#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		Enable if catnum = 29, 53, or 55		
		Inpatient Medication Reconciliation		
1	revptmed	Upon admission or during the 24 hours after admission, is there evidence in the medical record that the physician/APN/PA, pharmacist, or nurse reviewed the patient's list of medications and/or active medication list in the record <u>with the patient/caregiver</u>? 1. Yes 2. No 3. Documented medications were not currently prescribed for the patient upon admission	1, 2, 3 If 1 or 3 and dcdispo = 6 or 7, go out of module If 1 or 3 and dcdispo = 3, 4, or 5, go to trxlist; else if 1 or 3, go to dcrxlist	**The intent of the question is to determine if the clinical staff involved the patient/caregiver in the review of the patient's medication list and/or the active list of medications in the record at the time of admission.** **ED documentation prior to admission is acceptable.** • If there is documentation upon admission or during the 24 hours after admission that the clinical staff reviewed the patient's list of medications and/or active medication list in the record with the patient/caregiver, select "1". • If the documentation does NOT indicate that the patient/caregiver was involved in the review of the medication list, select "2." For example, physician noted, "Active med list reviewed. No changes noted." • Select "3" only if there is explicit documentation that the patient was not currently prescribed any medications upon admission. **Note:** For surgical care cases that have surgery on the day of admission, documentation of the current medication list in the pre-op H&P done prior to admission including provider documentation that the patient/caregiver participated in the development of list AND provider documentation prior to surgery that the medications are unchanged (or similar wording) from the pre-op H&P is acceptable. **Suggested data sources:** clinical pharmacy note, electronic recording (e.g. APHID), ED documentation, H&P, intake note, medication reconciliation note, progress notes, pre-operative anesthesia note

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2	noptlist	Upon admission or during the 24 hours after admission, did the medical record document that an emergent, life-threatening situation existed with this patient prohibiting completion of medication reconciliation at this time? 1. Yes 2. No	1, 2 If 1 and dcdispo = 6 or 7, go out of module If 1 and dcdispo = 3, 4, or 5, go to trxlist; else if 1, go to dcrxlist	**Answer "1" only if there is documentation that an emergent, life-threatening situation existed with this patient upon admission or during the 24 hours after admission.** **ED documentation prior to admission is acceptable.** Documentation of emergent, life-threatening situations may include, but is not limited to these types of conditions: patient coding, code blue (etc.), seizures, cardiac arrest, respiratory arrest, unresponsive, or similar condition that indicates an emergent situation. Documentation of emergent, life-threatening situations does not have to be linked to inability to obtaining a list of medications from the patient/caregiver. **Suggested data sources:** clinical pharmacy note, ED documentation, H&P, medication reconciliation note, intake note, progress notes, pre-operative anesthesia clinic visit note
3	noptlist2	Upon admission or during the 24 hours after admission, did the physician/APN/PA, pharmacist, or nurse document that the patient and/or caregiver were unable to confirm the patient's medications? 1. Yes 2. No	1, 2 If 1 and dcdispo = 6 or 7, go out of module If 1 and dcdispo = 3, 4, or 5, go to trxlist; else if 1, go to dcrxlist	**In order to answer "1" there must be physician/APN/PA, pharmacist, or nurse documentation that the patient and/or caregiver are unable to confirm the patient's medications. If a caregiver is not present, documentation that the patient is unable to confirm their medications and an attempt to contact the patient's caregiver is acceptable.** **ED documentation prior to admission is acceptable.** **Suggested data sources:** clinical pharmacy note, ED documentation, H&P, medication reconciliation note, intake note, nursing notes, progress notes, pre-operative anesthesia clinic visit note
		Discharge Medication Reconciliation		

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4	noptlist3	Upon admission or during the 24 hours after admission, did the physician/APN/PA, pharmacist, or nurse document at least two attempts to obtain the patient's medication list from a referring facility? 3. Yes 4. No 5. No, patient was not referred from another facility	3, 4, 5 If dcdispo = 6 or 7, go out of module If dcdispo = 3, 4, or 5, go to trxlist; else go to dcrxlist	**Referring facility: skilled nursing facility, assisted living, medical group home, etc.** **If there are at least two attempts by the physician/APN/PA, pharmacist, or nurse to contact the referring facility to obtain the patient's medication list, select "3." Unsuccessful attempts documented in the record are acceptable (e.g. "left message for nursing director to return call re: patient's medications").** **If the patient was not received from a referring facility, answer "5."** **Suggested data sources:** clinical pharmacy note, ED documentation, H&P, medication reconciliation note, intake note, nursing notes, progress notes, pre-operative anesthesia clinic visit note, telephone encounter notes
5	trxlist	At the time of discharge/transfer, is there documentation that a written list of the reconciled discharge medications was transmitted to the next level of care provider? 1. Yes 2. No 3. Documented medications were not prescribed at discharge	1, 2, 3 If 1, 2, or 3, go to end	This question applies to patients that are discharged/transferred to a hospice facility, another acute care facility, or other health care facility. If the next level of care provider has access to the complete electronic medical record (i.e. CPRS), select "1." CPRS should contain documentation that the next level of care provider has access to the CPRS. Methods for transmitting the written list of reconciled medications include, but are not limited to: FedEx, CPRS access. Suggested data sources: Transfer/Discharge summary, medication reconciliation note
6	dcrxlist	At the time of discharge, is there documentation that a written list of the reconciled discharge medications was provided to the patient/caregiver? 1. Yes 2. No 3. Documented medications were not prescribed at discharge	1, 2, 3 If 3, go to end	Documentation that a copy of the list of discharge medications was given to the patient/caregiver is acceptable. For example, pharmacist notes, "Copy of discharge meds given to patient." If there is documentation a copy of the discharge instructions were given to the patient AND the discharge instructions included the patient's discharge medications, select "1." **Suggested data sources:** Discharge summary, discharge instructions, medication reconciliation note

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7	medsame	Were the <u>medications</u> listed on the patient's discharge instructions the same as the medications listed in the discharge summary? 1. Yes 2. No	1, 2	**For the purposes of this question, it is necessary to compare medications only.** Disregard items such as alcohol pads, syringes, glucometer test strips, etc. • If the list of medications contained in the discharge instructions (e.g., physician discharge instructions, pharmacy discharge instructions, or nursing discharge instructions) given to the patient AND in the discharge summary are the same, select "1." • If the discharge medications are not listed on the discharge instructions given to the patient select "2." • If the discharge medications are not listed in the discharge summary select "2." • If the discharge medications are not the same in the discharge summary as the discharge instructions given to the patient, select "2". **Suggested data sources:** Discharge summary, discharge instructions given to the patient