

**THE JOINT COMMISSION CONFERENCE CALL  
ON MEDICATION RECONCILIATION  
FEBRUARY 28, 2007**

**CATHY BARRY-IPEMA:** Welcome to today's telephone conference call with Joint Commission President Dr. Dennis O'Leary and Dr. Rick Croteau, executive director for Patient Safety Initiatives for the Joint Commission International Center for Patient Safety. I'm Cathy Barry-Ipema, chief communications officer at the Joint Commission. Dr. O'Leary and Dr. Croteau will discuss medication reconciliation. When their comments are concluded we'll take questions from the audience.

For your convenience, a discussion brief and a listing of the Frequently Asked Questions pertaining to the National Patient Safety Goals on medication reconciliation were made available as your registered for this call. They are also posted on The Joint Commission extranet site, The Joint Commission Connect, your secure extranet site.

It is my pleasure to introduce Dr. Dennis O'Leary, president of the Joint Commission.

**DR. DENNIS O'LEARY:** When we created the National Patient Safety Goals the intent was to pick simple solutions whose justification was obvious and simply needed to be done. As we have progressed, it has turned out there's nothing that is simple—even the things that look really simple. And some of the new safety Goals and Requirements are really not simple, and we're going to be tackling one of them today. And while I would say that we understand that this is not simple, we are still facing a fairly significant and growing pressure from the public who, when they look at these issues, say "Why can't they do that?" And that's the challenge that I think we are all facing.

Here the issue is medication errors, probably the most common event that we deal with, and the issue of medication reconciliation is probably the most common underlying problem for these errors. Without further ado, I'm going to turn things over to Rick Croteau.

**DR. RICK CROTEAU:** First, to emphasize that the principle on which this set of requirements for medication reconciliation is based is simply the premise that to use medications safely one should know what medications a patient has been on up to that point in time. It does deal with transitions in care and it's largely an information management requirement. Gathering a list of the patient's medications, using that list to compare with what is being ordered, and then communicating that information to other providers of care as well as to the patient. We do want the patient to be involved in this process in the various steps along the way, plus it deals with transitions. It's important to recognize that this is not just an inpatient requirement. It does take place wherever and whenever medications are used, so it applies throughout the continuum of care, certainly in hospitals but in outpatient clinics, surgery centers, ambulatory surgery, home care, long term care, all the various settings of care where medications are used.

The process itself broken down to its basics is certainly fairly simple to describe. The complexity comes in the actual task of implementing it, and one of the reasons that it's been such a challenge is that, like many of our other requirements, it has been regarded by some as another add-on activity and certain tasks are then added on to existing processes. I think this has created a layer of complexity as well as problems with efficiency because it hasn't always been integrated into the existing processes. And I think the real challenge then is to incorporate medication reconciliation into your existing processes, recognizing that it's a multi-disciplinary activity. It's not something

that can be assigned to just a single person. It has to be developed as a shared accountability, and again integrated into your existing processes. It can be done in an efficient manner but only if that integration takes place and there is—of necessity—some redesign of the workflow process so that everything operates smoothly, not just as an add-on task. One of the factors that I again want to stress is the involvement of the patient. Ultimately, we would anticipate that the patient would be the owner, if you will, of the list. His or her list of medications would be part of the system for communicating that information and would eventually ease the burden of collecting that list of medications as a new activity on each patient encounter. It then becomes a matter of updating information and ensuring that it is adequately communicated among the various providers of care and as well updated and provided to open up the floor for discussion. We've had a lot of questions over the past couple of years which have been addressed in our National Patient Safety Goals' Frequently Asked Questions, and they run the full gamut of strategies for implementation and the details of how it plays out in the various settings of care, and I would particularly invite your questions about how this relates to the full continuum of care, not just hospitals.

**QUESTION:** My question is about 8B Element of Performance number two which is a new Element of Performance. It says the next provider of service should check over the medication reconciliation list again to make sure it's accurate. It's hard enough for us to even provide this list to the next provider. How are organizations supposed to check to make sure that the next provider checks over the list?

**DR. RICK CROTEAU:** The intent there was that that next provider of care will use the list—will look at it essentially and use that information in subsequent care of the patient

specifically in ordering new medications. It is not the intent of that expectation to ask that next provider to re-confirm the content of the list, but simply to accept the information, receive the information and to use it.

**CALLER:** So as a hospital that is surveyed and it has an M beside this EP, I just don't see how we can meet this standard.

**DR. RICK CROTEAU:** If I understand you correctly, your concern is with how do you measure compliance with that expectation. I would agree that the measurement of that is going to be a challenge and I may have to give that some thought and put that into the Frequently Asked Questions. The usual approach, although it is rather labor intensive, is to assess this type of requirement through direct observation. We don't really expect that you're going to do that as a matter of routine. It would be appropriate with any requirements of the standards or safety goals to periodically carry out some spot check if you will of your level of compliance. And direct observation plays a big role in that because, for example, it plays a big role in our outside survey process.

**QUESTION:** First of all, thank you for the FAQs, they've been very, very helpful. We have specifically asked the questions about this conveying to the next level provider or providers because if you have a patient who's got multiple co-morbidities but is also a patient who is very active and aware and participating in their care, it's double work for the organization. We give the patient all the information as we should and now there's this expectation that we also, that they're not capable of turning around and conveying that to their providers. So help me address that one.

