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 seven Cerner Health Systems, representing 27 hospitals and over 8,000 patient beds.

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.

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.

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

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.

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

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.

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.

    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.

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

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.

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