Medication reconciliation in primary care (Retired)

Alternate Name*

Medication reconciliation in primary care

INDICATOR DESCRIPTION

Description*

This indicator measures the percentage of patients with medication reconciliation in the past year.

Indicator Status*

Retired

HQO Reporting tool/product

Quality Improvement Plans (QIPs)

Dimension*

Safe

Type*

Process

DEFINITION AND SOURCE INFORMATION

Unit of Measurement*

Percentage

Calculation Methods*

The percentage is calculated as: numerator divided by denominator times 100.

Numerator including inclusion/exclusion*

Number of patients with medication reconciliation in the past year.

Denominator including inclusion/exclusion*

Number of patients who have had a visit in the past year.

Data Source

Local data collection

Ontario
Health Quality Ontario

Data provided to HQO by

Local data collection

OTHER RELEVANT INFORMATION

Comments Detailed

This is an additional indicator for QIP 2018/19. Current performance reporting period: most recent 12 month period. Primary Care Organizations are encouraged to determine the most appropriate patient population who will benefit from medication reconciliation (e.g., recent discharge from hospital, referrals to specialists who may prescribe medications, > 2 medications prescribed, high risk medications prescribed). Medication reconciliation is an important component of medication safety. While medication reconciliation processes should be implemented within each health care sector, linkages across sectors are required to be most effective for patients. As primary care is the setting in which patients receive the majority of their health care and is often the point of care coordination for the rest of a patient's care, this sector plays a key role in creating these linkages. For their QIPs, primary care organizations are encouraged to develop medication reconciliation processes that leverage available resources. The Institute for Safe Medication Practices (ISMP) has developed a resource to support medication reconciliation in the primary care setting. As a starting point, completing medication reconciliation in primary care involves four main activities: 1. Collect and document an accurate and up-to-date medication list, called the Best Possible Medication History (BPMH). This can be done, for example, during an office visit for any patient who takes numerous medications, has been recently discharged from hospital, or has been referred to numerous specialists. 2. Compare the BPMH with information in the patient's chart and identify discrepancies (i.e., differences between various sources of medication information) 3. Correct the discrepancies as appropriate through discussion with the primary care provider and the patient and then update the BPMH with the resolved discrepancies, thereby creating a reconciled list. Note: pharmacists, community-based or otherwise, are a great resource to help create a reconciled list. 4. Communicate the resulting medication changes to the patient and verify the patient's understanding of their medication regimen. This indicator was retired in the 2019/20 QIP.

TAGS

TAGS*

Primary Care

Process

Patient Safety and Never Events

Safe

Local data collection

PUBLISH

PUBLISH DATETIME*

Ontario
Health Quality Ontario

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