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Medication Reconciliation

Essentials

LilyAnn Jeu, PharmD, MHA, BCPS, CPHQ, CPPS, LSSGB
Director, Department of Patient Safety

In conjunction with Pharmacy, Ambulatory Care Providers, Internal Medicine Chief Residents, and HealthBridge/IT Guides

- **MiYoung Helena Hahn, BS, MS, PharmD, BCPS, BCCP**, Medication Reconciliation Pharmacist, Department of Pharmacy
- **Marcia Edmond-Bucknor, MD**, Assistant Professor/Medical Director, Department of Family Medicine
- **Lavonia Francis, DNP, RN, ACNS-BC, NEA-BC**, Assistant Vice President, Ambulatory Care Services
- **Marie Boursiquot, RN, MSN, CNS**, Assistant Director of Nursing, Outpatient Department
- **Nazeera Ghanie, MD, MBA, and Frank Lin, MD,** Chief Residents, Internal Medicine

SEP
2025

Why Medication Reconciliation

Medication reconciliation is the ***process*** of comparing medications a patient is taking with newly ordered/planned medications and **resolving discrepancies.**

GOALS of medication reconciliation

1. Create an accurate medication list
2. Identify and resolve discrepancies*
3. Prevent medication errors*

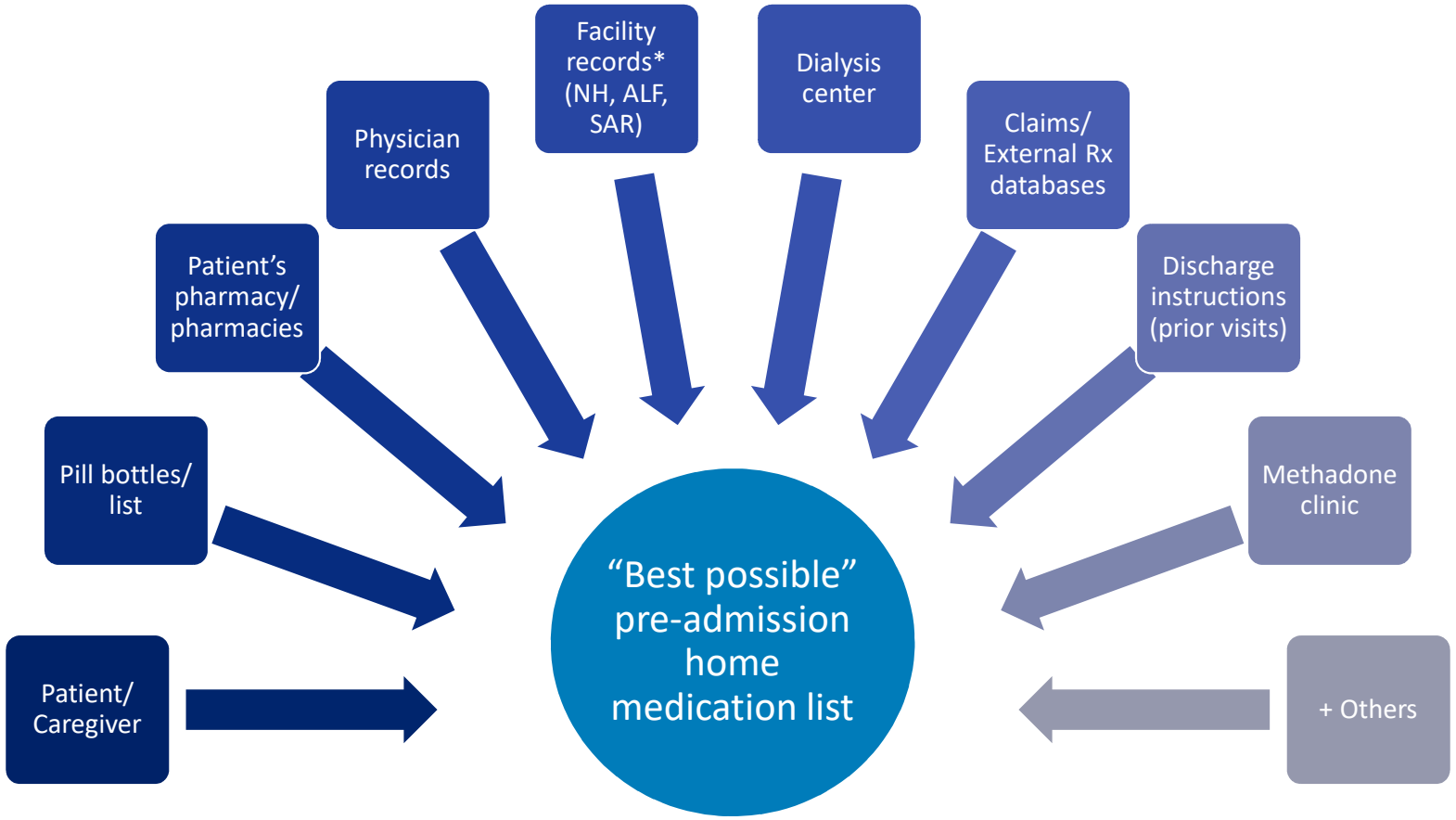
*Discrepancies and errors include omissions, duplications, contraindications, and drug interactions

Sources to Create the "Best Possible" Pre-Admission Medication List

Society of Hospital Medicine

Recommends 2 or more sources

What are common sources of patient's home medications?



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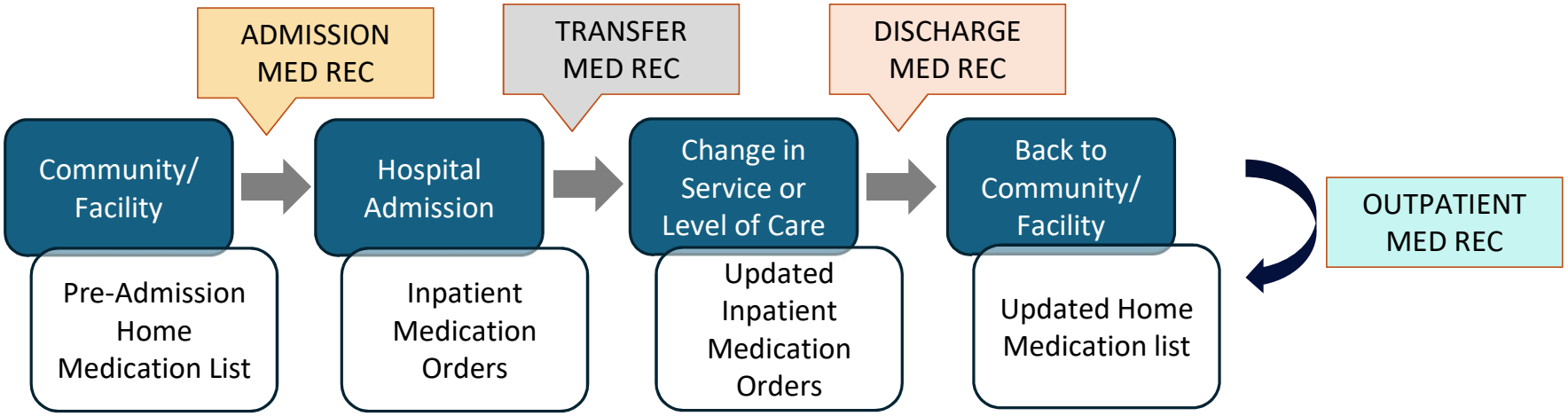
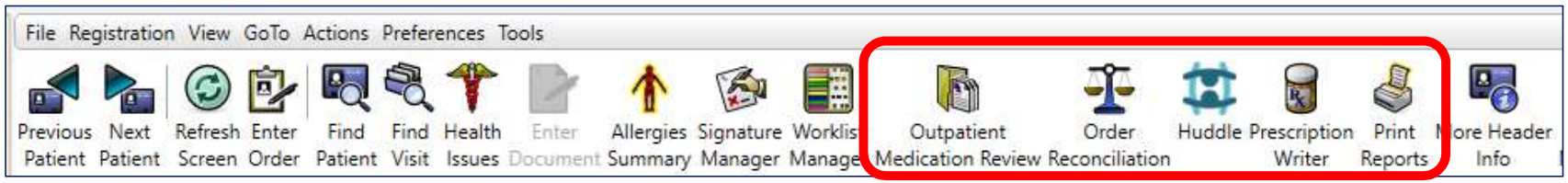
* NH = nursing home, ALF = assisted living facility, SAR = subacute rehab

Medication Reconciliation at Transitions of Care





Inpatient Medication Reconciliation

Admission
Medication Reconciliation

How to Complete **ADMISSION** Medication Reconciliation in HealthBridge

GOAL: Complete Step 1 and Step 2 within 24 hours of admission

STEP 1: Create home medication list in "Outpatient Medication Review" module

- ❑ Check 2 or more sources (e.g., patient, pharmacy, facility)
- ❑ For each medication, verify if patient still takes and indicate:
  - Verified (patient) taking
  - No Longer Taking (per pt report)
- ❑ Add additional Home Medications (icon in header)
- ❑ Save as Complete (List can be updated later)

STEP 2: Generate inpatient orders from pre-ADM med list using "Order Reconciliation"

- ❑ For each pre-admission home medication to continue, select one:
  - Continue medication regimen as inpatient order
  - Reconcile with existing order (If order already active)
  - Additional functions/options (e.g., Modify regimen)
- ❑ Select "Reviewed and Reconciled" to HOLD home med
- ❑ Enter Orders for new medications (icon in header)
- ❑ Save as Complete

Generates inpatient admission medication orders AND Order Reconciliation document.

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Stop if OMR not yet addressed

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Generates inpatient admission medication orders AND Order Reconciliation document.