**DR. RICK CROTEAU:** This topic is still under discussion, and we have in fact made an allowance within the context of emergency services or when patients are seen in an emergency department, treated and discharged back home from the emergency department that it will be sufficient only to give the list, an updated list to the patient and ask the patient to be the means of communicating that to their next provider of care.

Currently, that is not the case in other settings and clinical situations and the expectation from the outset with this is that the treating organization would be responsible for communicating that information to the next provider of care. The feeling of our advisory group was that it was not in the best interest of safe patient care to always rely just on the patient to be the means of this communication. This will be revisited in subsequent discussions to see in which clinical situations, in addition to the emergency services that I just mentioned, it might be safe and sufficient to rely on the patient as the means of communication.

**CALLER:** Thank you. We would really appreciate having that revisited because it's kind of counterintuitive with so much of what we're trying to do with getting the patients involved and yet you can't give them the information to carry forward.

**DR. RICK CROTEAU:** I understand, but remember a lot of the other clinical information that's communicated to the other providers of care like a discharge summary for example, is not communicated by way of the patient, so there should already be mechanisms in place to communicate that information. In fact, the discharge list of medications could and would reasonably be part of the discharge summary.

**QUESTION:** Our question has to do with patients receiving care in our ED, also our ambulatory surgery and patients coming in for tests involving IV contrast media. What else do we need to do to be compliant besides collecting a medication history and assessing whether or not we have contraindications between what the patient is taking and what has been prescribed new or perhaps used procedurally? That's our current process and we're wondering if that's enough to be compliant with the standard.

**DR. RICK CROTEAU:** What you're describing would be in compliance certainly with requirement 8A which says you collect a list of the medications the patient is currently on, and you use that list to compare with what is being given to the patient or prescribed for the patient to see if there are any duplications or potential interactions or possible dosing errors, that sort of thing. Now if, for example, it's an imaging center and you're doing a procedure and giving a single dose of a contrast agent and nothing is being prescribed for after the patient leaves your facility, then there are no changes to that patient's list of medications so there's nothing to update and the discharge list is essentially what information the patient provided to you. So in that sense requirement 8B doesn't apply. There's nothing further to be done. If there's a prescription, say following outpatient surgery, and there's a prescription for a pain medication or an antibiotic that will be continued after discharge, then the list of medications needs to be updated and that updated list now needs to be provided to the patient as well as any other subsequent providers of care.

**CALLER:** So in the ambulatory surgery scenario, it would be our responsibility then to get an updated list back to the provider and then that goes back to the previous caller's

question about how do we know that that person is using it. And I'm understanding that we only have to measure that we are providing that list for the next provider?

**DR. RICK CROTEAU:** Yes, that's correct. You're not responsible for ensuring that the other guy does what is expected of that provider. In your own organization you can reasonably establish expectations for your own clinical staff to use that information appropriately.

**CALLER:** Thank you. So, in the case of our IV contrast media, if we have a patient who's taking a Metformin containing medication such as Glucophage, we really only need to do that discharge teaching with the patient. We don't need to get a list to the next provider because we haven't added any medications to their list.

**QUESTION:** Thank you. My question actually follows the last one in the case of the IV contrast. We are not required to give the patients a list if we're not changing any of their medications?. One of the FAQs indicated that if the patient did not have a list—a physical list—that they just verbally told you the medications, then it says you should provide them a list.

**DR. RICK CROTEAU:** That's correct. The expectation is that the patient will leave your facility with a physical list of his or her medications. If the patient came to you with that list and it's not changing, then the job is already done. Certainly, if you had to gather that information through a verbal interaction you would create the list and then you'd simply give the patient a copy of that list.

**CALLER:** Right. And that of course applies outside of radiology to any other setting as well.

**DR. RICK CROTEAU:** Yes, anytime any medications are used for any purpose. Contrast agent is a medication.

**CALLER:** And including the minimal medication encounters as well. If they don't have a list they should walk out of our facility with a list.

**DR. RICK CROTEAU:** I sincerely regret ever having raised that phrase of minimum medication use because I think it's created a lot more confusion than it has provided service. I'm concerned that it is creating a separate category of medication use, which was not the intent.

**QUESTION:** I have a question about the requirement in 8B that the list does not have to include doses. We have a multi-specialty ambulatory clinic and patients see physicians from different services and when they cross from one clinic to the other some of the physicians have confirmed about the dosages of the medications that have been ordered in a previous clinic. Is the dose required?

**DR. RICK CROTEAU:** No. To answer most directly, it is not an explicit requirement for meeting the Safety Goals. The Goal says a list of the medications and we would take that at a minimum to mean the names of the medications. Now, it is also part of the Goal that that information will be used and in order to use it properly, and remember one of the uses is to avoid any dosing errors, one would reasonably also want to know what

the dose is that the patient should be on and the route of administration and the timing of administration and so on. This information may very well be available in a different location in the medical record. It doesn't have to literally be part of that physical list of the patient's medications but it is important information for the other providers to use as well as for patient education about the safe use of medications. They need to know what doses they're on and how to take it and so on. So it's really a matter of access to that information when it's needed.

I'll make one other comment because you expressed that some of your staff are uncomfortable with regard to their involvement with the doses of medications that have been ordered by other practitioners and it is our position and has been all along that creating a list of the patient's medication is not an order for those medications. If a nurse or physician is involved in developing that list they're not ordering the medications, they're not validating it as such, it's simply another document of information about the patient and I would just caution you against over interpreting what that list is. It's not an order for treatment, it's not a prescription; it's simply a list of medications.

