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| **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 with the patient/caregiver?  1. Yes  2. No  3. Documented medications were not currently prescribed for the patient upon admission | 1,2,3  If 1, go to idiscrp  If 3 and dcdispo = 6 or 7, go out of module; else if 3, go to dcdiscrp | **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.**  Select “1” 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.  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.”  **ED documentation prior to admission is acceptable.**  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 note, pre-operative anesthesia note. |
| 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; else if 1, go to dcptmed | **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 note, 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, go to idiscrp | **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 note, pre-operative anesthesia clinic visit note. |
| 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 4 or 5 and dcdispo = 6 or 7, go out of module; else if 4 or 5, go to dcptmed  If 3, go to idiscrp | **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 note, pre-operative anesthesia clinic visit note, telephone encounter notes |

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| 5 | idiscrp | Upon admission or during the 24 hours after admission (or by the end of the next day when an emergent situation was documented), is there documentation the physician/APN/PA, pharmacist, or nurse identified medication discrepancies between the patient’s medication list and the medication list in the medical record?  3. Documented medication discrepancies were identified  4. Documented medication discrepancies were not identified  99. No documentation upon admission or during the 24 hours after admission regarding medication discrepancies | 3,4,99  If 4 or 99, auto-fill ipaddisc as 95 AND if dcdispo = 6 or 7, go out of module; else if 4 or 99, go to dcdiscrp | **The intent of the question is to determine whether the physician/APN/PA, pharmacist, or nurse documented the presence or absence of medication discrepancies that were identified as a result of comparing the patient’s medication list with the medication list in the medical record.**  Select “3” if there is documentation that medication discrepancies were identified. For example, nurse notes, “The patient stopped taking the Lasix prescribed by the external provider.”  Documentation by the physician/APN/PA, pharmacist, or nurse that indicates medication discrepancies were identified and addressed is sufficient.  For example, physician notes, “Reviewed medication discrepancies with patient and updated medication list.”  Select “3.”  Documentation that does not indicate medication discrepancies were identified such as “any medication discrepancies were addressed” is NOT acceptable.  Select “4” if there is documentation that medication discrepancies were not identified. For example, pharmacist notes, “No medication discrepancies found.”  Select “99” if there is no documentation regarding the presence or absence of medication discrepancies.  ED documentation prior to admission is acceptable.  Suggested data sources: ED documentation, progress note, patient education/instructions note, medication note, medication reconciliation note |

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| 6 | ipaddisc | Upon admission or during the 24 hours after admission (or by the end of the next day when an emergent situation was documented), is there documentation the physician/APN/PN, pharmacist, or nurse addressed medication discrepancies?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if idiscrp = 4 or 99  If 1 or 2, AND dcdispo = 6 or 7, go out of module; else if 1 or 2, go to dcdiscrp | The intent of the question is to determine whether the physician/APN/PA, pharmacist, or nurse addressed the medication discrepancies at the time of discharge.  **Select “1” if there is documentation demonstrating that actions were taken to address medication discrepancies. Actions to address medication discrepancies include but are not limited to:**   * updating medication list * discontinuing medications * providing education to patient/caregiver * communicating medication discrepancies to the responsible prescribing provider * referring the patient to another provider with the necessary expertise for reconciliation   If there is no documentation that the medication discrepancies were addressed by the physician/APN/PA, pharmacist, or nurse, select “2.”  Suggested data sources: progress note, patient education/instructions note, medication note, medication reconciliation note |
|  |  | **Discharge Medication Reconciliation** |  |  |
| 7 | dcptmed | At the time of discharge, is there evidence that the physician/APN/PA, pharmacist or nurse obtained information from the patient/caregiver regarding medications the patient was taking prior to admission? | 1,2  If 2, go to dcrxlist | The intent of the question is to provide the organization with one final chance to gather information about the medications the patient was taking at home so they can complete a thorough reconciliation of medications at the time of discharge.  This question applies only when the answer to revptmed is “no.”  Select “1” if:  There is documentation at the time of discharge that the clinical staff reviewed the patient’s list of medications and/or active medication list in the record with the patient/caregiver.  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 “2” if no documentation exists demonstrating a review with the patient/caregiver of the medications taken prior to hospital admission.  **Suggested data sources:** progress note, medication note, medication reconciliation note |

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| 8 | dcdiscrp | At the time of discharge, is there documentation the physician/APN/PA, pharmacist, or nurse identified medication discrepancies?  3. Documented medication discrepancies were identified  4. Documented medication discrepancies were not identified  99. No documentation at the time of discharge regarding medication discrepancies | 3,4,99  If 3 or if idiscrp = 3, go to addmedis,  If 4 or 99, go to dcrxlist | The intent of the question is to determine whether the physician/APN/PA, pharmacist, or nurse documented the presence or absence of medication discrepancies that were identified. This is a result of comparing the patient’s original medication list, the most recent medication list while hospitalized and the discharge medication list.  Select “3” if there is documentation that medication discrepancies were identified. For example, physician notes, “Lisinopril and aspirin added during this hospitalization.”  Documentation by the physician/APN/PA, pharmacist, or nurse that indicates medication discrepancies were identified and addressed is sufficient.  For example, physician notes, “Reviewed medication discrepancies with patient and updated medication list.”  Select “3.”  Documentation that does not indicate medication discrepancies were identified such as “any medication discrepancies were addressed” is NOT acceptable.  Select “4” if there is documentation that medication discrepancies were not identified. For example, pharmacist notes, “No medication discrepancies found.”  Select “99” if there is no documentation regarding the presence or absence of medication discrepancies.  Suggested data sources: progress note, patient education/instructions note, medication note, medication reconciliation note |

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| 9 | addmedis | At the time of discharge, is there documentation the physician/APN/PN, pharmacist, or nurse addressed medication discrepancies?  1. Yes  2. No | 1,2 | The intent of the question is to determine whether the physician/APN/PA, pharmacist, or nurse addressed the medication discrepancies at the time of discharge.  **Select “1” if there is documentation demonstrating that actions were taken to address medication discrepancies. Actions to address medication discrepancies include but are not limited to:**   * updating medication list * discontinuing medications * providing education to patient/caregiver * communicating medication discrepancies to the responsible prescribing provider * referring the patient to another provider with the necessary expertise for reconciliation   If there is no documentation that the medication discrepancies were addressed by the physician/APN/PA, pharmacist, or nurse, select “2.”  Suggested data sources: progress note, patient education/instructions note, medication note, medication reconciliation note |
| 10 | 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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| 11 | medsame | Were the medications listed on the patient’s discharge instructions the same as the medications listed in the discharge summary?  1. Yes  2. No | 1,2 | If the list of medications is the same in the discharge instructions (e.g., physician discharge instructions, pharmacy discharge instructions, or nursing discharge instructions) given to the patient as the discharge summary, 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 |
| 12 | managmed | At the time of discharge, did the physician/APN/PN, pharmacist, or nurse explain the importance of managing medications to the patient/caregiver? | 1,2 | **Examples include but are not limited to:** instructing the patient to give a medication list to his or her other physicians; to update the information when medications are discontinued, doses are changed, or new  medications (including over-the-counter products) are added; to carry medication information at all times in the event of emergency situations  Suggested data sources: discharge instructions, medication reconciliation note |