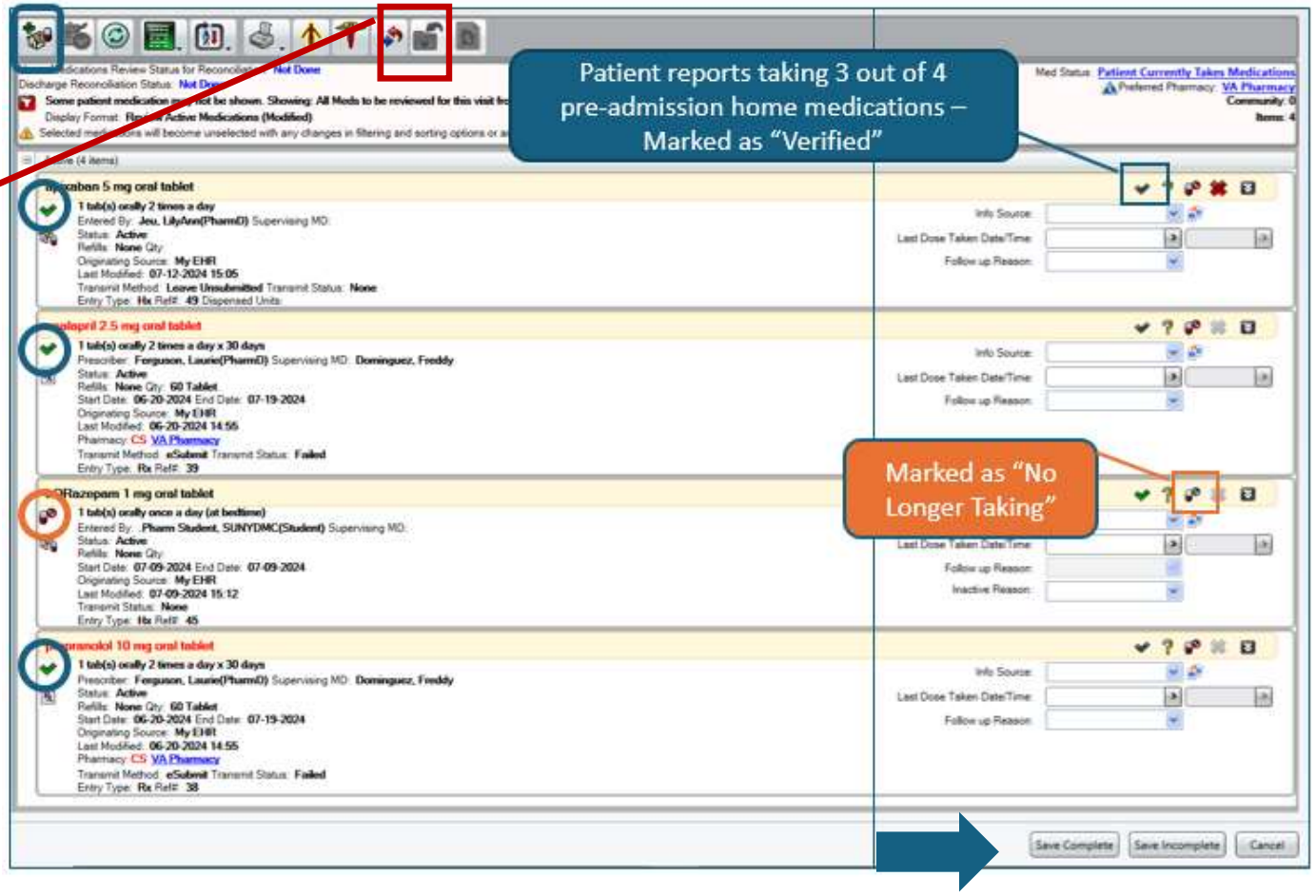
ADMISSION Medication Reconciliation Example

(OMR)

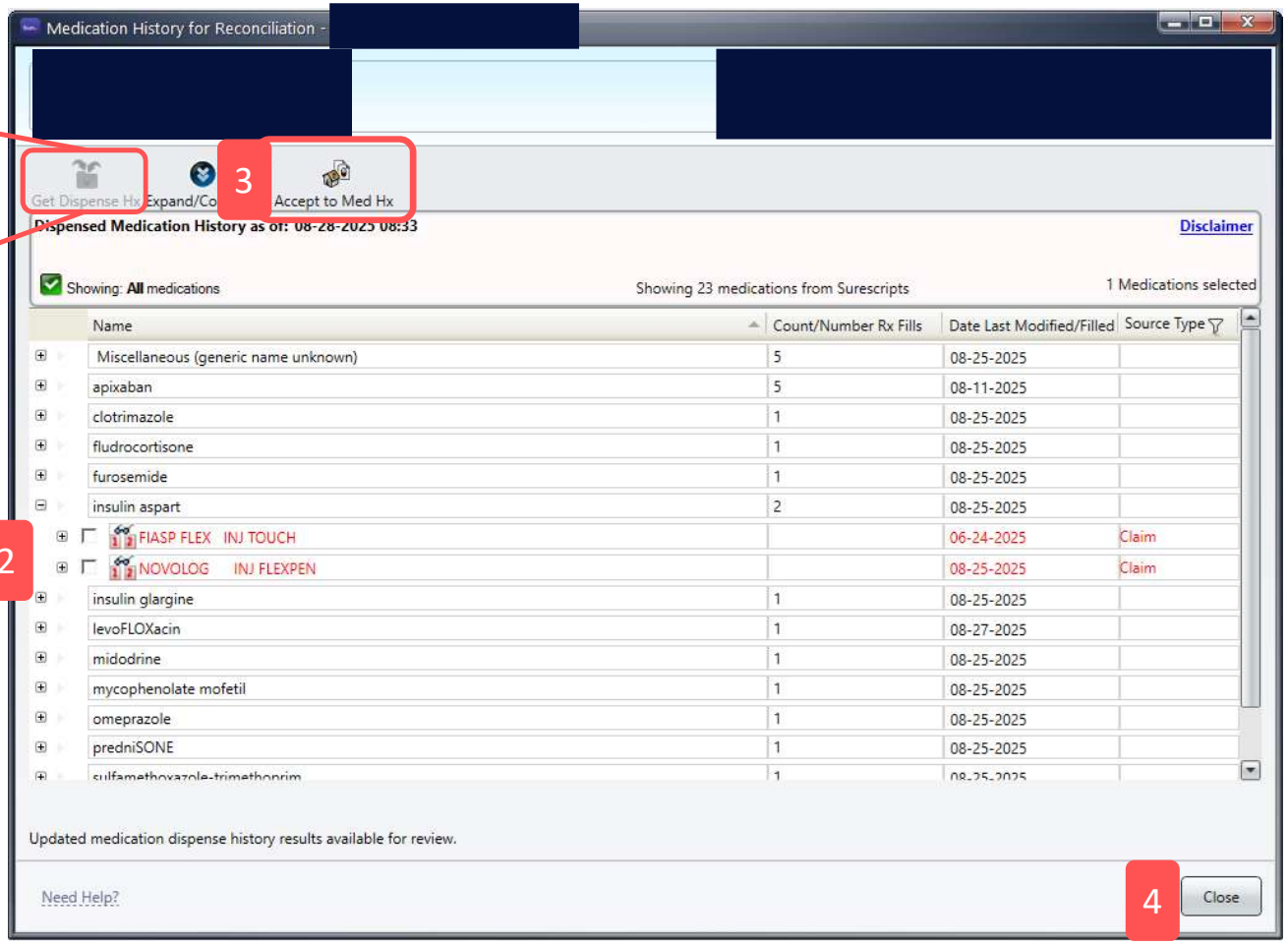
PRO Tip

Providers can click on the "Medication History for Ambulatory" icon to pull claims information from Surescripts

STEP 1: Outpatient Medication Review module (create pre-admission home med list)



ADMISSION Medication Reconciliation Example



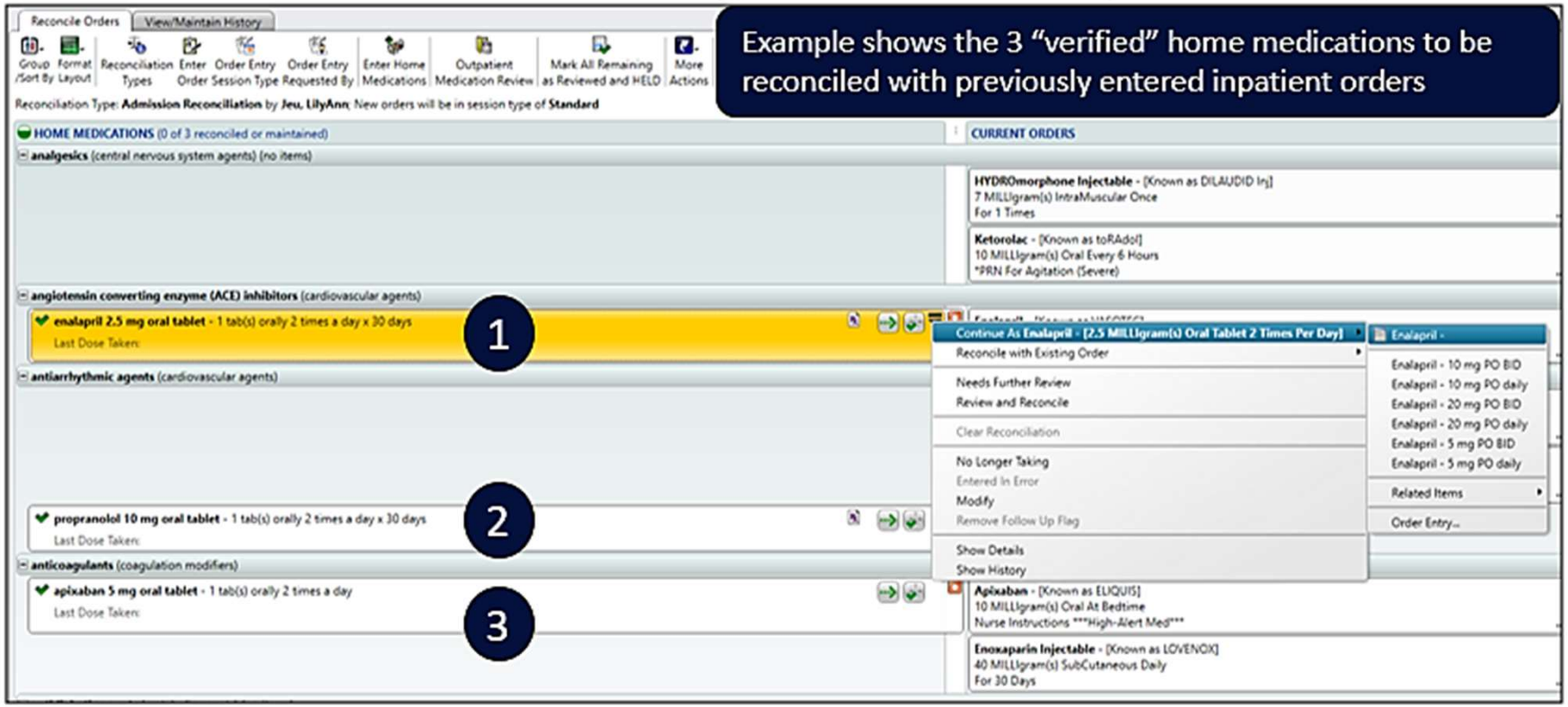
1.Click on “Get Dispense History.” (Try a second time if no list initially appears.)
2.Identify latest prescription for each medication (review dates)
3.Accept to Med Hx
4.Close to add selected medications to OMR list

Caution: Surescripts data may not be 100% complete

ADMISSION Medication Reconciliation Example *(Continued)*

Order Reconciliation

STEP 2: **Order Reconciliation** module (generate/reconcile inpatient orders)