**QUESTION:** I have a question about the medication reconciliation process for imaging outpatients. Who should be the person checking for interactions between intravenous media and medications on the patient's list?

**DR. RICK CROTEAU:** We do not specify any particular professional disciplines in terms of who should do what in the reconciliation process. The stipulation of course, and this is in our standards, is that anybody who does anything must be qualified and competent to do it, and that determination we leave to you in your organization as long as it's consistent with applicable law and regulations. So, what all of that means is that you

can assign that responsibility to certainly a physician or a nurse or a pharmacist, or even a technologist if it's determined that that person is sufficiently familiar with the drugs being used and what to look for and so on to at least raise questions about the appropriateness of proceeding with the imaging study, the administration of contrast and so on. It really comes down to a matter of determination of qualification and competence.

**QUESTION:** I'm a little bit confused about at either a transfer whether internal or at discharge particularly in the area of radiology and surgery. You know I realized also looking over your Frequently Asked Questions that you don't necessarily consider the reconciliation an order, although for the most part certainly at transfer we do. I'm more concerned with what to tell the patient when you have, for example, a surgeon who is not familiar with particular medications and is put in a position to make the decision whether to continue that medication or not and often they're encountering a medication which they have not ordered or are not familiar with and so forth so they feel that it's not in their area of expertise. So they're uncomfortable doing that.

It's easy to say contact the original prescriber, but sometimes that prescriber is not on our medical staff and is difficult to contact in a timely enough manner so that it's useful information for that patient whether they should continue that medication or not. They're put in a difficult situation and so you know we need a little direction about how to deal with that.

**DR. RICK CROTEAU:** One possibility is that a surgeon is put in a situation of having to make a decision about certain medications that he or she isn't familiar with, in which case they shouldn't be in that position. A physician should not be asked to do something

in terms of treating a patient that he or she is not qualified to do. On the other hand, if it is recognized, whether by that practitioner or a nurse or anyone else, that there are questions about the treatment of the patient that might involve medications ordered by someone else, that patient is a patient of your organization and therefore you have a responsibility to resolve any discrepancies. That, in fact, is fundamental to medication reconciliation and so the next step I suppose would be to assess the urgency of the situation. Is it something that really needs to be reconciled right away before the patient is discharged, in which case the onus would be on your organization? I'm not going to say specifically what individual, you decide that, but as an organization you have a responsibility to the patient to resolve these uncertainties about the patient's care. It may involve a phone call or some other communication or it may be something that could be done at a more leisurely pace if it's not a truly urgent situation.

**CALLER:** So simply referring this patient to the original prescriber or their attending physician would suffice?

**DR. RICK CROTEAU:** It might in some situations, and that's a clinical assessment that you have to make for yourself, but keep in mind that a failure to take the initiative on your part, to reconcile the difference may place you in some position of exposure if something happens with the patient.

**QUESTION:** My question is regarding the next provider of care. If a patient who has a primary care provider, but also has a cardiologist and an oncologist who the patient is seeing and he comes in and has hand surgery by a surgeon, who does the list go to?

**DR. RICK CROTEAU:** Well, if they're all next providers of care, if they are providing care to the patient they need to have all the available information about medications that the patient is on. It has to be current information. The challenge obviously is how do you do this in an efficient way? Those of you who have record systems, particularly electronic systems in which the information is accessible by essentially anyone on your staff who might be treating the patient, that's an acceptable means of communicating it. You don't have to send it as a separate document. All that's necessary is to ensure that any providers of care who need that information know that it exists and that they can access it. So this is an area clearly where the transition to electronic systems is going to be a big help in running this process efficiently.

**CALLER:** Okay, so in a case like this it should go to all of those physicians.

**DR. RICK CROTEAU:** Yes, if they're going to be participating in the patient's care in a timeframe that is relevant to whatever the changes are. What I'm thinking of specifically is if it's a short term antibiotic and the patient isn't expected to be seen by the cardiologist for the next six months or something, then it's not necessary to provide that update to that particular physician. It wouldn't be wrong, but it's not as directly relevant to the patient's safe care.

**QUESTION:** I'm wondering about the complete list of meds, any best practices, any examples that you can help us with? We do not have an electronic system. We do have a list upon admission and to combine that list, the list that we discharge the patient with, just wondering if you have any good examples out there to help us?

**DR. RICK CROTEAU:** Well, there are a couple of issues here, one is what do we mean by complete? And the other is this discharge list. Let me take that part first because we should be clear that the discharge list of medication is a single list. It includes all of the medications that the patient will be on following discharge. It doesn't and shouldn't include medications the patient received during the episode of care, during the hospitalization if they're not going to be continued afterwards. So it's just a list and it's a single list of everything the patient will be on following discharge. It should be complete but that's the ideal, and we recognize that coming in at the time of entry into the organization as well as even at discharge that as with anything else we get it as complete as we can. We get it as accurate as we can and the best practice is simply to make a good face effort to get it as complete and accurate as you can in the context of the clinical situation you're dealing with.

And what I'm getting at is there are some encounters in which a truly complete and accurate list is most important, others in which it's not really as important and the difference is do you go beyond what the patient tells you and call the patient's primary care provider or call the patient's pharmacy to validate certain information? In some cases you will do that. We don't expect you to do that in all cases.

**QUESTION:** After surgery, the recovery room RN is responsible for sending the patient home with a list of continued care afterwards, and so we are sending them home with a current list of medications but we were sending it home to be taken to their next physician. And as I'm reading this I understand that's incorrect, that we now have to fax it to that physician. But I guess my biggest question is when the physician writes we may resume.

