

MEDICATION RECONCILIATION

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive establishes policy for Medication Reconciliation across the continuum of care.
- 2. SUMMARY OF MAJOR CHANGES:** Major changes are as follows: alignment with VHA Directive 1164, Essential Medication Information Standards, dated June 26, 2015; and VHA Directive 1310, Medical Management of Enrolled Veterans Receiving Self-Directed Care from External Health Care Providers, dated October 4, 2021.
- 3. RELATED ISSUES:** VHA Directive 1164, Essential Medication Information Standards, dated June 26, 2015; and VHA Directive 1310, Medical Management of Enrolled Veterans Receiving Self-Directed Care from External Health Care Providers, dated October 4, 2021.
- 4. RESPONSIBLE OFFICE:** Pharmacy Benefits Management Services (12PBM) is responsible for the content of this directive. Questions may be referred to VHAMedInfoMgtActions@va.gov.
- 5. RESCISSIONS:** VHA Directive 2011-012, Medication Reconciliation, dated March 9, 2011, is rescinded.
- 6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of March 2027. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF THE
UNDER SECRETARY FOR HEALTH:**

/s/ Beth Taylor, DHA, RN, FAAN, NEA-BC
Assistant Under Secretary for Health
for Patient Care Services/CNO

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NOTE: All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

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MEDICATION RECONCILIATION

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes a system-wide approach to Medication Reconciliation as the foundation of patient medication information management. **AUTHORITY:** 38 U.S.C. § 501 and 7301(b). **NOTE:** *If a provider outside of the Department of Veterans Affairs (VA) requests medication lists, laboratory results or other health records, a written request from the outside physician is needed in all instances (see 38 U.S.C. § 5702). A signed written authorization by the patient is only required if the records are for conditions related to 38 U.S.C. § 7332, Protected Health Information, which includes Human Immunodeficiency Virus (HIV), sickle cell anemia and drug or alcohol abuse, and when the disclosure is for purposes other than providing health care, including hospital care, medical services and extended care services, to patients or performing other health care-related activities or functions. The patient's verbal consent is not acceptable in this circumstance. All disclosures including HIV, sickle cell anemia and drug or alcohol abuse must be tracked and accounted for in the Release of Information (ROI) Records Management software or on a spreadsheet, which is then given to the Privacy Officer for the accounting of the disclosure.*

2. BACKGROUND

a. Adverse drug events (ADEs) account for an estimated one-third of hospital adverse events and approximately 280,000 hospital admissions annually:

<https://health.gov/hcq/pdfs/ade-action-plan-508c.pdf>.

b. The VA Adverse Drug Event Reporting System has reported 651,335 Adverse Drug Events since 2007 and 71,005 for Fiscal Year 2021:

<https://health.gov/hcq/pdfs/ade-action-plan-508c.pdf>.

c. Many of these events occur at transitions in levels of care or as a result of clinical management by multiple independent health care providers. VA recognizes the impact that accurate medication information has along the medication management continuum and its role in safeguarding the health of our Veterans. The Joint Commission also recognizes the importance of successfully managing a patient's medication information, and they have 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 ADEs.

d. 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, patient's caregiver(s) or patient's family member(s), and appropriate members of the health care team.

e. This directive provides guidance to the VA community on effective strategies for managing Veterans' medication information, investing in continuous quality improvement strategies and demonstrating stewardship for Medication Reconciliation as the foundation of medication information management within the greater health care community.

3. DEFINITIONS

a. **Adverse Drug Event.** An ADE is an injury resulting from the use of a drug. For the purposes of this directive, this definition includes any harm caused by the drug as a result of adverse drug reactions (ADRs), drug-drug interactions, product quality problems or drug overdoses (whether accidental or intentional). See VHA Directive 1070, Adverse Drug Event Reporting and Monitoring, dated May 15, 2020. Severity levels are:

(1) **Mild Adverse Drug Event.** A mild ADE is an event that requires no intervention or minimal therapeutic intervention, such as discontinuation of the drug(s).

