Top Five Medication Reconciliation Priorities Needing Cerner's Attention
Response from Cerner

The following list is a compilation of recommended enhancements for Cerner's Medication Reconciliation workflow. This list was compiled with the help of CMIOs and physician leadership across eight Cerner Health Systems, representing 30 hospitals and over 8,000 patient beds.

Concerns were provided to Cerner leadership and they responded to the Top Five concerns raised.

Cerner responses are italicized and in blue.

Note: The Cerner Ideas referenced multiple times is a client-submission page to recommend enhancements (Ideas) to Cerner's engineering team for development in future releases. Cerner then reviews these Ideas for validity and client impact then accepts or rejects them. If accepted, they are put on the roadmap for development and availability in a future release. https://connect.cerner.com/community/ideas

Top Five Medication Reconciliation Priorities Needing Cerner's Attention

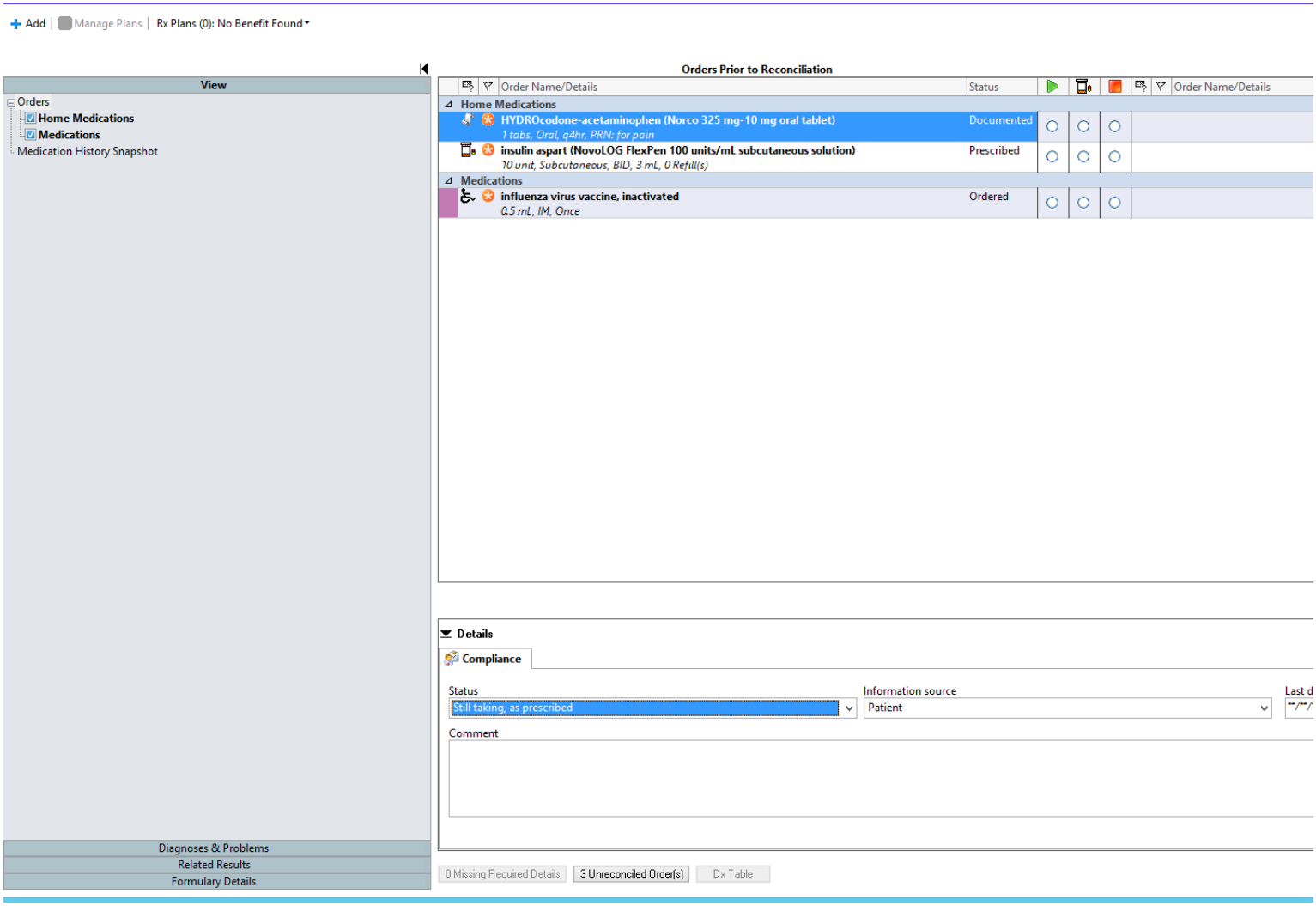
1. Need to combine same home medication and active/hospital medication into one radio button when reconciling in discharge medication reconciliation. This should also work for auto-substitutions.

    a. *There is some ability to do this if you have a "convert" relationship built into the background. Without that pre-determined relationship there isn't current functionality to do this. The request from [Cerner] is to put this into the Ideas space so they can work on getting it on roadmap.*

2. The provider needs the ability to review the chart when completing medication reconciliation. The locked Medication Reconciliation screen inhibits review without getting out of the window

    a. *There is some ability to see the chart, but not the full view. Screenshot below*

    b. *The ability to see the whole chart is one of the Top 5 Ideas that the Cerner Meds Rec team is working on*



3. Providers need the ability to complete documenting medication history and performing medication reconciliation in the same screen.

