, and post-ambulatory care appointment).

 Approximately 75% of veterans had at least one medication reconciliation note entered in their chart.
 However, on average there were 3.5 discrepancies noted per inpatient encounter and an average of 1.26
 discrepancies per ambulatory care encounter. Clinical Pharmacy Specialists had the lowest average rate
 of discrepancies identified at 0.6 discrepancies per visit (compared with Primary Care Providers – 1.92,
 Acute Care – 5.84, Inpatient Psychiatry – 3.32, and Emergency Room – with 1.24 discrepancies per
 patient stay and/or appointment).

**Conclusions:**

 The medication reconciliation practice at HAMVAMC requires improvements in quality, consistency, and
 documentation. Continuation of the mapping process, with a focus on prospective observation of the
 current processes will allow for insightful recommendations to improve the quality of the medication
 reconciliation process. Further efforts to research efficient use of resources (i.e. additional staff, cost-
 effective programs, note template, etc.) is required.