The Identification of Medication Related Problems from a Medication Review Provided by a Clinical Pharmacist in a Community Setting

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Introduction / Background

- Medication reconciliation refers to the process of collecting an accurate list of all medications that a patient is taking, including name, dosage, frequency, and route of administration.
- The purpose of a medication reconciliation is to avoid inadvertent inconsistencies throughout the continuum of care.
- Medication reconciliations are important in ambulatory care, as many patients receive prescriptions from more than one outpatient provider.
- Pharmacist-conducted medication histories are more accurate, save money, and increase patient safety when compared with nurse-obtained medication histories.

Objectives

- Describe the effectiveness of a pharmacist-performed medication reconciliation program in identifying and resolving medication related problems (MRPs) in a primary care setting.

Methods / Process

- Retrospective descriptive cross-sectional analysis to determine the benefits of pharmacist-performed medication reconciliation visit.
- Patients identified from electronic health record who had a pharmacist visit.
- 18+ years with an office visit from July 1, 2013 – September 30, 2013.
- With ≥7 medications and ≥2 chronic disease states.
- Not previously managed by the clinical pharmacist.
- Descriptive statistics were used to summarize the medication-related problems identified, recommendations, and recommendation status.
- Frequency of problems compared to characteristics was determined by a Mann-Whitney U test.

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Results

- An average of 8 medication related problems per patient was found.
- Providers approved 74% of pharmacist recommendations.
- There was a statistically significant difference in the number of medication-related problems found between patients seeing fewer than 7 providers and those seeing ≥7 providers (p<0.04).

Conclusions

- An average of 8 medication related problems per patient was found.
- Most common MRPs found include the following: patient taking medications not on provider’s list (28%), discontinued medication on record (21.7%), no monitoring for disease state or medication (12.8%).
- Providers approved 74% of pharmacist recommendations.
- There was a statistically significant difference in the number of medication-related problems found between patients seeing fewer than 7 providers and those who saw 7 providers or more (p<0.04).

Limitations

- Data limited to one community practice site.
- Practice setting in academic health center could limit generalizability.