**DR. RICK CROTEAU:** I would respond by saying yes the current requirement is that it also be sent to the next provider of care, not just given to the patient. Now it should be given to the patient as well, but you specifically said faxed to the next provider. That's fine, but we don't say you have to fax it. You can use whatever method. It might be electronic; it might be snail mail, whatever, as long as it gets to the next provider in a timeframe that's consistent with treating the patient. So it's got to get there at least before the next patient visit to that provider.

**QUESTION:** We managed to put together an inpatient program that seems to be functioning pretty well. Our question is as we move that out to our outpatient clinics and other parts of our system are there any good examples out there or anything that you can recommend for us to try to link that using either electronic media or some format? We'd appreciate that.

**DR. RICK CROTEAU:** I can't give you specific organizations but we have gotten a lot of information and support from the Massachusetts Coalition for Prevention of Medical Errors that has been actually promoting patient reconciliation among the Massachusetts hospitals for three or four years now. They actually had this in place before we introduced it as a Safety Goal and they have been very helpful to us in identifying best practices and so on and you might want to check their website. It's [www.macoalition.org](http://www.macoalition.org).

**QUESTION:** I've been reading about many organizations who are successfully introducing flexible arrangements within their policy for medication reconciliation. So, for

example in different areas it might be the home medication list might be developed by different individuals. Reconciliation process might be done by different individuals— pharmacists, nurses, physicians. And one of the things we struggle with is whether or not if we decide to do something like that to achieve better success, if we will jeopardize ourselves in terms of not having a similar standard of practice.

**DR. RICK CROTEAU:** The similar standard or comparable level and so on really has to do with is the patient getting a comparable level of care. And basically it comes down to regardless of who's doing what, is the process getting done so the patient gets safe care? And it sounds like that is the case that you've provided for all the steps in the process to be done, I will assume by people who are competent to do them, so that the reconciliation process is actually happening. Do we require that it be done by the same category of professionals throughout the entire organization? No, we haven't said that and we wouldn't hold you to that if your process is working. Now we might ask how do you make sure that people who are supposed to be doing certain things, know they're supposed to be doing it and are qualified to do those things. And I'm guessing that you have a good response to that type of question if our surveyor should ask you.

**CALLER:** Thank you for your response, I agree with you. I think that the more flexible it is the more challenging it is to educate people so that's one of the challenges with that, but thank you.

**QUESTION:** I have a question regarding our outpatient respiratory department. We perform outpatient pulmonary function tests there and the patients are given medication

at that time. So, at that time they would only have to take a list of the patient's current medications the same as they would be doing down in imaging?

**DR. RICK CROTEAU:** That's right. They'd have to have had the list. These are typically scheduled procedures. So you know in advance, you contact the patient; there may be certain pre-procedure instructions one of which might be to bring a list of your medications. Failing that then you would have to create that list and use it to compare against the medications that you're using and your pulmonary function tests.

**CALLER:** Okay, so if we create the list for the patient are we then giving that same list to the patients to go home with?

**DR. RICK CROTEAU:** Yes.

**QUESTION:** If a patient brings a typed list of their medications can we attach that to the form that we have for medication reconciliation or just put it in the chart and will that represent the patient's list?

**DR. RICK CROTEAU:** Well it's fine with me, but that's not really important. If it's acceptable legally to do that and if it's within your own policies and procedures to include that kind of information in that form in the medical record then the answer is yes, you can do that. But make sure that it fits within the existing guidelines that you're working under.

**QUESTION:** I have a couple of comments and a question. When I read this standard the way I interpreted it was the facility should compile an accurate list, as opposed to

what the patient tells you. Our patients are notoriously poor historians so we wind up spending a lot of time trying to piece together an accurate list rather than just taking what the patient is telling us at first blush. So one of the push back issues we have had from the medical staff is that they're very reluctant to sign off on an inaccurate list because it raises certain medical legal issues, particularly in the outpatient area. One of the previous speakers spoke about outpatient type procedures and you know surgeons specialize say an ophthalmologist or something totally unfamiliar with chemo drugs, psychotropic medications and the like. And the thought that was put forth in that regard is that perhaps they should be requesting a medical consult on each of these patients in order that the list be accurate for discharge and you would have an enormous health care cost if that became the common practice. But, I think for these specialized surgeons it's very difficult for them to be fully knowledgeable about every drug. So I guess the question is do we need an accurate list or do we just need the list of what the patient provides us?

**DR. RICK CROTEAU:** I think you actually gave the answer earlier in your comments when you made the statement that your patients aren't the best historians. And you're drawing an analogy between the list of medications and gathering a patient's history. I think that's a reasonable comparison. The list of medications is part of the medical history and to the extent that you can rely on the history that you get from the patient and determine whether you need to go to other sources to get additional or confirmatory information, you apply that same logic to the creating of a list of medications. I addressed the issue of completeness and accuracy earlier. You make a good faith effort to get as complete and as accurate a list as is appropriate for the clinical situation. I wouldn't recommend ordering a medical consult on every patient but I suspect you order

medical consults on some of your patients and I think the rationale for making that decision applies equally to the list of medications as to other aspects of the patient's history.

**QUESTION:** Can a non-physician do a medical reconciliation at discharge, like for outpatients?

**DR. RICK CROTEAU:** Yes. It doesn't have to be a physician. If there are orders to be written, new medication orders, obviously that has to be done by someone legally authorized to prescribe, but the reconciliation is simply comparing one list with the medications being ordered or that the patient is being discharged on and that can be done by a nurse, by a pharmacist or by whoever you determine is qualified and competent to do it.