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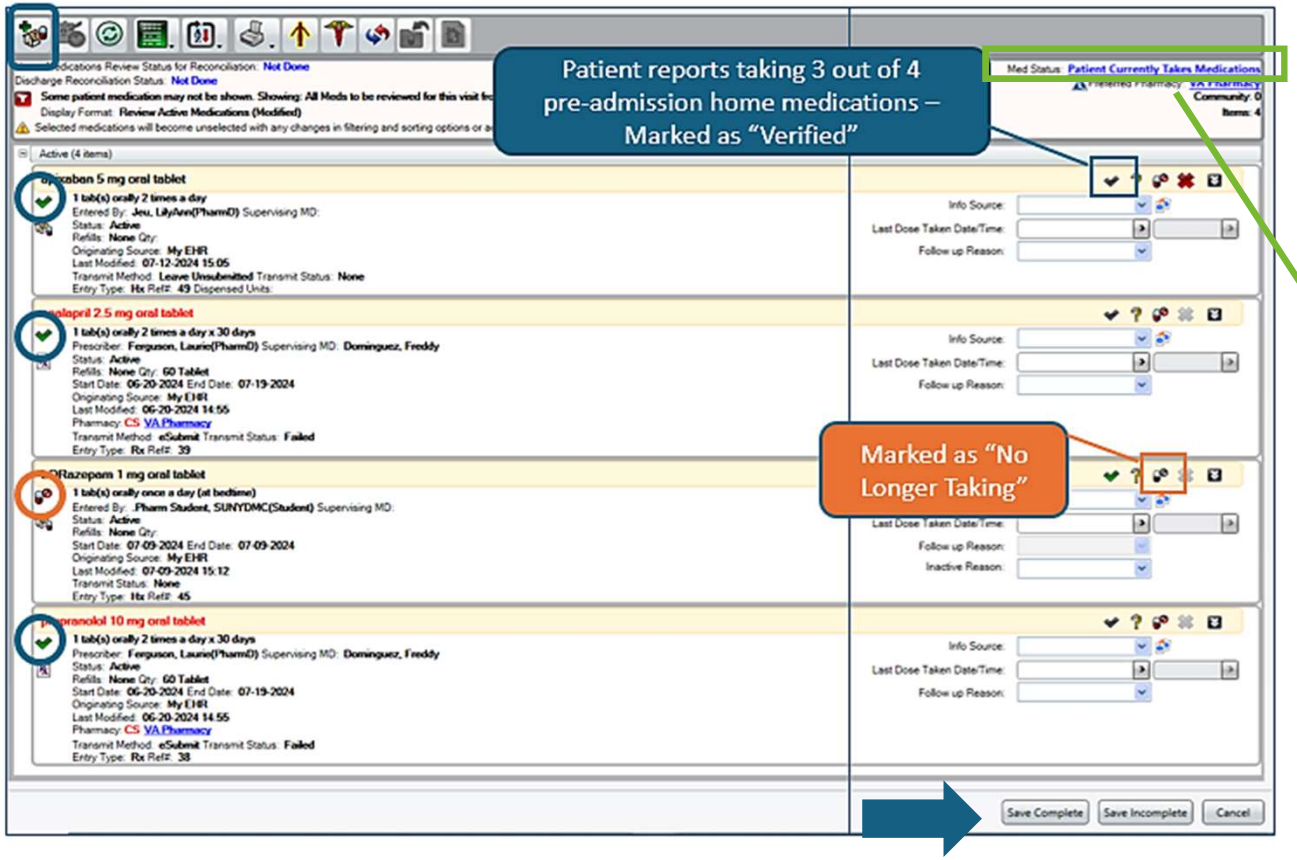
PRO Tip

Admission medication reconciliation does ***NOT*** need to be reset/repeated, even if additional home medications are added in the Outpatient Medication Review module during the admission

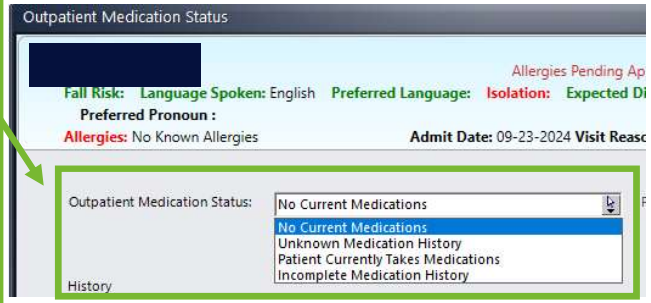
ADMISSION Medication Reconciliation Example

STEP 1: Outpatient Medication Review module (create pre-admission home med list)



Q&A

Question: What if the patient takes no medications at home (e.g., newborn)?



Answer: Document Med Status "No Current Medications," then Save Complete.

Question: What if the patient's pharmacy is closed/unknown at the time of admission?

Answer: You can initially mark the medication list as incomplete or unknown, then update the list as soon as possible.

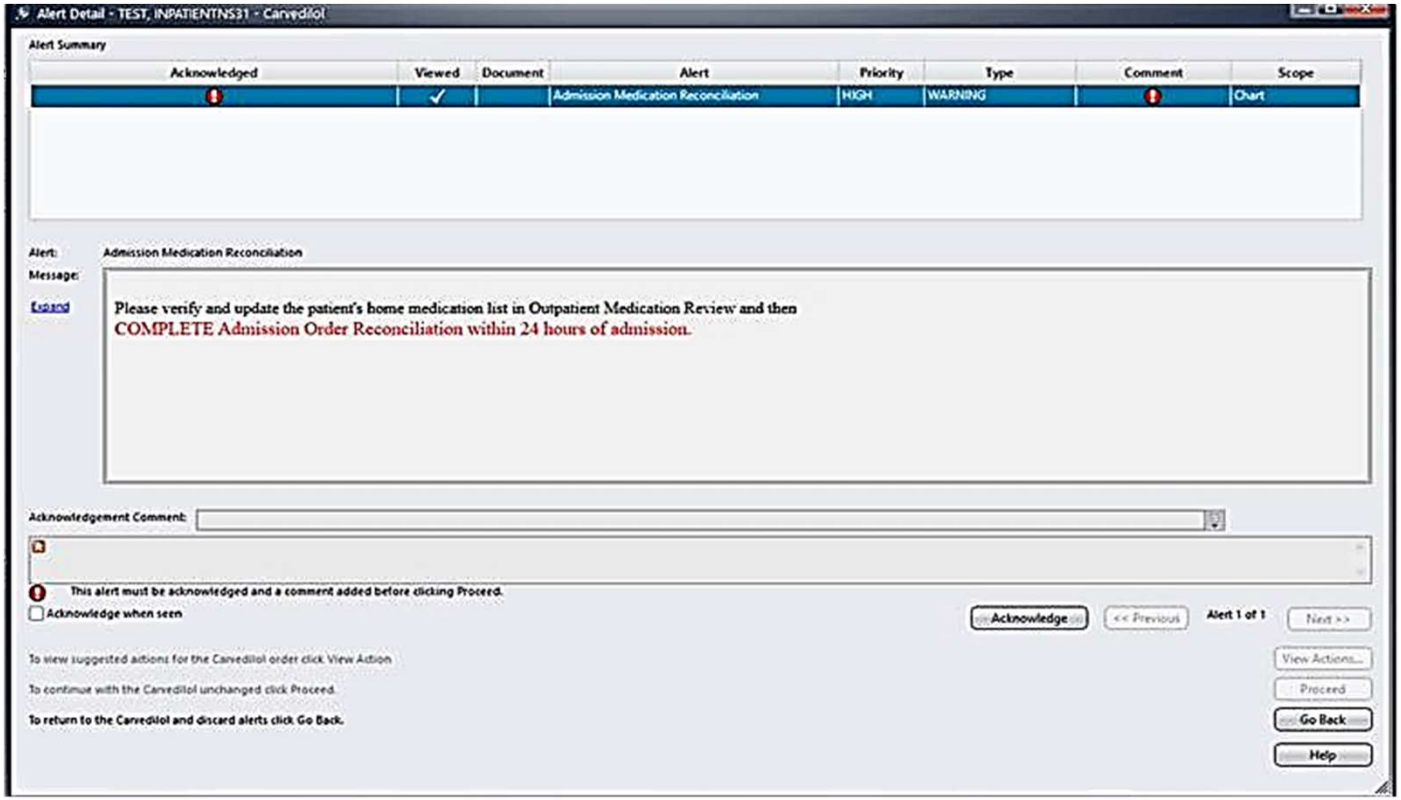
However, OMR and Admission Order Rec must be completed prior to initiating Discharge Order Reconciliation.

NEW Admission Medication Reconciliation Reminder Alert (*July 8, 2025*)

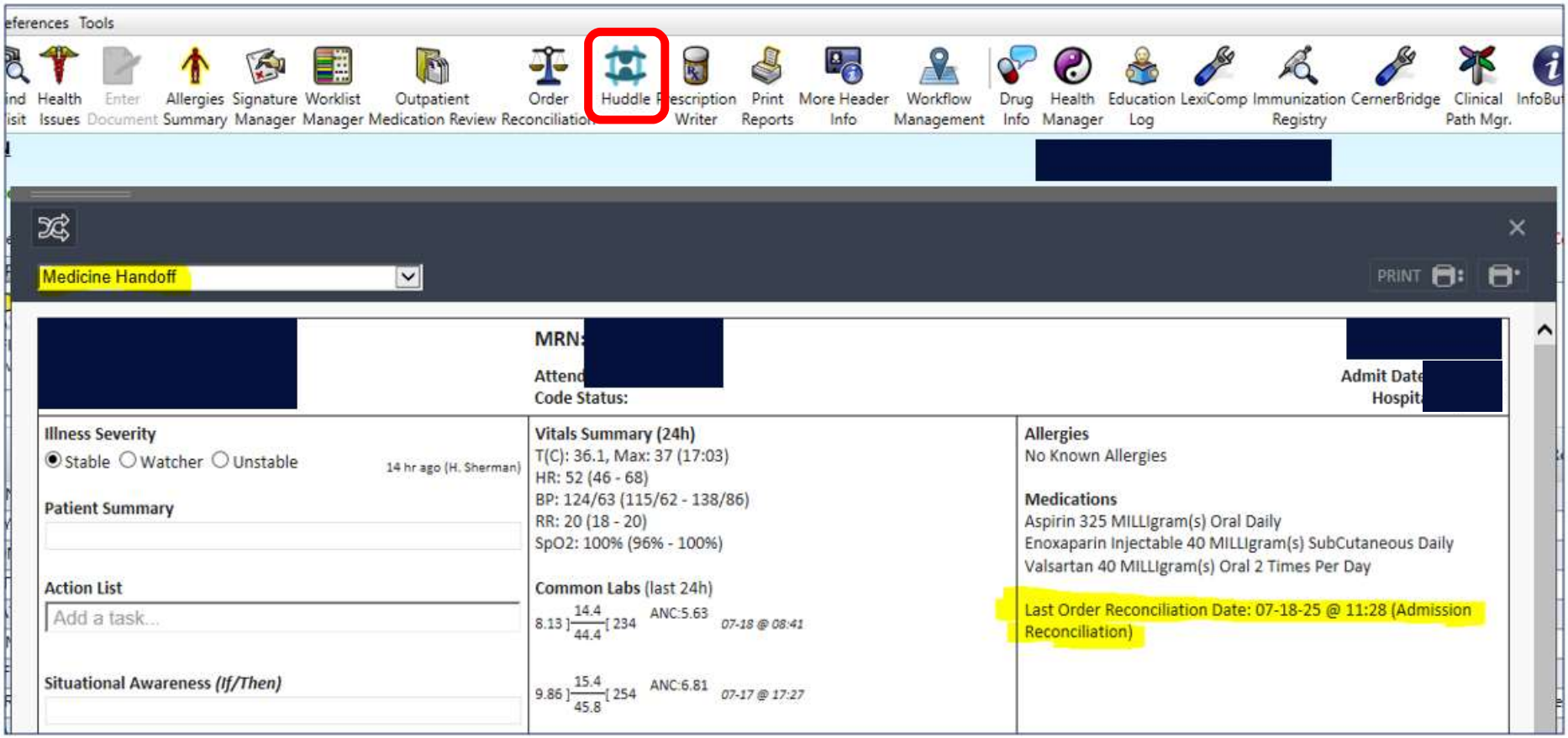
For admitted patients, the following alert will appear for residents/PAs/NPs upon attempting medication order entry ***until*** Admission Order Reconciliation has been completed.

