Dear Dr. Jeff:

My facility recently adopted a performance improvement measure to improve the concordance between hospital recommendations and post-acute admission orders. I feel this return to me to elementary school where I am being graded for my ability to copy off the board. Is this really a quality metric at all?

Dr. Jeff responds:

A decade ago, skilled nursing facilities complained that transfers from the hospital frequently arrived without any medical information. Access absent to the hospital chart, receiving physicians looked for discharge diagnoses, results from significant diagnostic studies done in the hospital, and some minimal information regarding operative procedures performed. Particularly, they asked for a list of current medications as new residents rarely knew the names of said medications, much less the dosages.

Tremendous progress has been made in hospital discharge processes in recent years. Although some facilities continue to struggle to obtain basic medical information at the time of post-acute admission, many now complain that they are being overwhelmed with reams of documentation to review, requiring time to find the significant information among pages of medication administration records, vital signs, and routine laboratory results. Most hospitals have brought their processes into the 21st century partially as a response to an evolving medical system that encourages collaboration between hospitals and preferred post-acute facilities, to the case with which most hospital electronic health records can print out transfer information, to pressure from the Joint Commission for safe discharge standards, and certainly to avoid the financial penalties on hospitals for rehospitalization. It is certainly better to be a medication scribe than to be totally in the dark.

The whole notion of medication reconciliation, or “MedRec” as it is frequently called, is relatively vague. Although medication is a straightforward concept, reconciliation is not a medical or scientific process. Although it is universally recommended and mandated by The Joint Commission, there is little evidence to support the role of medication reconciliation in the prevention of medical errors, much less of best practices by which it should be accomplished. A knowledge of prior medication usage is obviously a significant element of any past medical history. Any wise clinician appreciates that the knowledge of what medication has worked and what has failed for a patient is extremely useful in planning future therapy. This would certainly extend beyond the medications used on the day of hospital discharge to an extended understanding of prior medication usage.

**What Is Reconciliation?**

The first definition of reconciliation describes the restoration of friendly relations. Steps to overcome the ongoing low-level hostility between acute and subacute providers might be desirable, but MedRec is not a feel-good process. Similarly, the second common definition, involving peneance and the Christian sacrament of reconciliation, does not apply in this setting — desirable as it might be for post-acute providers to confess their sins. Rather, the accounting practice of reconciliation is closer to what your facility has in mind. Reconciliation in accountancy is the process of ensuring that two sets of records are in agreement. For example, reconciling bank statements involves bringing the calculations in a spreadsheet in sync with the column of figures provided by the bank; unlike the beloved Monopoly card of “Bank Error in Your Favor,” generally this involves correcting miscalculations in your own running balance. Thus, the described process with MedRec involves verifying your list against that provided by the hospital to eliminate transcription or omission errors — exactly what your facility’s quality assurance process attempts to control.

The practitioner who believes that this process alone will produce good outcomes and protect their residents from medication errors is sadly mistaken. Current hospital practices are frequently inappropriate for the elderly, and often they are downright dangerous. For example, many hospitalists or medical house staff continue to routinely prescribe proton pump inhibitors for all medical admissions, even when their combination with any required antibiotics places patients at high risk for *Clostridium difficile* colitis. Asymptomatic bacteriuria produces reflexive and potentially dangerous treatment as well, often with prolonged courses of broad spectrum antibiotics. Far too often impaired sleep is treated with sedating antidepressants or with haloperidol, quetiapine, or other sedating antipsychotics. Even a medication regimen that might have been sensible for an acutely ill patient — such as when venous thrombosis prophylaxis is given to temporarily bedridden, elderly medical patients — may place a rehabilitation patient who is now active at excessive risk of bleeding.

Continued insulin regimens designed for tight control of an inactive patient, or while unable to take oral hypoglycemics expose post-acute residents to excessive risk of devastating hypoglycemia. Transfer medication regimens often fail to include significant “as needed” medications, including analgesics, antiemetics, and anticoagulants administered in varying doses. Alternatively, they may include a lengthy list — such as medication for diarrhea and for constipation — that leaves the clinician totally unaware of the resident’s current bowel status.

One experienced clinician described to me his joy in discontinuing statins in 90-year-olds with no history of arteriosclerotic disease or diabetes.

One study of 597 discharges from a hospital internal medicine service identified 66% with a total of 1,012 problematic instructions. These included 393 omissions affecting 251 patients of which 32% were evaluated as potentially harmful. In addition, 17% of discharge medications (619 of 3,691) were considered unjustified, affecting 318 patients. Of these, 16% were potentially harmful (Qual Saf Health Care 2009;18:205–8). The major categories for inappropriate medications were proton pump inhibitors, cardiovascular drugs, and psychiatric medications.

Some hospital transfer documents also include admission histories that may, in turn, include lists of medications used before hospital admission. This is potentially useful information, particularly in the identification of needed medications that have been omitted or for chronic medications that were actually used before admission. Unfortunately, these lists are often rife with error. A University of Wisconsin review of 200 consecutive medical intensive care unit admissions identified 1,628 inconsistencies between home medication lists obtained by physicians and the list for the same patients obtained by the pharmacist (Hosp Pharm 2011;46:262–8).

