Medication Reconciliation Best Practices

- Credentialed support staff should do the initial medication history intake for all patients.
- Periodically, a dedicated medication reconciliation committee should identify and assess opportunities for improvement and implement solutions system-wide.
- Physicians and nurses should focus on obtaining an accurate medication history list at the start of a care episode for each patient.
- The institution must develop and train its providers on clear definitions and processes for reviewing expired medications, remote medications, and discontinued medications that patients may still be taking.
- The institution should use pre-visit summaries to query patients about their medications prior to visits and should provide after-visit summaries with complete medication lists in layperson terms.
- The institution should develop and implement a process to review and clean up medication lists without inadvertently removing important information.
- Institutions should educate staff on the meaning of actions like "complete", "discontinue", “on-hold”, and "cancel" for medications and their implications for medication lists.
- Institutions should empower and enable ancillary staff to enter medication changes to be reviewed by providers.

- Institutions should educate staff not to trust explicitly external medication data but to verify information received with the patient or caregiver.
- Before direct patient encounters (virtual or in person), when technically and practically feasible, patients should receive a reminder to review and verify their prescription and OTC medications/supplements in their patient portal.