Recommendation: Generate initial inpatient medication orders via Admission Order Reconciliation.

Note: Review/update the home medication list in the Outpatient Medication Review module BEFORE attempting Admission Order Reconciliation.

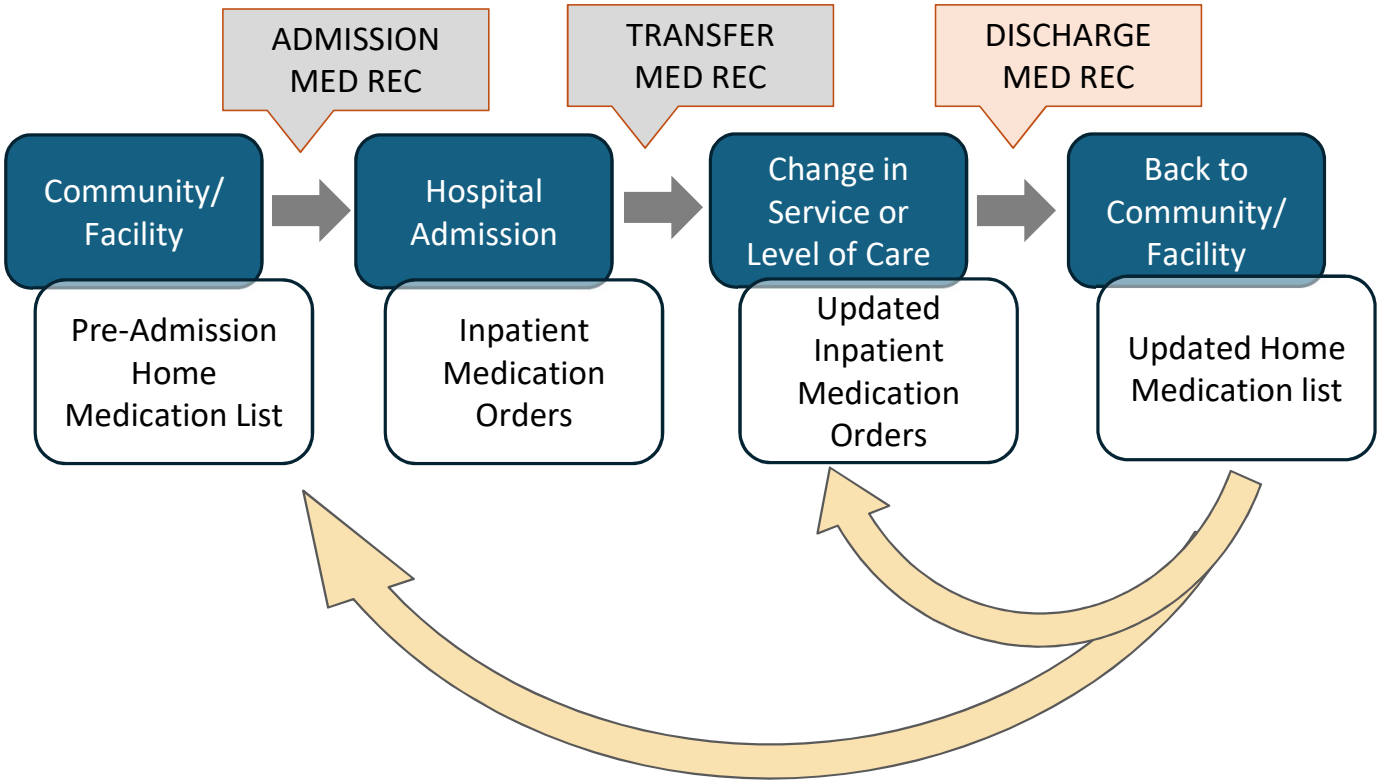


Improving Medication Reconciliation Hand Off



Discharge
Medication Reconciliation

Medication Reconciliation at Transitions of Care



“Look Back” with Changes in Service or Level of Care

Rationale	Scenarios/Examples
Changes in clinical status	Renal dosing no longer needed with resolution of AKI
Reconcile discrepancies	Pressors (ICU) vs antihypertensives (home)
Discontinue medications no longer indicated	Antipsychotics for inpatient delirium Stress ulcer or VTE prophylaxis
Discontinue/hold contraindicated meds	Anticoagulants and/or antiplatelets stopped due to acute GI bleed
Prevent omissions of held home medications	Antiplatelet or anticoagulants held for surgery/procedure Oral contraceptives
Avoid duplications	Lisinopril taken at home vs enalapril ordered inpatient

PRO Tip

Review **consult service notes** for recommendations for medication regimen adjustments during the hospital visit AND upon discharge.

How to Complete **DISCHARGE** Medication Reconciliation in HealthBridge

MUST complete Discharge Reconciliation before Discharge Instructions are printed to provide an accurate medication list to patients

Generate discharge home medication list using "Order Reconciliation" module

- ❑ Review and reconcile home medications and inpatient orders
  NOTE:  = 2 related orders for the same medication
- ❑ In-line reconciliation actions:
  - Continue as … (Adds med to home list; No new Rx generated)
  - Create new prescription (Generates Rx and adds med to home list)
  - Mark as not required (Med will be omitted/removed from home list)
  - Suggest to continue as … (Adds med to home list; No new Rx generated)
- ❑ If new medication (not in lists), enter prescriptions via "Prescription Writer" module (icon in header) 

PRO Tip

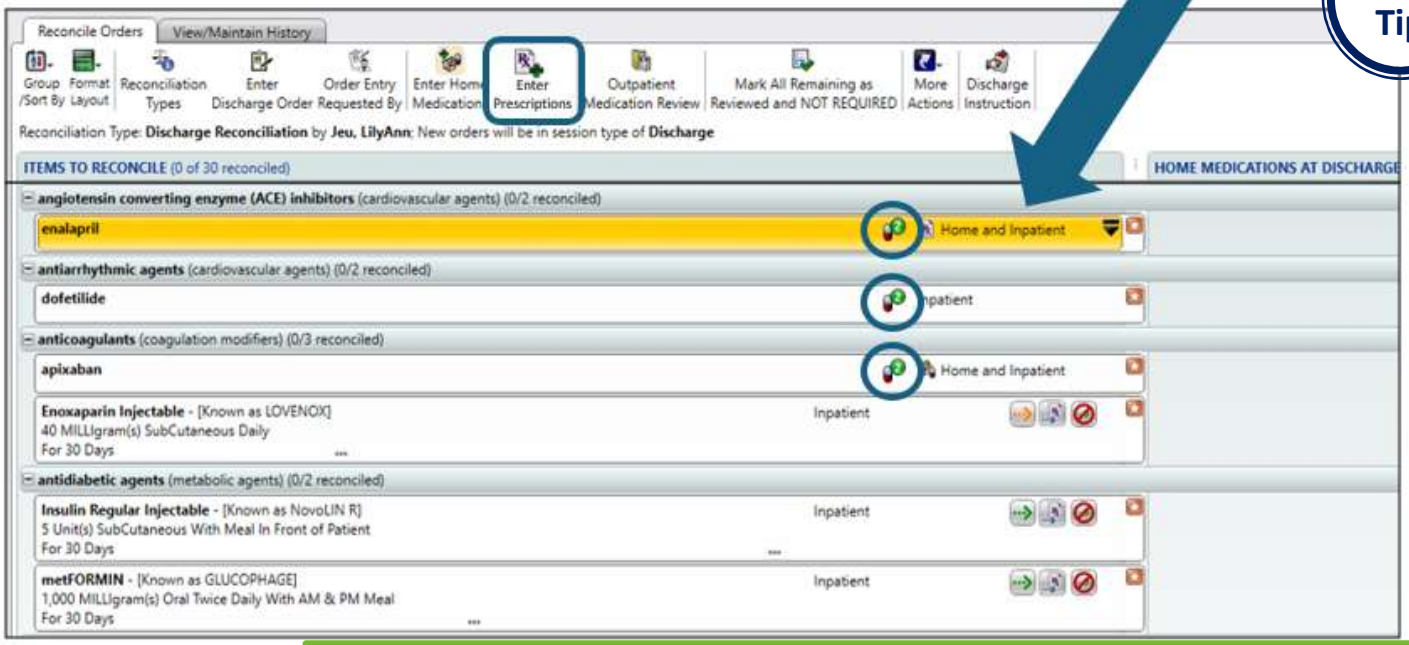
Before submitting e-prescriptions, confirm the patient's preferred pharmacy for discharge prescriptions even if it was already reviewed upon admission.

DISCHARGE Medication Reconciliation Example

Discharge Reconciliation – Use of "Order Reconciliation" module is **REQUIRED before creating the Discharge Summary or printing Discharge Instructions.**

PRO Tip

Select to continue the Home or Inpatient medication (not both).



Q&A

Question: "Why do the new prescriptions I entered for discharge home medications not appear in the Home Medication section in the Discharge Instructions? I used the Prescription Writer module."