**QUESTION:** We would like to have some clarification about the patient receiving a list upon transfer to another facility. Most of our patients come to us from a long term acute care hospital. They come to us with altered level of consciousness and are not really capable of managing their own list. And most of them upon discharge or when we receive them have no family members to transport this list. What do we do in those cases because we're concerned about HIPAA violations, et cetera, just handing it to a person who cannot manage it?

**DR. RICK CROTEAU:** Yeah I certainly agree with your concerns about that situation and you would handle it pretty much the same way you handled patient education. In general we expect that you will provide certain patient education but the patient has to

be able to receive and understand that information. If they're not capable then you look to the patient's support system, a family member or whoever the patient may have designated for that purpose and if there's no one that fits into that category then the next provider of care is the person to whom that information will be communicated along with the appropriate instructions, which you would do anyway. But we certainly aren't asking you to give the patient information that he or she is not capable of understanding or using.

**QUESTION:** Regarding behavioral health settings where the provider is a mental health therapist who does not prescribe medication, do you see any application of this in that setting?

**DR. RICK CROTEAU:** If no medications are being used, and I'm using the term medication use as a broader term than just prescribing medications, if you're administering medications to the patient, that may have been ordered by another practitioner, you're still using medications for that patient under your care and there is an expectation that you would then have a list of all of the patient's medication. If you're using medications in any sense of prescribing, dispensing, administering, that is medication use and the medication reconciliation requirements come into play. If you're not using medications, if it's simply a therapy session without medications then medication reconciliation doesn't apply.

**QUESTION:** I want to verify what you said about the electronic medical records. Currently, we have electronic records and we have a meds pad that has the inpatient meds, outpatient meds and home meds that's always available. And in addition when

they're putting in their orders it's always doing the drug interactions, drug allergy interactions and duplicate checking. So if it handles it, then to do our drug medication reconciliation will we just need to provide the list at discharge, and we can say our system is providing the other pieces of the medication reconciliation if they're putting the list in, you know the home meds from the patient?

**DR. RICK CROTEAU:** As long as that information is being used when medications are ordered during the hospitalization or encounter. I have two questions that come to mind as you described the system. One is how do you know that it's actually being used? And I have to say I wouldn't be comfortable relying exclusively on the electronic decision support process and warning system in all of that. I would like to know that the prescriber is actually looking at that information and using it. The other is, does it also check for omissions of medications? In other words, something the patient was on at home that might be discontinued at least temporarily when the patient is admitted but would need to be resumed later on. That's a common type of error in a hospital situation—is forgetting essentially to resume home meds when it's appropriate to do so whether during the hospitalization or at discharge.

**CALLER:** If they're doing the discharge summary we can bring in home meds, inpatient meds and outpatient meds so he would be doing that to show what he's going to prescribe on discharge and what came in and it would also report what their active home meds were at that time.

**DR. RICK CROTEAU:** Well, that takes care of the discharge process but we expect this reconciliation process to take place at points of transition within the hospital when new medications are ordered or there's a rewriting of the orders.

**CALLER:** What I'm saying is that the nurse gets the home meds from the patient and they enter those in the system. And all our doctors are doing computerized physician order entry on the system. And so anytime they write their prescriptions in the system it's checking those home meds that the nurse put in and the allergies and so to me the electronic piece is handling all of that area because the doctor can't order anything without those warnings coming up.

**DR. RICK CROTEAU:** It's nice to have good electronic tools like that but we're not going to accept total reliance on the system which may itself be unreliable. We need to get the prescriber involved in the practice. Thank you.

**QUESTION:** I had a question about the next provider issue. I work in a surgical center and most of our patients really don't even have a change in their medications other than the pain medication they go home on. And the next provider is actually the physician who ordered that pain medication because that would be the surgeon.

**DR. RICK CROTEAU:** Well, the pain medication is a change so we need to be clear on that, that the list would be updated because there's now a new medication. If the next provider is the surgeon and the surgeon has that list or has access to that list then the job is done. It should be given to the patient as well, obviously. But you've already provided it to the next caregiver.

**CALLER:** We actually give the patient a card with it that we transcribe all their medications on and then we write the additional pain medications in pencil so they can eliminate that when they're finished.

**DR. RICK CROTEAU:** That's okay.

**QUESTION:** My question pertains to discharging a patient from an inpatient hospital and the notification of the physicians of the patient's current med list. If a patient was seen by a cardiologist and they also have a family physician, an OB/GYN, an eye doctor, an oncologist, are you saying that we have to send that list to every single doctor that currently sees that patient whether they see them regularly or not?

**DR. RICK CROTEAU:** This is a judgment call, and we don't want to get unreasonable about it. It's the providers who are providing active care to the patient in a timeframe in which that information is relevant. So, if the patient is going to be seeing more than one provider over the next month or so, depending on what changes have been made to that medication list, then we would expect you to forward that information, to communicate that information to those providers—medications or the antibiotic or pain reliever after surgery, for example. The patient may have multiple other providers of care but won't be seeing them for quite some time. We wouldn't expect you to be sending that information to all of them.

**CALLER:** Okay and are we supposed to document that we sent all this and who we sent it to?

**DR. RICK CROTEAU:** That's entirely up to you. The only documentation requirement under the medication reconciliation goal is the list of medications.