(2) **Moderate Adverse Drug Event.** A moderate ADE is an event that requires active treatment of an adverse reaction, further testing or an evaluation to assess the extent of a non-serious outcome.

(3) **Serious Adverse Drug Event.** A serious ADE occurs when a patient's condition has one or more of the following outcomes (or requires medical intervention to prevent one of these outcomes): death, a life-threatening experience, inpatient hospitalization (or a prolonged hospitalization), a persistent or significant disability or birth defect.

b. **Adverse Event.** Adverse events are unpleasant incidents, diagnostic misadventures, therapeutic misadventures, iatrogenic injuries or other occurrences of harm or potential harm directly associated with care or services provided within the jurisdiction of the VA health care system. **NOTE:** *To determine which incidents need to be considered for Root Cause Analysis (RCA), consult VHA Handbook 1050.01, VHA National Patient Safety Improvement, dated March 4, 2011.*

c. **Adverse Event and Close Call Reporting.** Adverse event and close call reporting is the reporting of incidents involving patients that cause harm or have the potential for causing harm. **NOTE:** *For additional information see VHA Handbook 1050.01, and VHA Directive 1004.08, Disclosure of Adverse Events to Patients, dated October 31, 2018.*

d. **Adverse Drug Reaction.** An ADR is a response to a drug which is noxious and unintended, and which occurs at doses normally used in individuals for prophylaxis, diagnosis or therapy of disease or for the modification of physiologic function. **NOTE:** *There should be a causal or suspected link between a drug and ADR. However, a*

causality assessment or association of the drug to the ADR does not have to be established in order to report an ADR or ADE. (See VHA Directive 1070.)

(1) **Historical Adverse Drug Reaction.** A historical ADR is a past event or an event that reportedly occurred in the past at another health care setting. A historical ADR is defined in the Computerized Patient Record System (CPRS) as reported by the patient as occurring in the past and no longer requires intervention. **NOTE:** *This may be represented differently in subsequent electronic health record (EHR) systems.*

(2) **Observed Adverse Drug Reaction.** An observed ADR is defined in CPRS as a reaction that is directly observed or occurring while the patient was on the suspected causative agent. **NOTE:** *“Observed” refers to a newly noted adverse outcome. Although the term implies that the provider of record made the diagnosis, the fact that a provider may not have visually “observed” an ADR does not preclude reporting as “observed.” This may be represented differently in subsequent EHR systems.*

(3) **Allergy.** An allergy is an ADR mediated by an immune response (e.g., rash, hives).

e. **Brown Bag Inventory.** A brown bag Inventory is a health care team’s review or inventory of the patient’s medication(s) in their containers. Brown Bag/medication inventories are completed in an effort to compile an accurate list of the patient’s current medication use ideally before an encounter, as needed, and from home so the patient does not have to transport all of their medications to an encounter in a VA medical facility.

f. **Close Call.** A close call is an event or situation that could have resulted in an adverse event, but it did not either by chance or through timely intervention. These events have also been referred to as “near miss” incidents.

g. **Community Providers.** Community providers are non-VA providers including physicians, advanced practice registered nurses, physician assistants and other health care professionals who provide health care to patients outside of VA. This includes health care services not provided by VA and reimbursed by VA via contract or provided through Department of Defense (DoD), TRICARE, Medicare, private pay or other health insurance.

h. **Electronic Health Record.** EHR is the digital collection of patient health information resulting from clinical patient care, medical testing and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software including CPRS, Veterans Information Systems and Technology Architecture (VistA) and Cerner platforms. **NOTE:** *The purpose of this definition is to adopt a short, general term (EHR) to use in VHA national policy in place of software-specific terms while VA transitions platforms.*

i. **Essential Medication List for Review.** The Essential Medication List for Review is all the medications patients may be taking. In CPRS, the essential components are