Answer: New prescriptions must be entered via the "Enter Prescriptions" icon/link WITHIN the "Order Reconciliation" module to appear in the Discharge Instructions (**NOT** the "Prescription Writer" module from the main screen)

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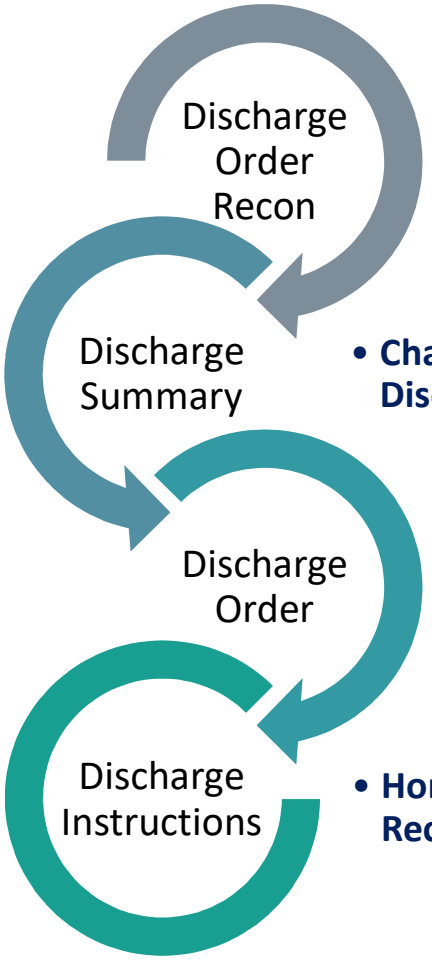
Order of Operations Matters



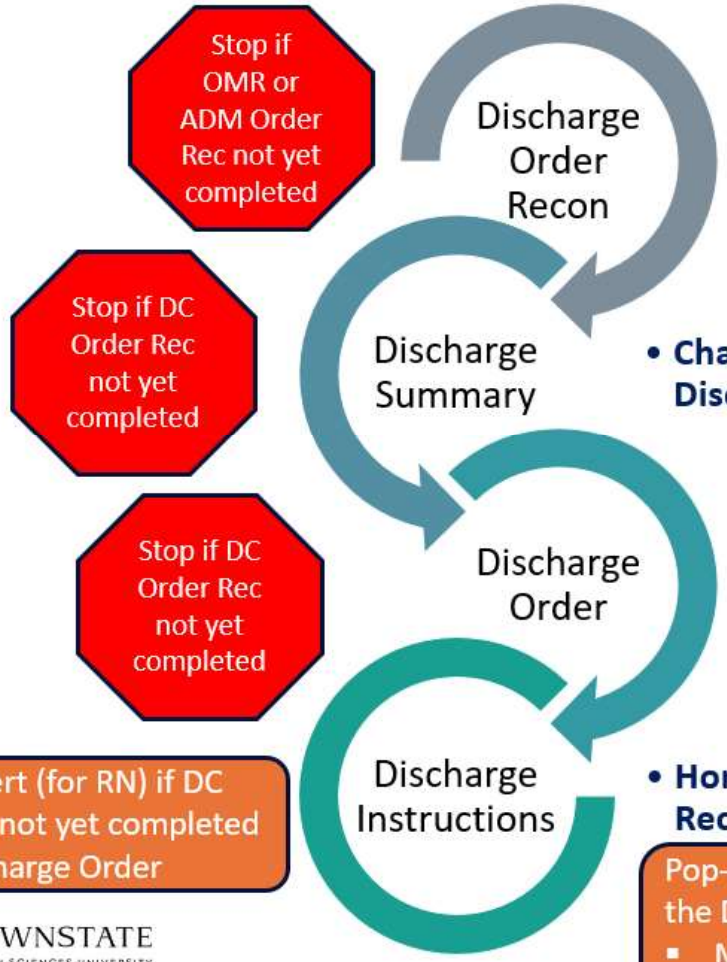
- Reconcile inpatient orders and pre-admission home medications with new home medications
- Add new Rx's
- Generates "Order Reconciliation" document

- **Changes to home medications are pulled from the Discharge Order Reconciliation document**

- May occur earlier in the discharge process
- ***CAUTION:*** Discharge Order prompts nurse to print Discharge Instructions

- **Home medications are pulled from the OMR and Discharge Order Reconciliation. Changes are pulled from the Discharge Summary.**

Order of Operations Matters



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- **Home medications are pulled from the OMR and Discharge Order Reconciliation. Changes are pulled from the Discharge Summary.**

Pop-up Alert (for RN) if DC Order Rec not yet completed or no Discharge Order

Pop-up Alert (for MD) if Discharge Order Reconciliation is updated *after* the Discharge Instructions have been printed:

- MD must modify and refresh Discharge Summary
- MD asks RN to regenerate and reprint Discharge Instructions

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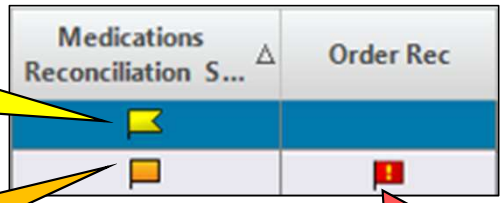
Reminder Flags Available in Patient List (Time Limits Apply)

ADMISSION

DISCHARGE

Home Medication Review Status:
Requires MD approval

Home Medication Review Status:
Not Done



Admission Order Reconciliation is overdue

Active Discharge Order WITHOUT completing Discharge Order Reconciliation

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Outpatient Medication Reconciliation

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SEP
2025

OUTPATIENT Medication Reconciliation Workflow

STEP 1: Update home medication list

RN

- Review and update list
  - Verified (patient) taking
  - No Longer Taking (per pt report)
- Add new home medications

- Update patient's preferred pharmacy

STEP 2: Confirm/update home med list

MD

- Review and update list (same as RN instructions)

MD must (also) save Complete

- Publish home medication list in the progress note (next slides)

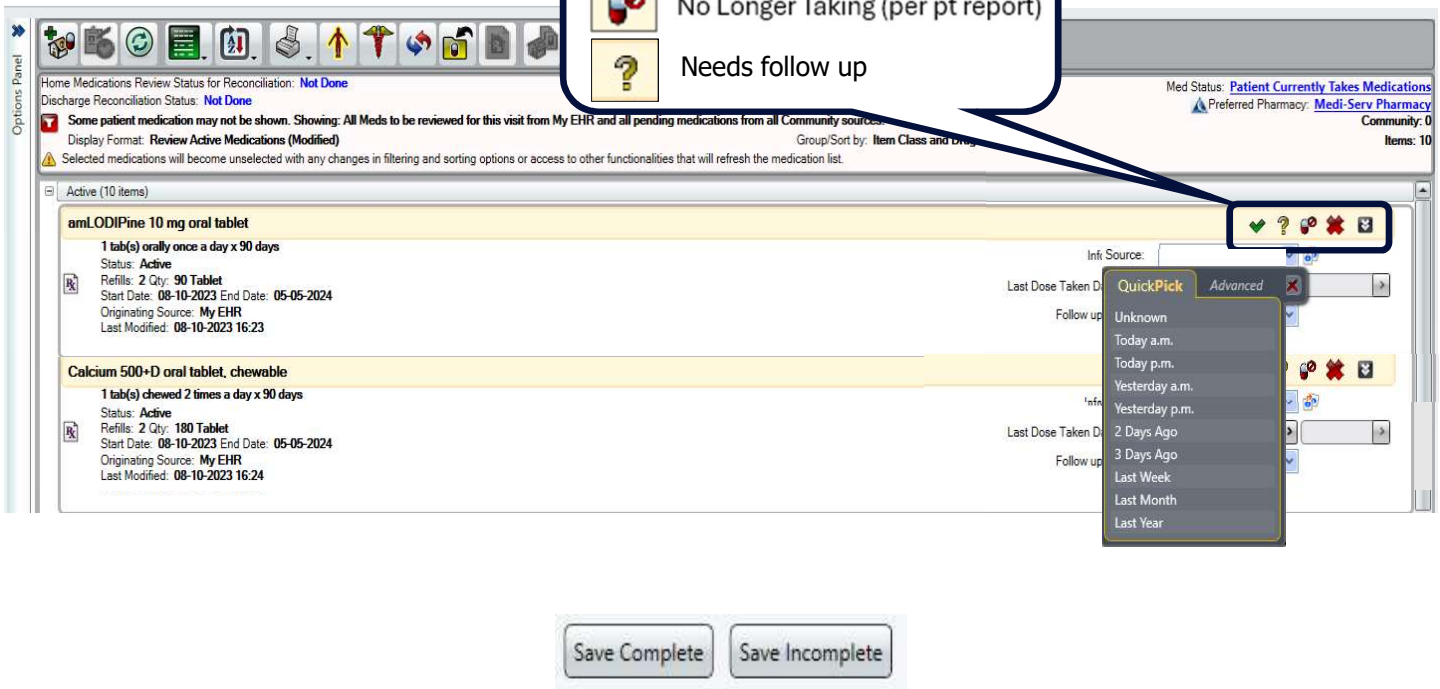
STEP 3: Print new home medication list

- Print a stand-alone medication list (later slides)
  or medication list in Encounter/After-Visit Summary

Step-By-Step for How to Update the Home Medication List

Update the home medication list in the HealthBridge Outpatient Medication Review module

1 Ask the patient if he/she is still taking each medication listed and then mark:



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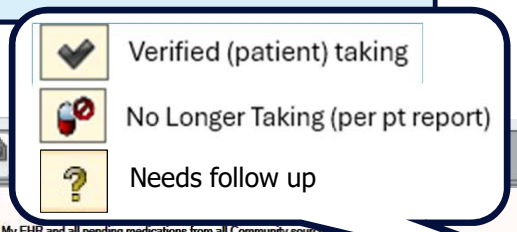

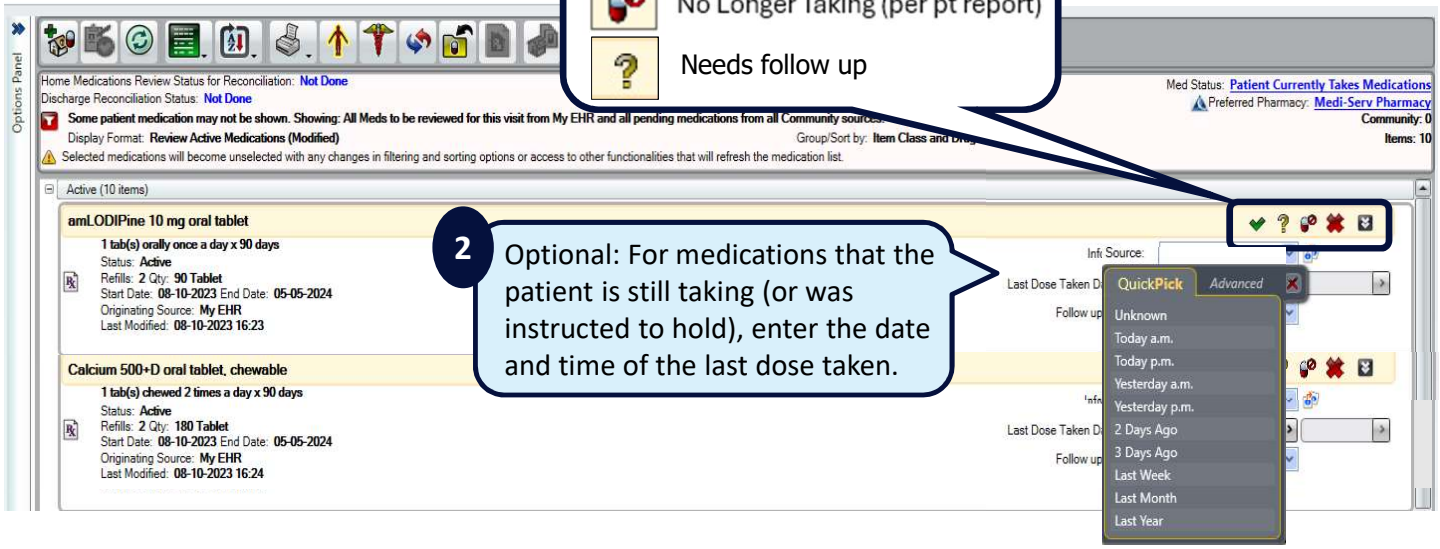

2 Optional: For medications that the patient is still taking (or was instructed to hold), enter the date and time of the last dose taken.

