Medication Prescribing, Reconciliation, and Allergy Tracking Policy and Procedure

Effective Date: 08/15/2025

Approved By: Director of Medical and Clinical Services

Review Schedule: Annually or as Needed

Applies To: All Programs — Outpatient MH/SUD, IOP, PHP, and Integrated Primary Care/Behavioral Health

Policy Statement
The organization shall ensure that all medications prescribed, reconciled, and tracked for allergies are managed safely, accurately, and in accordance with applicable laws, clinical best practices, and organizational standards. All prescribing clinicians are responsible for maintaining up-to-date medication and allergy information to ensure patient safety, continuity of care, and coordination across medical and behavioral health disciplines.

Purpose
To establish a standardized process for:
- Safe and compliant medication prescribing;
- Accurate medication reconciliation during every phase of care; and
- Ongoing identification and documentation of allergies or adverse drug reactions (ADRs).
This policy is designed to reduce medication errors, adverse drug interactions, and duplication of therapy.

Scope
This policy applies to all prescribers (MDs, DOs, NPs, PAs), nurses, case managers, and clinical support staff involved in medication management for individuals served in primary care and behavioral health programs.

Procedures

1. Prescribing Practices
a. Authorized Prescribers
- Only licensed and credentialed providers (physicians, nurse practitioners, or physician assistants) with active prescriptive authority may prescribe medications.
- Controlled substances must be prescribed in compliance with state and federal laws, including Ohio Automated Rx Reporting System (OARRS) review and documentation before each prescription or renewal.

b. General Prescribing Requirements

- All prescriptions must include:
  - Client's full name and date of birth
  - Medication name (generic preferred), dosage, route, frequency, and duration
  - Quantity prescribed and number of refills (if any)
  - Date and prescriber's signature (electronic or written)
- Prescriptions must be documented in the Electronic Health Record (EHR) immediately after issuance.
- Polypharmacy should be avoided unless clinically justified and documented.
- For behavioral health medications, the prescriber shall collaborate with primary care to coordinate management of chronic conditions and avoid drug–drug interactions.

c. Controlled Substances
- Prescribers shall review OARRS prior to prescribing or renewing any controlled medication.
- Prescribers must:
  - Document the OARRS check in the EHR.
  - Counsel the client on safe use, storage, and disposal.
  - Use treatment agreements for long-term controlled medication use (e.g., MAT, stimulants, benzodiazepines).
  - Monitor for misuse, diversion, or dependency.
- Random urine drug screens may be required for clients receiving controlled substances.

2. Medication Reconciliation
Medication reconciliation will occur:
- At intake, each clinical encounter, and transition of care (admission, discharge, or transfer).
- During referral to external providers or following hospitalization.

a. Process Steps
1. Collection – Obtain a complete list of all medications the client is currently taking, including:
   - Prescription drugs, over-the-counter medications, vitamins, and herbal supplements
   - Dosages, frequencies, routes, and start dates
   - Prescribing providers and pharmacy information
2. Verification – Compare current medication lists with:
   - Active prescriptions in the EHR
   - Pharmacy dispensing records or pill bottles
   - Hospital discharge summaries (if applicable)
3. Reconciliation – Identify and resolve discrepancies such as:
   - Omissions, duplications, incorrect dosages, or potential interactions
   - Changes in therapy due to new diagnoses or adverse reactions
4. Documentation – Update the medication list in the EHR immediately after reconciliation.
5. Communication – Communicate changes to the care team, including primary and behavioral health providers, as well as the client and/or guardian.

b. Responsibility
- The prescriber maintains responsibility for reviewing the reconciled medication list at each encounter.
- Nursing or clinical support staff may perform collection and verification steps under supervision.
- All reconciliations must be electronically dated, signed, and stored in the EHR.

3. Allergy and Adverse Reaction Tracking
a. Identification
- Allergies and adverse drug reactions (ADRs) shall be assessed:
  - At intake, each medical or behavioral health visit, and upon any medication change.
  - Using open-ended questioning (e.g., "Have you ever had a reaction to a medication?").
- The type of reaction, severity, and outcome must be documented.

b. Documentation
- All allergies shall be clearly recorded in the designated EHR allergy field (noted in both medication and problem list sections).
- The entry must include:
  - Allergen name (drug or substance)
  - Type of reaction (e.g., rash, anaphylaxis, nausea)
  - Severity (mild, moderate, severe)
  - Date of reaction (if known)
- If no known allergies (NKA), this must be documented and verified at every visit.
- Updates or new allergies discovered at external facilities must be added to the EHR within 24 hours of notification.

c. Alerts
- The EHR shall automatically alert prescribers to potential allergies or cross-reactivity before finalizing any new prescription.
- Staff are required to acknowledge and address all alerts prior to medication ordering.

4. Medication Review and Monitoring
- Each prescriber must review the client's full medication and allergy list at every visit before prescribing or adjusting medications.
- The review must include:
  - Current labs or diagnostics (e.g., A1c, lipid panel, liver/kidney function, ECG if indicated).
  - Evaluation of efficacy, side effects, and adherence.
  - Ongoing risk–benefit discussion with the client.
- Nonadherence or suspected side effects must be addressed through education, motivational interviewing, and care coordination.

5. Collaboration and Communication

- Behavioral health and primary care providers must communicate regularly to ensure medication regimens are coordinated and consistent.
- Interdisciplinary case conferences shall include medication updates, adherence issues, and side effect monitoring.
- When external providers are involved, coordination must occur via secure fax, encrypted email, or shared health exchange systems.

6. Education and Client Engagement
- All clients shall receive counseling about:
  - Purpose and expected outcomes of each medication
  - Potential side effects and what to report
  - Safe storage, particularly of controlled substances
  - Refill procedures and medication disposal options
- Clients shall be encouraged to maintain an updated personal medication list and share it with all healthcare providers.

7. Quality Assurance and Compliance Monitoring
- The Quality Improvement (QI) Committee shall review:
  - Accuracy of medication lists and reconciliation documentation
  - Allergy tracking compliance
  - OARRS utilization and controlled substance prescribing patterns
  - Incident reports related to medication errors or adverse reactions
- Results will be used to guide training, improve workflow, and maintain CARF and regulatory compliance.

Performance Indicators
- 100% of clients have current medication and allergy lists documented in EHR.
- Medication reconciliation completed at all intake and discharge points.
- Documentation of OARRS checks for all controlled substance prescriptions.
- Reduction in medication-related errors or discrepancies.
- Client satisfaction with medication education and safety.

Staff Responsibilities
- Prescribers: Review, prescribe, reconcile, and educate clients; ensure OARRS compliance.
- Nursing/Support Staff: Collect medication history, verify accuracy, and update allergy records.
- Care Coordinators/Case Managers: Communicate medication changes and coordinate with external providers.
- Quality Improvement Team: Audit records and monitor compliance metrics.
- Supervisors/Directors: Ensure staff training and corrective actions when needed.

Review and Revision
This policy shall be reviewed annually or as regulatory changes occur and revised as needed

to ensure continued compliance with CARF, SAMHSA, DEA, and state pharmacy laws.