VA prescriptions that are pending, not yet furnished to patients, all the medications patients have received from the VA recently or administered in clinic including prescriptions that have recently expired or been discontinued. The Essential Medication List for Review must include Non-VA Medications. All of these medications are part of the comprehensive medication review/history process and is sometimes referred to as “the kitchen table review” because it is from the patient’s perspective of what medications they may have on hand and are taking either intermittently or routinely. An Essential Medication List for Review tool should include Allergies and Adverse Drug Reactions for review with patients and caregivers, glossary of terms and instructions for how to use the tool. See VHA Directive 1164, Essential Medication Information Standards Directive, dated June 26, 2015. **NOTE:** *Future electronic medical record systems will have a comparable Essential Medication List for Review and related processes will be available for patients, caregivers and their health care teams.*

j. **Joint Patient Safety Reporting System.** Joint Patient Safety Reporting System (JPSR) is the national patient safety event reporting software that is used jointly by the DoD and VA. While all safety events can be reported in JPSR, the medication event reports in JPSR tend to be medication errors, close calls or unsafe conditions rather than ADRs because most drug reactions are reported through a CPRS entry which automatically feed into the VA-Adverse Drug Event Reporting System. However, ADEs that will be analyzed by RCA will need a JPSR entry in order to link it to the RCA document. **NOTE:** *This process may be different in subsequent EHR systems.*

k. **Local Medications.** Local medications are medications documented and/or prescribed by the primary treating VA and/or DoD medical facility of the patient.

l. **Medications.** For purposes of this directive, medications include:

- (1) Prescription medications from a VA or other health care provider.
- (2) Over-the counter-medications such as aspirin and acetaminophen.
- (3) Alternative medications such as Cannabidiol (CBD).
- (4) Herbal medications such as ginkgo.
- (5) Nutraceuticals such as multivitamins.
- (6) Sample medications obtained by providers outside VA.

m. **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.

n. **Medication Discrepancy.** Medication discrepancies are differences found in the patient’s medication information when compared to the medication information available on the EHR. These discrepancies may be omissions, commissions, inappropriate duplications, changes or additions. These discrepancies may be generated from the patient or the health care system.

o. **Medication History.** Medication history is obtained by reviewing with patients and/or caregivers what medications they are taking/using, how they are experiencing them (efficacy, problems taking, adverse reactions) and if they are having any trouble managing their medications at home. Important: Medication use is the only component of medication history required in medication reconciliation.

p. **Medication Information Management.** Medication information management is all the information and related processes patients, caregivers, and their health care teams require for successful, safe, high quality and patient driven medication care. This includes patient medication information, effective strategies to execute medication review/history, shared and clinical medication decision making, patient education/assessment of understanding of medication treatment plan, and standard processes to communicate medication information during hand offs and at transitions in care. Determining medication use and using that data to inform an updated medication treatment plan is the cornerstone of medication reconciliation which is in turn part of larger medication information management process.

q. **Medication Reconciliation.** Medication reconciliation is a process of ensuring the maintenance of accurate, timely, and complete medication information by:

(1) Obtaining medication use information from the patient, patient's caregiver(s) or patient's family member(s) for review.

(2) Comparing the information obtained from the patient, patient's caregiver(s) or patient's family member(s) to the medication information available in the VA electronic medical record as defined by VHA Directive 1164, to identify and address discrepancies.

(3) Assembling and documenting the medication information in the VA electronic medical record. Communicating with and providing education to the patient, patient's caregiver(s) or patient's family member(s) regarding updated medication information as defined by VHA Directive 1164.

(4) Communicating relevant medication information to and between the appropriate members of VA and non-VA health care team as defined by VHA Directive 1164.