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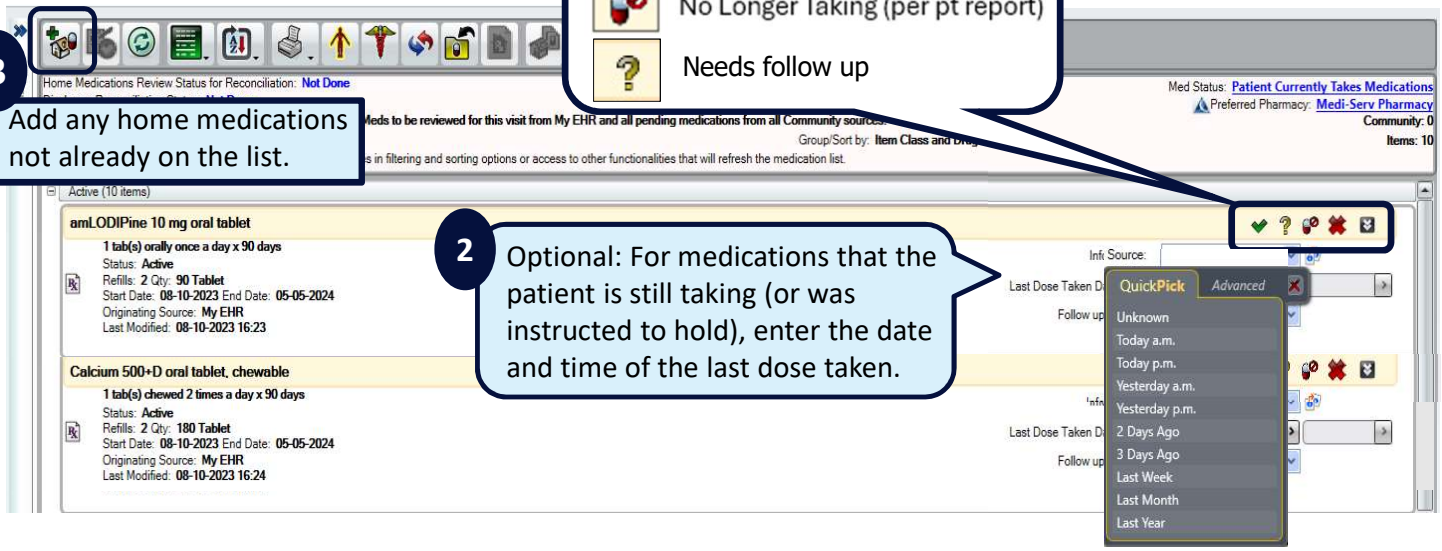

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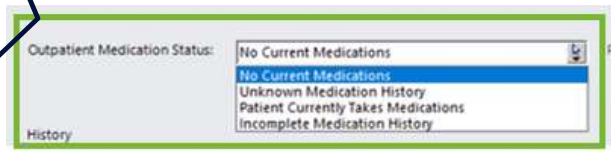

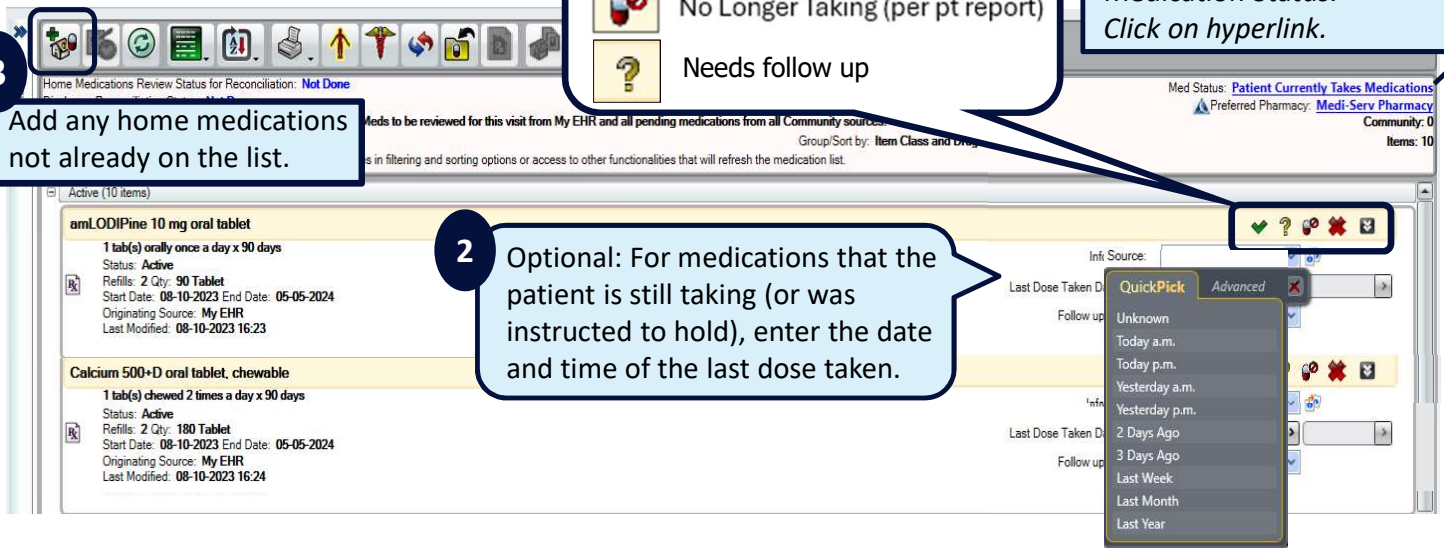

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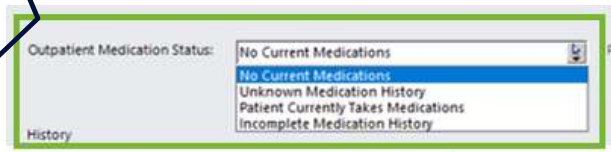

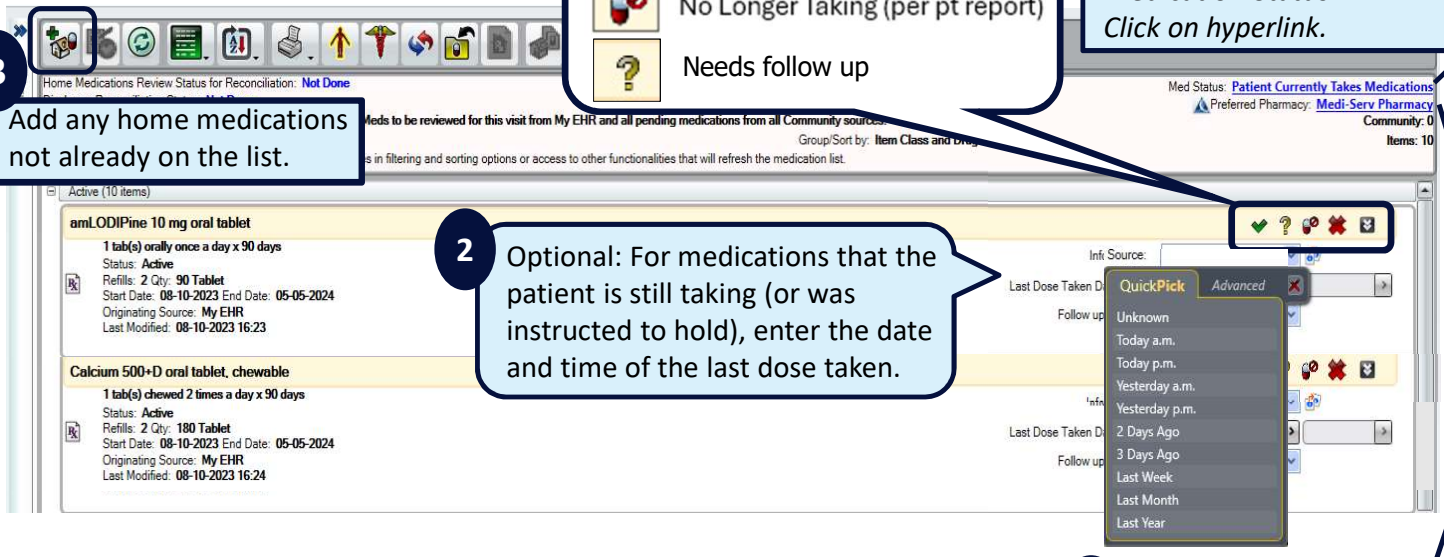

5 Confirm or update the patient's preferred pharmacy. *Click on hyperlink.*

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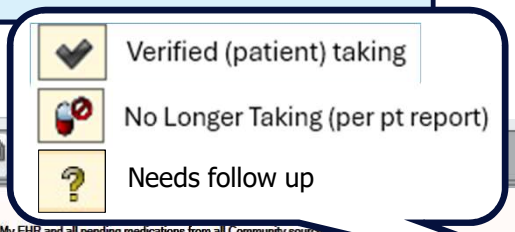

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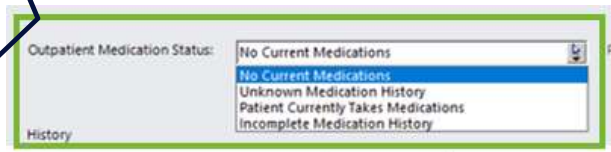

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6 Save the home medication list. Home Medications Review Status will become marked as "Complete" or "Incomplete."

Patient has provided the names, doses, and frequencies of all medications (including OTC medications and supplements) ***OR*** the patient reports taking NO medications.

The home medication list is missing one or more medication names, doses, or frequencies.

