

35. A FACILITATOR TOOL OF THERAPEUTIC CONCILIATION IN THE TRANSITIONS OF THE PATIENT BETWEEN THE HOSPITAL & PRIMARY HEALTH

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BACKGROUND:

The process of therapeutic reconciliation involves reviewing a patient's medication history, resolving discrepancies, and identifying the appropriate list of medications for the patient – both at admission and at discharge.

For the purposes of admission medication reconciliation, the medication list is often referred to as the Pre-Admission Medication List (PAML). For discharge, another Pre-Discharge Medication List (PDML) must be configured.

OBJECTIVES:

- Develop an active, structured process within the Electronic Health Record (EHR), where each item on the PAML or the PDML is affirmed or suspended on a dedicated reconciliation screen
- Develop an electronic medication reconciliation tool available within our EHR
- Perform an electronic linkage between the primary care computerised prescriber order entry (CPOE) system (ECAP®) and the hospital CPOE system (SILICON®)

METHODS:

The development of the new process was based on the experience gained during an R&D project, carried out in the ICS hospitals over two years, to implement pharmacotherapeutic reconciliation. Hospital pharmacists from the different centres led the project. They identified the shortcomings of the current reconciliation process, as well as the unmet needs of healthcare professionals involved in the prescription, validation and treatment management process, in order to optimise time and resources. The following issues were identified:

- ✓ Paper-based procedure for PAML and PDML construction
- ✓ No automated adaptation of current outpatient prescriptions to hospital formulary
- ✓ Need for manual transcription of medications between different lists and prescriptions

The design of the computer application and its functionalities aimed to facilitate the tasks of the professionals in charge of carrying out the reconciliation process.



Using an app to facilitate therapeutic reconciliation.
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RESULTS:

What has been achieved?

- ✓ Flow charts of structured processes within the EHR for medication reconciliation on admission and on discharge were made
- ✓ A computer application was developed to perform the following functionalities:
 - Upon admission to the hospital, the patient's community treatment is imported into the Pharmacy's Silicon® app
 - The programme makes a proposal to convert community treatment into active treatment in the hospital
 - Based on this proposal, the doctor can decide which prescriptions remain active on admission and, if necessary, modify them
 - Upon discharge from the hospital, Silicon® compiles the patient's active treatment in the hospital and the community treatment, so that the doctor can decide which medications should be continued and which changes should be introduced in the community medication plan
 - Once decided, Silicon® exports the new patient treatment to the primary care CPOE application, updating the treatment that the patient will receive

TAKE-AWAYS:

What has been learned?

- ✓ It is possible to have a fully implemented EHR – including computerised prescriber order entry and documentation systems – yet have a suboptimal medication reconciliation process
- ✓ This project has made some improvements to the medication reconciliation process, by establishing structured processes and making an electronic tool available
- ✓ The electronic tool needs to be validated under conditions of real clinical practice
- ✓ An important limitation for an automated process is that the information from the community CPOE is not always complete and in some cases is missing
- ✓ One of the most important steps in this process is the patient interview, but this is very difficult to perform systematically
- ✓ Explicit criteria to establish priorities among patients should be put in place to overcome this limitation

