Supplemental Digital Content, Figure 2. Medication Reconciliation Process after MATCH implementation

Patient Discharged from Hospital

Reconciliation

Sources of Information and Orders

**Intake Nurse/Provider**

Reconciliation documentation and context cues to help patients resolve medication discrepancies and incorrect usage

**Clinic Waiting Room Assistant**

Uses standardized One Source of Truth for medication list MedManage, symptom driven documentation (including over the counter and PRN)

**Pre-Visit Preparation**

Fax number corrected, improved access to discharge information

Medication list printed by reception

**New prescription orders**

Patient/caregiver empowerment and education

Pharmacy strategies to maintain correct usage

**Hospital:**

1. Discharge Orders/Transition of Care (TOC) appointment (if eligible)
2. Fax to Clinic
3. Access Portal (Clinic)

**Providers:**

1. Electronic Medical Record/Clinic Provider
2. Specialists
3. Pharmacy
4. Home health or care facility
5. Insurance list

**Individuals:**

1. Patient
2. Caregiver

**Hospital Floor Nurse**

**Emergency Room Nurse**

**Clinic Intake Nurses**

**Pharmacists**

Challenges:

Electronic health records vary creating inconsistent communication across providers

Multiple providers

Hospital formularies differ from outpatient

Medication Comparison