(April 2025)

Option: Medication History from Surescripts Claims Data

Caution: NOT 100% complete

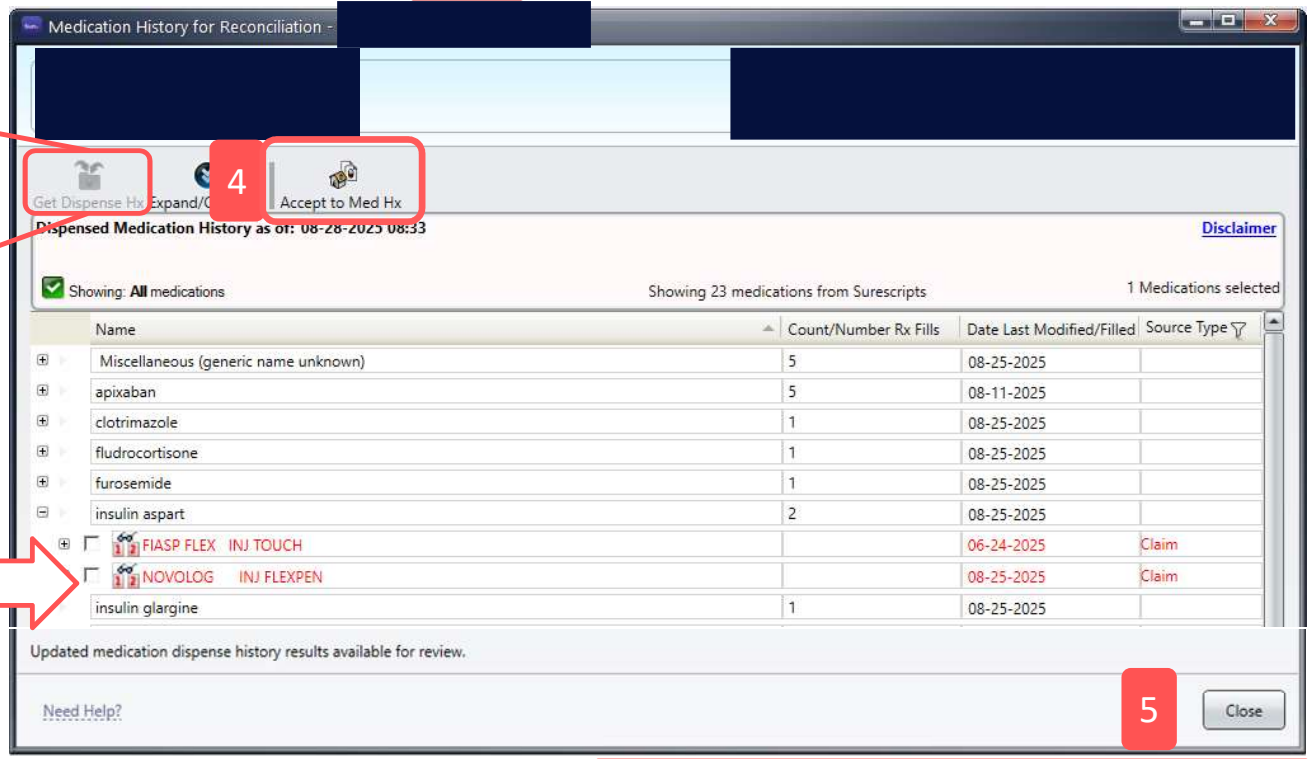
Outpatient Medication Review

1 Click on the "Medication History for Ambulatory" icon to pull filled prescriptions from claims data (not cash Rx's)

2 Opens new window. Click on "Get Dispense Hx"

If no medication list appears, click on "Get Dispense Hx" a second time.

3 Review dates and identify latest prescription for each medication -> Select checkbox



Close window to add selected medications to Outpatient Medication Review list

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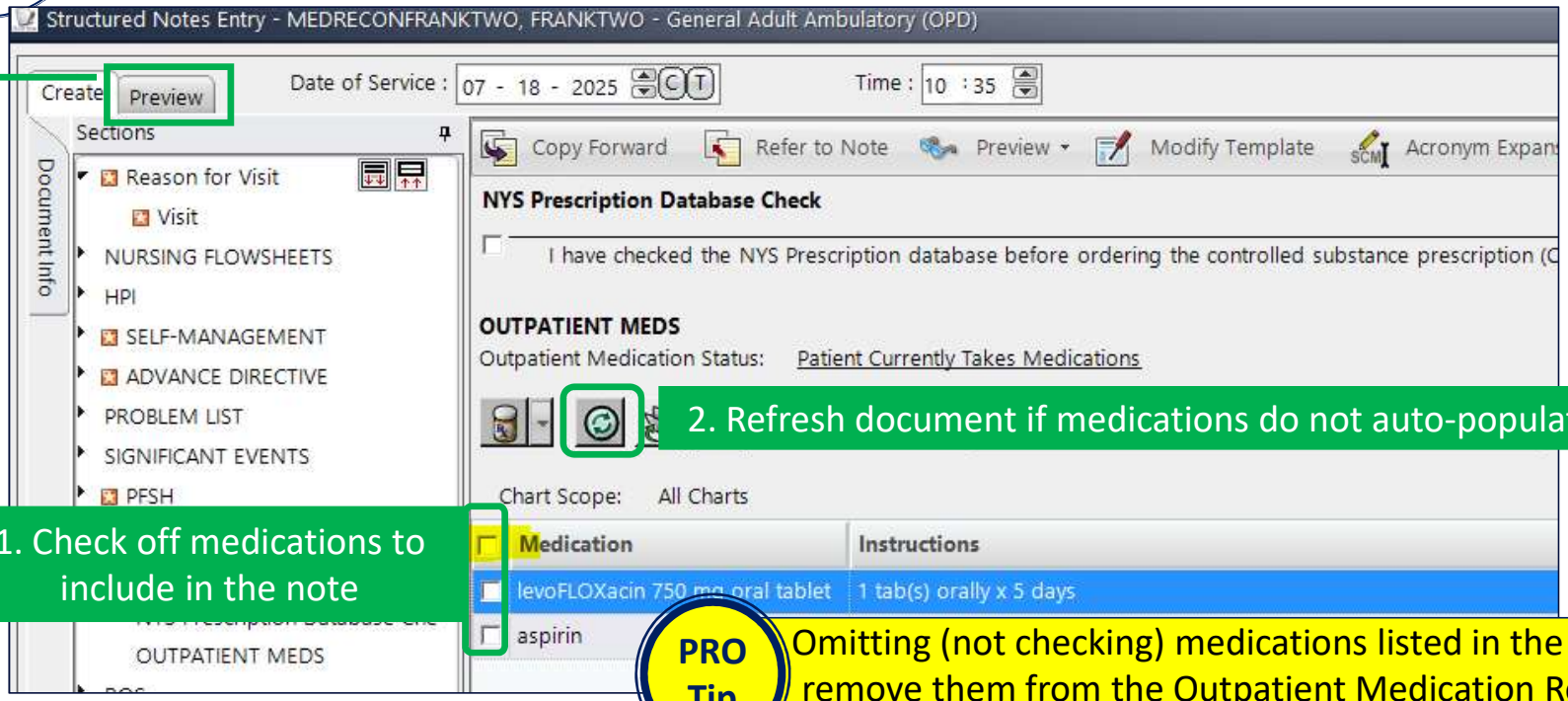
OUTPATIENT Medication Reconciliation Workflow

MD — **Publish home medication list in the progress note**



1. Check off medications to include in the note

2. Refresh document if medications do not auto-populate

3. Preview note to confirm that the medication list date matches Visit Date AND the medication list appears in the note

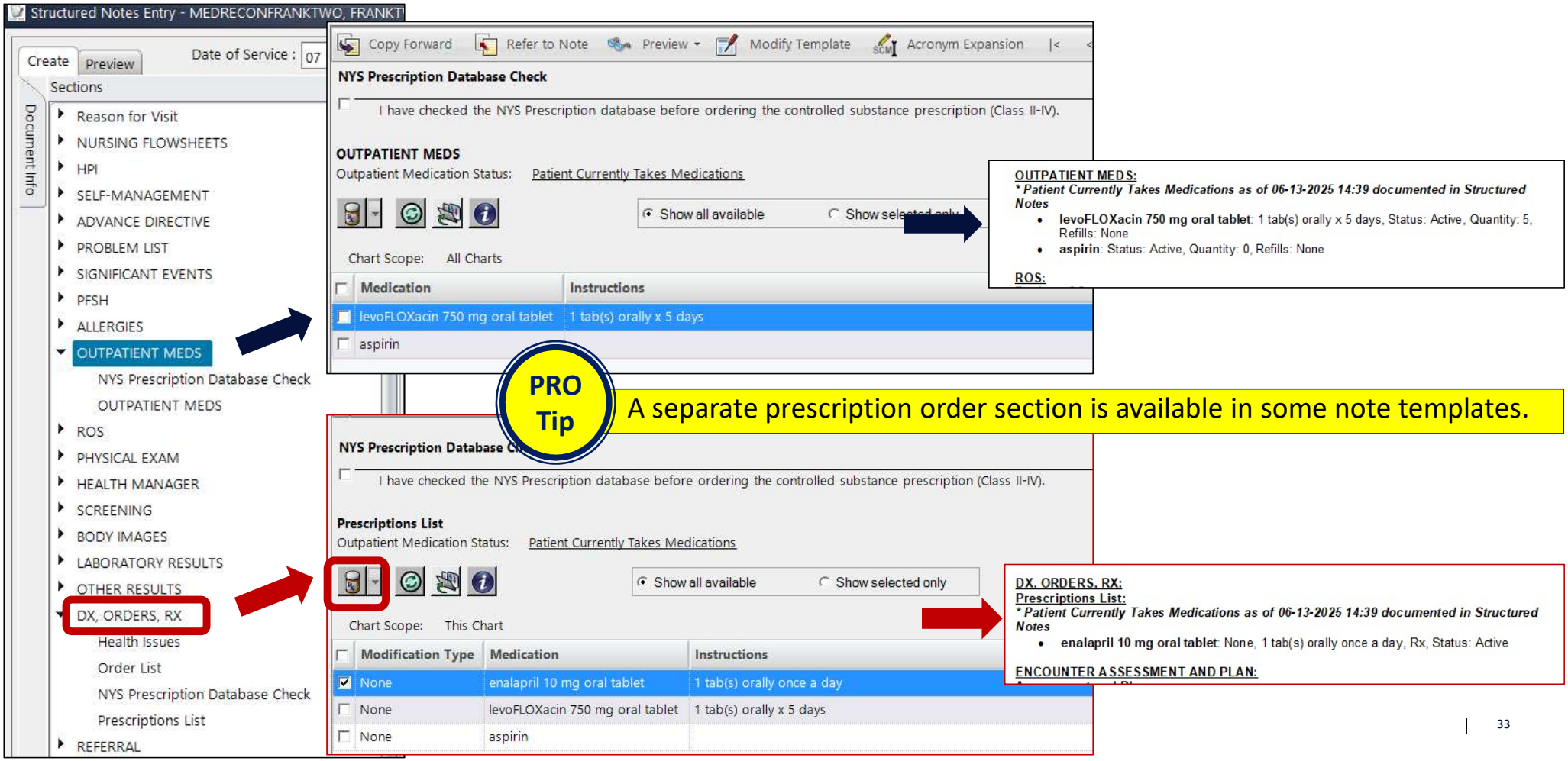
PRO Tip

Omitting (not checking) medications listed in the note does NOT remove them from the Outpatient Medication Review module. Provider must make these updates through the Outpatient Medication Review or Prescription Writer modules.