(5) Providing the patient or family member with written information on the medications the patient should be taking when discharged from the hospital or at the end of the outpatient encounter.

r. **Medication Treatment Plan.** Medication treatment plan is a list of all the medications the patient is meant to take and any information associated with those medications necessary for successful medication care. This includes follow up, diagnostics and anticipatory guidance.

s. **Non-VA Medications.** Non-VA medications are currently documented by the health care team (i.e., providers, pharmacists, nurses and specially trained technicians) in CPRS and are a component of the Essential Medication List for Review. These data

are part of the order check system and are included in clinical decision support. Future electronic medical record systems will have a comparable Non-VA Medication List including all the components available in CPRS and related processes will be available for patients, caregivers and their health care teams. These include:

- (1) Non-VA provider-prescribed medications filled at non-VA pharmacies.
- (2) VA provider-prescribed medications filled at non-VA pharmacies.
- (3) Other Veteran-obtained medication such as herbals, over-the counter-medications, nutraceuticals, samples, alternative medications, or any other medication on hand.

NOTE: For additional information see VHA Directive 1310, *Medical Management of Enrolled Veterans Receiving Self-Directed Care from External Health Care Providers*, dated October 4, 2021.

t. **Patient-Focused Local Metrics.** Patient-focused local metrics are metrics established at the local level. For example, VA may use discrepancy rates, which are the rates of unintentional differences found in the patients' medication information when compared to the medication information available on the VA electronic medical record.

u. **Patient Medication Information.** Patient medication information is information on all the medications.

(1) Patient medication information includes:

(a) **Medication Use.** All medications the patient is taking, stopped taking, takes differently than prescribed, has on hand, or can't say.

(b) Problems with the medication.

(c) If the medication is effective or not and to what degree.

(d) Self-management information and tools patient requires for successful medication care at home and for sharing with caregivers and health care teams including how to track medications, journal, report problems, participate in shared decision making, request refills, renewals, and consultation, and medication education.

(2) Patient medication information is obtained from the Brown Bag Inventory, a verbal history, the patient, the patient's caregiver or the patient's family members furnishing the medication information. It can be obtained from electronic tools, like a mobile application or via secure messaging. This information is augmented by inquiries to pharmacies and health care teams.

v. **Prescribing Providers.** Prescribing providers include physicians, clinical pharmacist/specialists (scope of practice), advanced practice registered nurses, physician assistants and other health care professionals who provide health care to

patients, and for the purpose of medication information management, have the ability to write prescriptions.

w. **Remote Medications.** Remote VA medications are medications documented and/or prescribed by a VA and/or DoD medical facility that is not considered the primary treating facility of the patient.

x. **VA Medication Reconciliation Evaluation.** VA Medication Reconciliation Evaluation will be performed and reported locally including national peer review quality indicators and are aligned with external and internal mandates.

y. **Veterans Receiving Community Care.** For purposes of this directive, Veterans receiving community care, refers to Veterans who receive ongoing health care in both VA and in the community health care settings.

4. POLICY

It is VHA policy to utilize intentional medication reconciliation standards to ensure that all eligible Veterans cared for within the VA system receive well-coordinated, safe, appropriate and patient-centered health care at all levels and transitions of the health care continuum.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

(4) Ensuring that each VISN Director has sufficient resources to fulfill the terms of this directive in all of the VA medical facilities within that VISN.

c. **Assistant Under Secretary for Health for Patient Care Services.** The Assistant Under Secretary for Health for Patient Care Services is responsible for providing national direction and education to support implementation of this directive.

d. **Executive Director, Pharmacy Benefits Management Services.** The Executive Director, Pharmacy Benefits Management Services is responsible for providing national

direction, collaboration and education to support implementation of this directive as national subject matter expert consultants in collaboration with other program offices and the Office of the Assistant Under Secretary for Health for Operations. The Executive Director has primary oversight of this directive.

e. **Director, VA Medication Reconciliation Program Office.** The Director of the VA Medication Reconciliation Program Office works under the direction of the Chief of Pharmacy Benefits Management to provide national direction and education to support implementation of this directive, and the Director is responsible for reviewing the directive annually for any changes that might be needed.

f. **Veterans Integrated Services Network Director.** The VISN Director is responsible for assigning a VISN Medication Reconciliation Point-of-Contact (POC), direction, collaboration with clinical executives to include Chief Medical Officers (CMO), Chief Nursing Officers (CNO) and Chief of Pharmacy and other clinical executives, and education to support implementation for this directive.