**Steps to Reconciliation**

The independent Institute for Healthcare Improvement has produced an excellent how-to guide designed to avoid medication errors in the reconciliation process. Although not directed toward the post-acute setting, most of the concepts and suggestions still apply. They emphasize that MedRec should be a patient-centered process. It begins with what they call “verification,” which is the patient’s medication history, including the transfer recommendations, along with what is obtainable regarding pre-hospital medication use. The second step is “clarification,” the adjustment of medications and dosages to the patient’s current needs. Finally comes “reconciliation,” the documentation as to why medications were continued, changed, omitted, or added.

Although this three-step process must begin at admission to the nursing home, it can be continued and adjusted over the first several days as more information is obtained. The days after admission may be an ideal opportunity for a “brown-bag” review of what the newly admitted resident actually took before hospitalization. The clinician should emphasize to the family or friends who are bringing in medications from home to include over-the-counter medications, topical medications, and eye drops. The correct medication orders should represent a synthesis of the hospital medications, the pre-hospital medications, and the additions or subtractions dictated by the wisdom and judgment of a post-acute professional, filtered through the preferences of the physician who will be treating the resident after discharge and the limitations of the resident’s drug plan formulary.

Some adjustments may require clarification with laboratory tests, such as when the gastric irritant ferrous sulfate is eliminated for a resident with adequate iron stores or sliding-scale insulin injections for patients who are not even diabetic. Some modifications can only be achieved gradually, such as when patients must be weaned off inappropriate sedatives and hypnotics to which they have become habituated, or off opioids as their acute pain subsides. The reconciliation process should include these as well, explaining why, for example, a hospital order for a medication listed by Beer’s Criteria as inappropriate for use in the elderly is being continued.

A comparison of changes between the medication before hospital admission and in the discharge recommendations on transfer to post-acute care allows a review of the changes instituted in the hospital. Sometimes the need for additional medicines is obvious: a new adverse medication reaction, an analgesic prescribed for post-operative pain, management of a chronic condition modified after a decompensation or flare-up of
that condition, or an antibiotic continued to complete the treatment of the infection that precipitated the hospitalization. However, even here it is often necessary to consider modifications. Should the narcotics be tapered as the surgical wound heals? Were the antibiotics modified from broad spectrum after a specific organism was identified and sensitivities obtained? Should the high-dose diuretics used to correct fluid overload be decreased now that excess fluid has been removed? Should medications such as angiotensin-converting enzyme inhibitors be used or increased to maintain future stability?

Confident clinicians also use the medication reconciliation process to remove medications that have apparent indications but whose benefit, in their judgment, are outweighed by risks and burdens for this particular patient. One experienced clinician described to me his joy in discontinuing statins in 90-year-olds with no history of arteriosclerotic disease or diabetes. A referral hospital routinely might perform a MoCA (Montreal Cognitive Assessment) or SLUMS (St. Louis University Mental Status) dementia screen on every admission — which is not necessarily bad — but then starts everyone who scores below 26 on 5 mg of donepezil. Dementia cannot be accurately diagnosed during an acute illness, although the information that a patient has memory deficits may be useful in guiding patient education and rehabilitation. Scores below 26 could represent sick patients with underlying normal cognition or mild cognitive impairment, which is not helped by cholinesterase inhibitors.

Medications that were omitted in the hospital may represent an ideal opportunity to simplify the treatment regimen or simply a failure to obtain full information on hospital admission. Families frequently arrive in the post-acute facility bearing the glaucoma eyedrops used at home or the liniment that grandpa finds more effective than the nonsteroidal anti-inflammatory prescribed in the hospital for chronic musculoskeletal pain.

MedRec is not a one-step or one-time process in post-acute and long-term care. It is certainly not a copying task. Verification and clarification often require time and thought, but they are vital to quality, person-centered care. And, as with everything in long-term care, the documentation justifying our treatment and reflecting our considered judgment should be fully recorded.

In Memoriam

The PA/LTC field recently lost two practitioners who were well known and admired by Society members.

Mary E. Cohan, MD, 60, died on Feb. 23 after a brief battle with cancer. Dr. Cohan joined the Medical College of Wisconsin faculty in 1989, where she spent her professional career. Dr. Cohan was medical director of several nursing homes, and held leadership positions in the Wisconsin Association of Medical Directors, including past president. She also was associate professor of medicine, geriatrics, at MCW, and staff physician at Froedtert Hospital and the Clement J. Zablocki Veterans Affairs Medical Center.

Robert Lewis Kane, MD, 77, died unexpectedly on March 6. Dr. Kane was an internationally renowned physician and geriatrician. He was the chair of aging and long-term care at the University of Minnesota’s School of Public Health, where he was a professor for more than 30 years. He was a distinguished researcher, author, and educator, and advocated for improved delivery of long-term care and better management of chronic illnesses.

“Dr. Kane was determined to help people age with grace and dignity. To him, work was always deeply personal. Bob was committed to his scholarship and advocacy; he was also devoted to his colleagues with whom he collaborated generously, and his students for whom he was a gracious and supportive mentor. Bob will be remembered for his intelligence, wit, wry humor and deep generosity,” according to his obituary, published in the Minneapolis Star Tribune.