**QUESTION:** My question is related to ambulatory care programs. It's not clear to me whether when you're dealing with a telephone conversation with a patient and adjusting therapies or starting new medications, whether a list is required to be provided to the patient. I can't find that scenario specifically addressed in the National Patient Safety Goal or in the FAQs.

**DR. RICK CROTEAU:** Interesting, that's the first time that that's come up. I can see where that can happen. In a situation like that you're dealing with the patient first of all who is competent to have that kind of interaction and respond appropriately to it. And as the provider you will have made that judgment. Using that same logic I think we could reasonably say that the patient has a list of medications and perhaps either had it prior to the call or you can work with the patient as part of the call to know what medications the patient is on and then you can interact with the patient to update that list based on what changes you're making on the patient's therapy. So the process takes place, it's just done in a different medium than is the traditional encounter.

**CALLER:** Okay, so it wouldn't require a written document, it could be done verbally with the patient?

**DR. RICK CROTEAU:** I would ask the patient to make a physical list. We do that anyway, as sort of a community outreach part of the program, to encourage everybody to keep a list of their own medications.

**QUESTION:** For outpatients, specifically a pain center, when the patient comes in we're going to get the list from the patient. Then we will fax that list to the primary care. Every time the patient comes in, we'll update the list for the patient, but then what will happen is there will be a dictated report that will go to the physician at the end. Is that acceptable?

**DR. RICK CROTEAU:** Yes, I think it will be. Now, you're saying you're updating the list. That makes it sound like you're giving the patient different medications every time. If it's a repeat visit for the same treatment each time, then the medications you're using on those visits would be part of a list, and it would indicate that it's an intermittent administration at a particular visit. Can you tell me which is the case? Are you using different medications each time or the same one every time?

**CALLER:** They can be both ways. They can be different or the same, you know.

**DR. RICK CROTEAU:** If it's different, then you do need to update the list.

**CALLER:** We would update the list with the patient, but do we also have to send the updated list to the physician, or could it wait until we did the whole dictated piece?

**DR. RICK CROTEAU:** If it's a series of visits and the patient isn't going to be seeing this other practitioner until the conclusion of that series of visits, then you only need to provide that physician with an updated list at your discharge of the patient from the series. But if the patient is seeing both you and your pain clinic and this other provider, and the medications are changing, then you do have to keep that other provider apprised of the changes.

**CALLER:** But, if the dictation that we send includes the information regarding any changes, would that be enough, or does the actual list itself have to be faxed to the provider?

**DR. RICK CROTEAU:** I think as long as the provider has the information that's needed, that would be acceptable. I will add that we don't accept piecemeal lists given to the patient. In other words, providing the patient with the original list and then a separate piece of paper with changes will not meet the requirements; however, when you're dealing with another provider that's acceptable as long as they have sufficient information to know everything that the patient is currently on.

**QUESTION:** We're struggling with the requirement to provide the next provider of care with a list, because the list that we are generating is part of our medical records, and in the VA system we have strict rules on our release of information. In fact, we have to have a request from that new provider and then have the release of information form signed by the patient before we can send off that information. I was wondering how other facilities are dealing with this? Or, do you have any suggestions on how we can do this in a timely manner?

**DR. RICK CROTEAU:** Well, it sounds like you're bound up in the VA regulations. I'm not aware that there are comparable regulations in the private sector, because I haven't heard that before, but I think you might want to look into it to see if the existing regulations allow you a little more latitude for communicating information to other caregivers of the patient, whether within your system or even outside your system when you're discharging the patient or transferring the patient to their care.

One of the expectations, and as just a good practice expectation, is that when you transfer a patient, you also provide the necessary information for taking care of that patient, and I guess I'm questioning whether the regulations are really a barrier to providing what is essentially that good care.

**QUESTION:** The question I have is, according to your recent Frequently Asked Questions, the only documentation required is the list. You go on to say reconciliation may or may not be supported by documentation; however, you should be able to answer the question, how do I know reconciliation is happening consistently. We are hearing that surveyors are finding no documentation of reconciliation in the records. Is the documentation of the process of reconciliation required or not?

**DR. RICK CROTEAU:** It is not. The process is required. You need to do the reconciliation, you need to have the list, you need to look at the list when medications are being prescribed. You decide whether to document it or not. That decision may be based on how you intend to assess your own performance with regard to the reconciliation process.

I'm making an assumption that you'll want to know if you're doing it consistently. There are a number of ways you can make that determination. Some ways involve documentation, others involve direct observation or interviews with staff, in other words the same techniques that our surveyors use.

**QUESTION:** My question is for an outpatient chemotherapy infusion center. How do we go about doing a medication reconciliation? The physician that's ordering the chemo is not their primary care provider, and our patients will come back on multiple visits. Some patients will come back on a daily visit, some patients will come back every two weeks, some patients will come back every three weeks. Do we need to do a medication reconciliation every time they come in? What is the recommendation for those patients that are on multiple visits of treatment?

**DR. RICK CROTEAU:** Typically, the visits involve the same medications. They're on a series of doses of certain medications which are ordered at the outset of that series of treatments. It's at that starting point that reconciliation needs to be done. If the patient is coming in for multiple visits and with medications – same medications being administered at each visit—there's really no change in the patient's current medications. Those chemotherapy agents or whatever else is being administered during that series of visits, that's part of the list of the patient's current medication. So, the reconciliation should be done at the beginning when the chemotherapy is initially ordered, and then at the conclusion of the treatment regimen, when the patient has been discharged and will now have a new and updated list of medications that he or she will continue to take at home.