OUTPATIENT MEDS:

**** Patient Currently Takes Medications as of 06-13-2025 14:39 documented in Structured Notes***

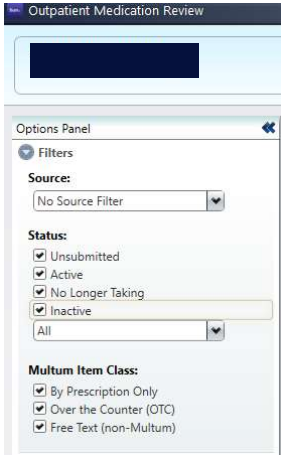
OUTPATIENT Medication Reconciliation – Documentation in Notes



How to Manage Outdated Prescription Requests in HealthBridge

When an Rx Request is more than 7 days old, remove listing from the Outpatient Medication Review module:

- Check all categories under “Status” and “Multum Item Class”
- Mark as “No Longer Taking”



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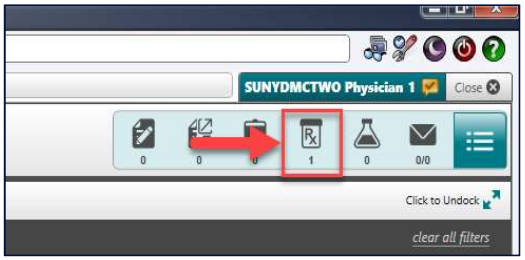
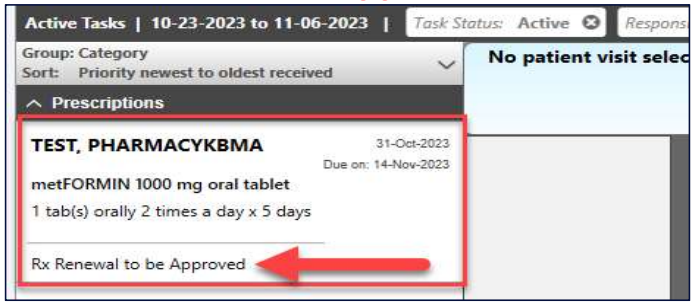
How to Manage Renew Prescription Requests in HealthBridge (Within 7 Days)

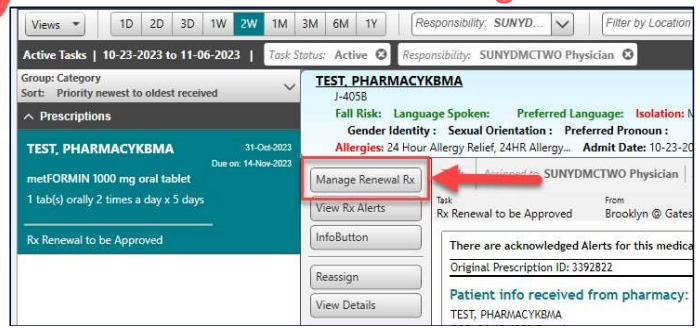
1 Compass -> **Prescriptions**



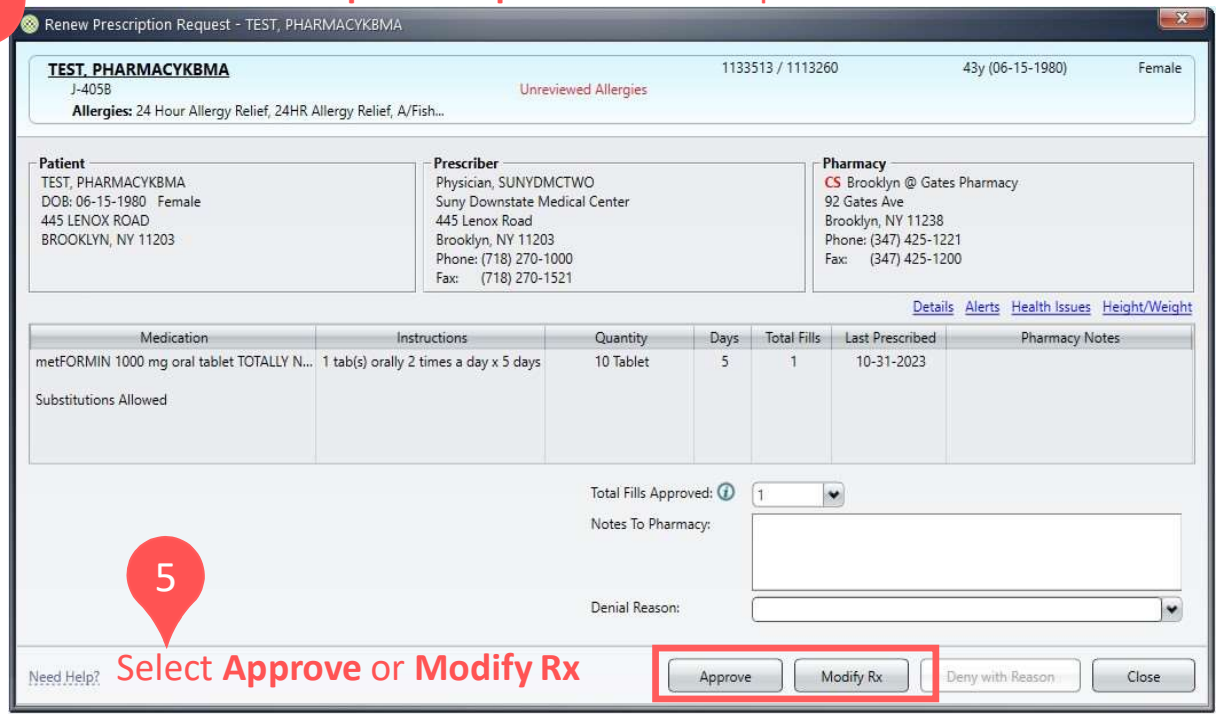
2 Select prescription with task type **"Rx Renewal to be Approved"**



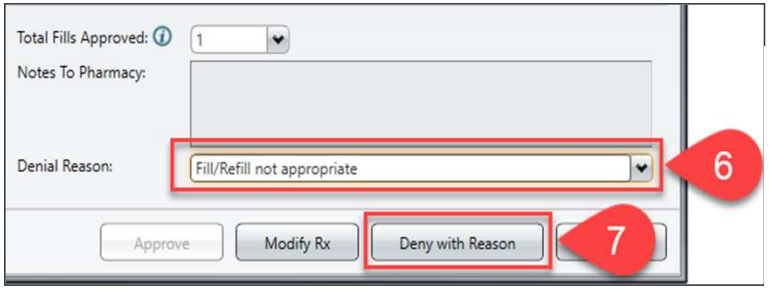
3 Action column -> click **"Manage Renewal RX"**



4 The **"Renew Prescription Request"** window opens



5 Select **Approve** or **Modify Rx**



If you wish to deny this refill request, select a **Denial Reason** from the dropdown

Then click **Deny with Reason**

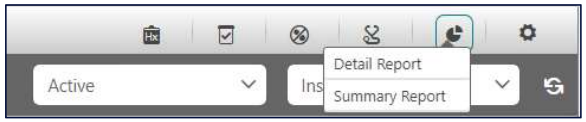
OUTPATIENT Medication Reconciliation – Provide Medication List

STEP 3: Print new home medication list

MD (or RN)

Prescription Writer

- ❑ Select all “Active” medications
- ❑ Open Reports menu
- ❑ Select and print “Detail” or “Summary Report”



- ❑ Select printer and print for patient

Patient Medication List

Facility Name: SUNY Downstate Medical Center

Printed: 07-18-2025 12:00

MEDRECONFRANKTWO, FRANKTWO

Primary ID: 9784668

DOB: 05-27-1976

Location: Mock NS 1

Allergies: No Known Allergies **Intolerance:**

Adverse Event:

Hx **aspirin** Active

Ref #:

Generic Drug Name: aspirin

Submitted By: .Physician, SUNYDMC1(MD Attending)

On Behalf Of:

Entered: 06-13-2025 14:14 Updated: 06-13-2025 14:14

Rx **levoFLOXacin 750 mg oral tablet** **1 tab(s) orally x 5 days** Active

Ref #:

Generic Drug Name: levoFLOXacin

Submitted By: .Physician, SUNYDMC1(MD Attending)

On Behalf Of:

Entered: 06-13-2025 14:38 Updated: 06-13-2025 14:39

Rx **enalapril 10 mg oral tablet** **1 tab(s) orally once a day** Active

Ref #:

Generic Drug Name: enalapril

Submitted By: .Physician Resident Fellow, SUNYDMC(MD Resident)

On Behalf Of:

Entered: 07-18-2025 11:22 Updated: 07-18-2025 11:22

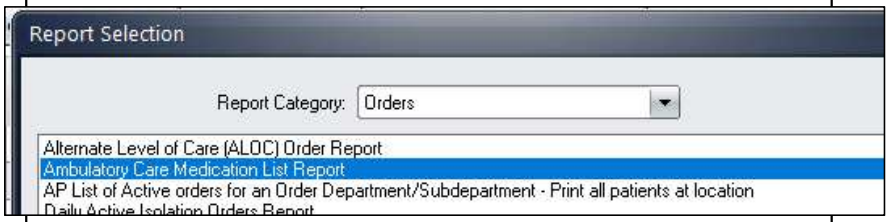
OUTPATIENT Medication Reconciliation – Provide Medication List

Alternative STEP 3: Print new home medication list

MD (or RN)

Print Reports

- ❑ Report Selection: Category “Orders”
- ❑ Select “Ambulatory Care Medication List Report”



- ❑ Select printer and print for patient
- ❑ Contains section for Special Instructions and Signatures

SUNY Downstate Medical Center
Ambulatory Care Patient Medication List

Patient Name:	**MEDRECONFRANKTWO, FRANKTWO**	**MRN/Acct#:**	9784668 / 1113435	**Current Location:**	Mock NS 1
Admit Date:	**06/09/2025**	**Attending Provider:**		**Gender:**	Female
DOB:	5/27/1976				

Status	Drug Name	Dose & Frequency	Entered by/ Prescribed by
Home Medication			
	aspirin		.Physician, SUNYDMC1
Active Medication			
	enalapril 10 mg oral tablet	1 tab(s) orally once a day	.Physician Resident Fellow, SUNYDMC
	Reason for taking medication:		
	levoFLOXacin 750 mg oral tablet	1 tab(s) orally x 5 days	.Physician, SUNYDMC1
	Reason for taking medication:		

Special Instructions:

Patient/Patient Representative Signature: _____ **Date/Time:** _____

Copy sent to next provider of care: _____ ☐ Yes
Physician Name

Nurse Signature: _____ **Date/Time:** _____

Physician Signature: _____ **Date/Time:** _____

DOWNSTATE
HEALTH SCIENCES UNIVERSITY

Questions?

Medication Reconciliation
Essentials

LilyAnn Jeu, PharmD, Department of Patient Safety
lilyann.jeu@downstate.edu