g. **Veterans Integrated Service Network Pharmacist Executive.** The VISN Pharmacist Executive is responsible for advising the VISN Network Director regarding pharmacy practice and providing expertise regarding the oversight of the directive at the VISN level.

h. **Veterans Integrated Service Network, Medication Reconciliation Point-of-Contact.** The VISN medication reconciliation POC is responsible for receiving information and disseminating new medication reconciliation information to VA medical facility medication reconciliation POCs within the VISN. This communication and collaboration may include VISN CMOs, CNOs, Chief of Pharmacy and/or other clinical executives.

i. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Assigning a VA medical facility medication reconciliation POC who can receive information and help disseminate new knowledge about the medication reconciliation process from the VISN medication reconciliation POC, as it is made available.

(2) Ensuring local level standard operating procedures conform to critical quality and safety elements and guidance from accreditation organizations where applicable.

(3) Ensuring processes exist that allow the patient, patient's caregiver(s) or patient's family member(s) to be full and active partners in the Veteran's medication information management, which includes education and assessment of Veterans' understanding of their medication treatment plan according to accepted standards (e.g., the Agency for Health care Research and Quality Teach Back tool <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html>.)

(4) Ensuring the multidisciplinary health care team is knowledgeable about and accepts stewardship of the medication reconciliation, as part of Medication Information

Management process, as well as by complying with VHA Directive 1010, Case Management of Transitioning Service Members and Post-9/11 Era Veterans, dated February 23, 2022.

(5) Defining the roles, tasks and steps of the medication reconciliation as part of the medication information management process. **NOTE:** *This process and the tools used may be different in subsequent EHR systems.* This includes:

(a) Preparing to talk to the patient. Staff may include Provider, Nurse, Pharmacist or specifically trained Technicians trained to perform medication history according to VA medical facility standard operating procedures.

1. Furnishing to the patient the Pre-Visit Summary, Medication Review or History template/tool that includes the components of the Essential Medication List for Review for the patient to complete and to help the patient participate in the medication history process. This can be paper or digitally derived.

2. Reviewing the chart thoroughly by reading the Cover Sheet, Medications, Allergies/ADR, Problem List and Recent Notes.

3. Preparing and reviewing note template/document strategy used to assist in the Medication History/interview to ensure accuracy.

(b) Interviewing the patient regarding Medication History. Staff may include Provider, Nurse, Pharmacist or specifically trained Technicians trained to perform medication history according to VA medical facility standard operating procedures as follows:

1. Reviewing each component of the Essential Medication List for Review and asking the patient and/or caregiver if they are Taking, Not Taking, Taking Differently, Can't Say or if they are on any new medications.

2. Going through each component of the Essential Medication List for Review and asking patient and/or caregiver to describe their medication experience; the questions should include if they have had any problems with the medications, including problems taking, efficacy and ADRs. **NOTE:** *This can be done in conjunction with paragraph 5.i.(5)(b)1.*

a. Example: "I am going to ask you if you are taking, not taking or taking your medications differently now one by one. Please also tell me if you are having any problems with your medications? Please tell me if you are taking any new medications?"

b. The interview will be commensurate with the clinical expertise of the interviewer, setting and scenario presented. For example, Coumadin clinic may delve more deeply into nutrition, medication use and experience that may affect anticoagulation therapy.

3. Inquiring with the patient/caregiver if there are problems with medication self-management.

4. Documenting Medication History/Interview in the patient's chart using VA medical facility documentation strategy.

(c) Prescribing providers validate this medication history/interview information obtained from the patient to make clinical and shared decisions regarding medication care. This includes ordering, prescribing and recommending medications in a timely manner.

(d) Prescribing providers prepare the patient/caregiver for home by ensuring they have been furnished an updated medication treatment plan, performing medication counseling including what the purpose of each medication is and any anticipatory guidance necessary. This is included in their After Visit Summary which states all the medications patients are meant to take, those that are new, changed, stopped and to be continued.