**CALLER:** What if their home meds change?

**DR. RICK CROTEAU:** If their home meds change then the list needs to be updated, and that information needs to be provided to whomever is currently also providing care to the patient.

**CALLER:** So then, on each visit, if we ask the patient are there any changes, would that be sufficient?

**DR. RICK CROTEAU:** Sure. That's the same as when you gather the initial list. You put some reliance on the patient to know what he or she is on.

**QUESTION:** We are seeing children and adolescents in a mental health psychiatry office. It's an ongoing process. We see them for years at a time. Upon entering to the clinic, we ask them what are their current medications. We repeat this question every time they come in, and we actually have them repeat our medications that we prescribed too, just to see that they're complying. Then they are seen and perhaps there's a change, sometimes there is no change. When do we need to actually give them a written list?

**DR. RICK CROTEAU:** Whenever it changes.

**QUESTION:** Whenever it changes we need to hand them a written documentation saying now your medication has changed accordingly? What if they're telling me, okay,

I'm no longer on the medication prescribed by another provider? I just take their word for it and update my list. Do I need to give them a list of it as well?

**DR. RICK CROTEAU:** The patient needs to have a list of all of the medications that he or she is currently on, so anytime that changes for whatever reason.

**CALLER:** Even the dosage?

**DR. RICK CROTEAU:** Yes.

**CALLER:** Okay, so after each visit they need to get a current list of medications.

**DR. RICK CROTEAU:** Right.

**CALLER:** I wasn't clear if there is like, every three months kind of a thing, because it's an ongoing series.

**DR. RICK CROTEAU:** It's an ongoing series, but the medications don't necessarily change every time, but when they do change, the list should be updated.

**QUESTION:** We have a manual system, we're an acute care facility and we just had Joint Commission surveyors in for our periodic review. We explained our process to them and they asked, when does the pharmacy become involved and how do we get the list of admission information to the pharmacy? And recommended, because we don't do

that currently, recommended that we do follow their list that is taken on admission history through the pharmacy, and I just wanted to know what your comment is on that?

**DR. RICK CROTEAU:** Well, my comment would be that the pharmacy, which is filling medication orders I presume and dispensing medications for that patient does need that information. Typically, it's part of the pharmacy profile. If you're not providing that information to the pharmacist, because that is a professional standard of practice, the pharmacist is then obligated to get the information, and rather than duplicating the effort of gathering this information by different professionals in different locations, it would be much more efficient to gather it one time and share the information among the various professionals who were providing care. And so, I think the surveyor's advice to share that information with the pharmacy was really in that context of making the process as efficient as possible.

**QUESTION:** We have one question regarding the outpatient having contrasts, and we have a very good algorithm for screening out the diabetics who are on metformin that would need special discharge instructions. Can you tell me, is there a requirement that those discharge instructions be signed by a radiologist?

**DR. RICK CROTEAU:** No. The medication reconciliation requirements do not include any kind of signatures. I realize that a lot of organizations, in implementing a process for medication reconciliation, have decided to have the lists and other steps in the process be signed off, and that, for a lot of organizations, has created a real barrier to getting the job done, because in general, practitioners don't like signing things that they don't feel they should be responsible for. For example, the list of medications, the information for

which came from various sources. We don't require the signature, and we would suggest that if you're requiring signatures, that you might want to reconsider that, if it appears to be a barrier for you to get the job done.

**CALLER:** Bless your little heart. That's wonderful news.

**DR. RICK CROTEAU:** Well, thank you for your blessings.

**QUESTION:** In our hospital-based outpatient practices, we do not have RNs staffing or supervising those practices in many areas. We have certified medical assistants that have minimal schooling. I see that in your National Patient Safety Goals that 8A and B indicates the two models that either a physician does the reconciliation, and in the other model, a pharmacist or a nurse does the reconciliation. How do we get around and go about achieving this and meeting this goal without that staffing resource?

**DR. RICK CROTEAU:** Did I understand that the only provider is the medical technician?

**CALLER:** It's not the only provider. There is a physician there. But, upon the intake of the patient, the reconciling of the medications could be done at that time, when their vital signs are taken and their chief complaint is discussed and documented, and the feeling is that this level of staff does not have the competency to obtain this list from the patient. There have been many spelling inaccuracies, dosage inaccuracies, so on and so forth.

**DR. RICK CROTEAU:** If you have determined that those individuals are not competent to do that, then obviously they shouldn't be doing it, and what I'm understanding is the only other individual available to do it would be the physician. If medications are being used, then the reconciliation requirement does apply. I would say under your current staffing model the physician will have to do that. I was hoping that you could say that the med tech could collect the list and the actual use of the list would be done by the physician, but it sounds like you're saying that even that won't work.

My other suggestion would be, is there a way to either get that list done beforehand, involve the patient more in the process perhaps, or have some other pre-visit opportunity to put that list together, or is there a way to get a nurse or a pharmacist involved in the process? I'm just offering suggestions on how to get it done, but the bottom line is that if you're using medications, it does have to be done.

**CALLER:** Our other thought was that we would give the patient a document and ask them to complete the document upon arrival at our registration area to document their medications that they are currently on. Many patients come with a list, many patients do not. They could collect the data, the CMA could collect the data, and I know that it would be reviewed by the physician for accuracy. I guess we look at the documentation as a legal document, and spelling and dosage and many errors could be obtained from a staff member that is not competent to do the task.