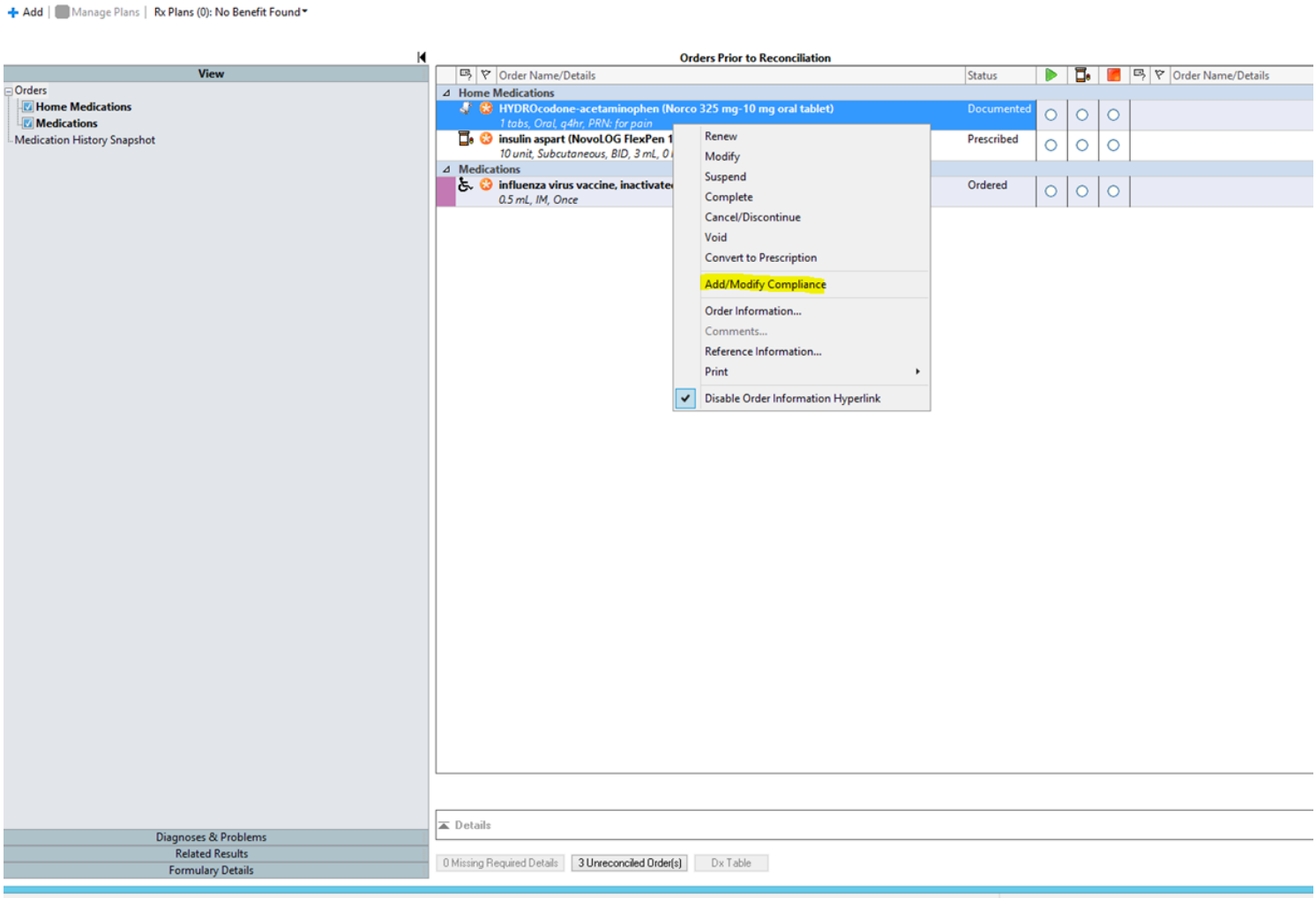
    a. *Not currently on our radar. Likely due to many institutions having a MA (outpatient) or nurse(inpatient) completing the med history, with the provider doing the medication reconciliation. Considering the workflow of physicians completing both history and reconciliation it would be beneficial to add to the Ideas space.*

4. Need to be able to include IV continuous medications and IV PRN medications in discharge medication reconciliation. They currently only have the ability to include IV piggyback.

    a. *For cross encounter reconciliation, this functionality is presently available. For discharge medication reconciliation it's on the Cerner med rec team's radar.*

5. Compliance information documented on the home medication needs to be visible when completing medication reconciliation.

    a. *This is currently possible. Screenshot below*



Other Medication Reconciliation Needs:

1. Enhancement of Ambulatory Medication Reconciliation. Providers would like to see active medication list (for example, discharge med list from recent hospital stay) and the last clinic medication list within medication reconciliation when reconciling meds.

    a. *Not addressed*

2. Improvements for functionality of partial medication reconciliation icon for hospitalized patients.

    a. For example, if an active med order is placed between planned and initiated admission medication reconciliation, the admission medication reconciliation icon goes to Partial upon initiation. This causes confusion and workflow frustration.

        i. *Not addressed*

    b. On the other hand, if a new home med is added/documented, the admission medication reconciliation stays as Complete - thus, there is no way for the provider to know that a new home medication has been added other than communication from the medication reconciliation tech and/or nurse to the provider.

        i. *Not addressed*

3. Need improved workflow for continuous/long term medications that need to be on hold for multiple days/time period.

    a. *Not addressed*

4. Discharge medication reconciliation/prescribing meds needs to be streamlined. There are lots of dependencies on education and end users for use of the following fields: Special Instructions, eRx Note to Pharmacy, Order Comments, Notes for Patient.

    a. *Not addressed*

5. In general, medication reconciliation always needs to be hardwired. There are too many options that lead to variability, inconsistencies, and frustration with providers.

    a. *Not addressed*