(e) Prescribing providers must document the medication treatment plan and the updates relevant for coordination with providers accountable for the encounter of care.

(f) Providers, Nurses, Pharmacists, Technicians trained to perform medication information sharing contribute to making sure relevant members of the patient's health care team are apprised of the updated medication treatment plan upon transfer of care and hand off communication with other team members.

(g) Provider, Nurse, Pharmacist or Advanced Practice Pharmacy Technicians trained to perform medication list education will explain the importance of keeping patient medication information up to date and shared with their health care team. They will also ensure the patient understands what medications they are recommended to take, how to manage their medications at home and how to ask for refills and renewals. Each patient will be furnished an updated medication treatment plan.

(6) Requiring that medication reconciliation is initiated at every episode or transition in care where medications will be administered, prescribed, modified or may influence the care given.

(7) Outlining how care is coordinated with the appropriate members of the health care team, including community care or non-VA providers, through effective communication mechanisms and in conformity with VHA Directive 1310.

(8) Defining the processes 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.

(9) Defining processes to assist patients and caregivers when they have problems understanding or endorsing the medication treatment plan.

(10) Defining patient-focused local metrics to evaluate the quality and efficacy of the program. **NOTE:** For vetted VA strategies and templates please see

<https://dvagov.sharepoint.com/sites/VHAMedRecon/SitePages/MedMgmt.aspx>. This is an internal VA website that is not available to the public.

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

(a) Ensuring that the patient, patient's caregiver(s) or patient's family member(s) provided medication information obtained at the episode of care using the components of the Essential Medication List for Review, is represented in the VA electronic medical record for review as defined by VHA Directive 1164.

(b) Comparing the patient, patient's caregiver(s) or patient's family member(s) provided medication information to the medication information available in the VA electronic medical record as defined by VHA Directive 1164.

(c) Updating of medication information at the end of the episode of care and ensuring it is represented in the VA electronic medical record (including changes relevant to the episode of care) as defined by VHA Directive 1164.

(d) Ensuring discharge information in the VA electronic medical record is consistent with discharge instructions provided to the patient, patient's caregiver(s) or patient's family member(s) at the end of the episode of care and includes the updated and comprehensive medication treatment plan.

j. VA Medical Facility Chief of Staff and VA Medical Facility Associate Director of Patient Care Services. The VA medical facility Chief of Staff and VA medical facility Associate Director of Patient Care Services, as established by the VA medical facility organizational structure, are responsible for ensuring:

(1) VA providers and Nursing Staff are adequately trained and educated on the Medication Reconciliation process and understand its importance in the scope of quality patient care and patient safety. See paragraph 6 for additional information on training.

(2) VA providers and Nursing Staff 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, as part of standard care which conforms to all relevant VA and VHA privacy policies and Federal law.

k. VA Medical Facility Medication Reconciliation Point-of-Contact. The VA medical facility medication reconciliation POC is responsible for receiving information from the VISN medication reconciliation POC and disseminating new knowledge on medication reconciliation to relevant VA medical facility staff.

l. VA Provider. The VA provider is defined as any individual providing medication care (e.g., physicians, clinical pharmacists, APRNs physician's assistants) responsible for:

(1) Completing medication reconciliation in accordance with this directive. This process should include non-VA medication list, to diminish the potential safety risk for Veterans who receive care from both VA and community (non-VA) providers.

(2) Documenting a plan to address medication discrepancies in the chart 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 about the importance of sharing their medication information with all their health care teams in accordance with VHA Directive 1310.