**DR. RICK CROTEAU:** Yes, and we recognize that there are certain limitations of the process, but in that setting, which is comparable I think to a doctor's office visit, what you described is what happens in a lot of doctor's offices. The patient is given a form to fill out and one of the items on the form is a list all of your medications. It's then checked

by the physician at the point of care, and there may be some question that the patient will be asked to clarify certain information, but that's a perfectly acceptable way of doing it.

**QUESTION:** We were surveyed last week and I got zinged on medication reconciliation and I have a couple of questions.

**DR. RICK CROTEAU:** You got zinged?

**CALLER:** Yes. If the purpose is to check for duplication, omission or potential interaction, does the list have to have a dosage or could it just be the name of the medication?

**DR. RICK CROTEAU:** In a practical sense, you should have as much of that information about dosing as is reasonably obtainable, because you are also looking for potential dosing errors. If you're ordering for inpatient care a medication that the patient was on at home, I would think you would need to know not just the name of the medication, but what the dose was that they were on, how often they were taking it, and maybe even when the last dose was, so you know when to give the next dose.

**CALLER:** Well, actually, we are an ambulatory surgery center, so none of the medications, not only would we not be giving here at the facility, we would not be telling them to resume it or to stop taking it. They are only coming in for their two hour or three hour procedure. So, having a list of their medications but not necessarily their doses is what we got zinged on. We had the list, we just didn't have dosages.

**DR. RICK CROTEAU:** There is not a strict requirement that you must have the dose. You must have information that's necessary to provide good care to the patient, but what you're describing is a situation in which the dose may not be relevant. And if that's the case and if that's your clinical determination, then we would not require you to gather that information.

**CALLER:** As I was listening to the questions that have been coming in, we don't have to document on our medication reconciliation records the anesthetic drugs that were given, because once they're given, the patient is not continuing them.

**DR. RICK CROTEAU:** That's right. Any medications that are given as part of the treatment during the episode of care, but not being continued after discharge, they don't go on that discharge list.

**CALLER:** Okay, so if I'm only sending them home on pain meds for the next five days, that's the only thing I need to add as far as a new medication onto their list?

**DR. RICK CROTEAU:** Yes. That's right.

**CALLER:** Thank you very much for your help.

**QUESTION:** We are also a freestanding ambulatory surgery center. Prior to admission we collect the patient's list of home meds, and we also just send them home either with

an antibiotic or a pain medication for a short period of time. My question is how are we different than that ED in your Frequently Asked Questions?

**DR. RICK CROTEAU:** I get your point and the answer I'm sure at the moment won't satisfy you, is that that relaxation of the requirements has been approved only for the ED setting. I recognize that there are similarities to other settings of care, and as I said earlier, we will be revisiting that. We're going to be interested in what the experience is with these emergency department patients and how that is working and so on, but it sounds on the surface like it's reasonable to ask the patient to bring the list to the next provider of care, if it's determined that the patient is competent to do that task, and there would be that additional burden, if you will, on you to make that determination. That's what we're going to seek approval for, but I can't project what the outcome will be right now.

**CALLER:** So, for right now, is it sufficient for it to go to the surgeon?

**DR. RICK CROTEAU:** Yes, if the surgeon is the next provider of care. Now, if there are other providers who are going to be active in the patient's care while that new additional medication is being taken, then you should also provide the information to those providers.

**CALLER:** We don't really know. I mean they could leave here and decide to make an appointment.

**DR. RICK CROTEAU:** That's different. You don't know what you don't know. And, you should communicate information based on what you do know. And, I should point out that there are some situations in which the patient might not want you to communicate that information, and it is always the patient's right to refuse to have information communicated. Your obligation then is to make sure they understand the implications of that.

**QUESTION:** My question is concerning the administration of IV contrast with a diabetic patient on Glucophage with discontinued meds prior and post. Earlier in the phone call, I believe I heard, perhaps incorrectly, that that was not necessary to do.

**DR. RICK CROTEAU:** The decision to discontinue medication that might interact is a clinical decision, and you do what's right clinically to do. We are not addressing that in the context of medication reconciliation. What we have said, though, is that if you're administering medication, including a contrast agent, you must have a list of the patient's current medications available to you. You then use that list as the basis for your screening. Now many imaging centers in the past have not obtained a list of the patient's current medications, but rather had simply asked are you on Glucophage, Metformin and so on. Now, some patients don't have a clue as to what that means, and so in consultation with the American College of Radiology, we agreed that in all of these cases at a minimum, a list of the patient's current medications should be available.

**CALLER:** Okay, so in other words, just for clarification, if it is our policy to discontinue meds post imaging, then medical reconciliation would be necessary.

**DR. RICK CROTEAU:** Well, it's necessary just by virtue of the fact that you're using a contrast agent.

**CALLER:** Thank you.

**CATHY BARRY-IPEMA:** Thank you again everyone for joining us on today's call. We hope it was of value to you. Please remember to visit the Joint Commission website, [www.jointcommission.org](http://www.jointcommission.org) or your secure extranet site for more information on this topic.

Some individuals have had a problem getting information about the conference calls. Please know that on the extranet site there is a link there that you can click on and add your contact information, so we can make sure that we send you information on upcoming conferences. We send the information about a week prior to each conference call for registration.

After today's call, you will all receive an e-mail with a toll-free phone number that you can call to hear a playback of today's call, and a written transcript will also be posted on our website and the extranet within the next few weeks. A list of upcoming telephone conference calls is also posted on the extranet site.