(4) Documenting and reporting ADEs and close calls, consistent with existing policy. **NOTE:** *For further information on adverse events, see VHA Directive 1004.08 and VHA Handbook 1050.01.*

(5) Assisting the patient, patient's caregiver(s) or patient's family member(s) to maintain, update and take ownership of the patient's medication information. This information includes education and assessment of the Veteran's medication treatment plan according to accepted standards (e.g., Teach Back). This includes referral to any services necessary to help them with engagement and success in their medication self-management, especially if assessment revealed difficulty with understanding their medication treatment plan. Patients are encouraged to be active participants in the decision making of their treatment plan. When possible, the patient's health care team will request the following information from the patient, patient's caregiver(s) or patient's family member(s):

(a) The patient's goals of care.

(b) Personal medication utilization.

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

1. Allergies or ADRs.

2. Difficulties with access to health care.

3. Difficulties with self-management.

4. Financial hardship.

5. Personal preference, recommended medication treatment plan declined.

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

(d) Non-VA medication and community provider information.

(e) Any medication and provider information from other VA medical facilities.

(f) The patient's authorized surrogate decision maker, if the patient lacks decision-making capacity to participate in medicine reconciliation. Consult VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009, for further details.

m. **Clinical Pharmacists.** Clinical Pharmacists are responsible for:

(1) Supporting medication review, history and verification in a variety of clinical settings.

(2) Providing medication counseling, education and written or digital information to the patient or caregiver, when indicated.

NOTE: *Clinical Pharmacists, both General Schedule (GS)-12 and GS-13 Pharmacists, with support from Pharmacy Technicians, because of their distinct knowledge, skills and abilities, are uniquely qualified to coordinate interdisciplinary efforts to establish and maintain an effective Medication Reconciliation as part of a medication information management process in hospitals and across the continuum of care.*

6. TRAINING

a. There are no formal training requirements associated with this directive, for training resource recommendations please contact VHAMedInfoMgtActions@va.gov.

b. The following training is **recommended** for Interprofessional team, Interprofessional Medication Information Management. For the VA Provider or Clinical Pharmacist involved in medication care: VHA's Tune into the Patient, Explore the Patient's Concerns, Assist the Patient with Behavior Changes, Communicate Effectively, Honor the Patient as a Partner (TEACH) for Success Veteran-centered communication skills training program.

7. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

8. REFERENCES

a. 38 U.S.C. §§ 501, 5702, 7301(b), 7332.

b. VHA Directive 1004.08, Disclosure of Adverse Events to Patients, dated October 31, 2018.

c. VHA Directive 1010, Case Management of Transitioning Service Members and Post-9/11 Era Veterans, dated February 23, 2022.

d. VHA Directive 1070, Adverse Drug Event Reporting and Monitoring, dated May 15, 2020.

e. VHA Directive 1164, Essential Medication Information Standards, dated June 26, 2015.

f. VHA Directive 1310, Medical Management of Enrolled Veterans Receiving Self-Directed Care from External Health Care Providers, dated October 4, 2021.

g. VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

h. VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, dated March 4, 2011.

i. VA Form 10-2633, Report of Special Incident Involving a Beneficiary, dated February 1990 (<https://vaww.va.gov/vaforms/medical/pdf/vha-10-2633-fill.pdf>). **NOTE:** *This is an internal VA website that is not available to the public.*

j. Adherence to Long-Term Therapies: Evidence for Action. World Health Organization, 2003.
http://www.who.int/chp/knowledge/publications/adherence_full_report.pdf **NOTE:** *This linked document is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*

k. The American Society of Health-System Pharmacists (ASHP) statement on the pharmacist's role in medication reconciliation, Am J Health Syst Pharm. 2013 Mar 1;70(5):453-6.

l. Joint Commission National Patient Safety Goals, 2018.
<http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/>. **NOTE:** *This linked document is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*

m. National Action Plan for Adverse Drug Event Prevention; Health and Human Services, 2014. <https://health.gov/hcq/pdfs/ade-action-plan-508c.pdf>.

n. Pharmacy Benefits Management Services (PBM) Website Standardized Definitions of ADE's and ADRs:
<https://www.pbm.va.gov/PBM/vacenterformedicationsafety/tools/AdverseDrugReaction.pdf>.

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