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| **Enable if catnum = 70** | | | | | |
|  |  | **Inpatient Medication Reconciliation** |  |  | |
| 1 | revptmed1  revptmed2  revptmed3  revptmed4  revptmed5  revptmed6  mrec42 | Upon admission or during the 24 hours after admission, is there evidence in the medical record that a member of the health care team reviewed the patient’s list of medications and/or a medication list for review to include all of the following components with the patient/caregiver?   |  |  | | --- | --- | | **Medication List Component** | 1, 2  If (any revptmed1 – revptmed6 = 1) and dcdispo = 6 or 7, go out of module  If (any revptmed1 – revptmed6 = 1) and dcdispo = 3, 4, or 5, go to trxlist; else if any revptmed = 1, go to dcrxlist  If all revptmed1 – revptmed6 = 2, go to nomedadm | | 1. Local Active VA Prescriptions | 1. Yes 2. No | | 2. Remote Active VA Prescriptions | 1. Yes 2. No | | 3. Non-VA Medications | 1. Yes 2. No | | 4. Recently Expired VA Prescriptions (range 90 – 180 days) | 1. Yes 2. No | | 5. Recently Discontinued VA Prescriptions (range 90 – 180 days) | 1. Yes 2. No | | 6. Pending Medication Orders where relevant (e.g., patient is seen by multiple providers in the same day) | 1. Yes 2. No | | | | **The intent of the question is to determine if the health care team member involved the patient/caregiver in the review of the patient’s list of medications and/or a medication list for review at the time of admission.**  Health care team member may include but is not limited to: physician/ resident/fellow physician/APN/PA,RN, LPN, pharmacist, pharmacy technician or other health care team member who by virtue of educational background AND approved credentialing, privileging, and/or scope of practice, has been determined by the facility to be capable of performing medication reconciliation.  **Emergency Department or Urgent Care Clinic documentation prior to admission is acceptable.**  **A medication list for review (may also be named Essential Medication List for Review) must include:**   * Local Active VA Prescription(s) * Remote Active VA Prescription(s) * Non-VA medication(s) * Recently Expired VA Prescription(s) (range 90-180 days) * Recently Discontinued VA Prescription(s) (range 90-180 days) * Pending Medication Order(s) where relevant (e.g. where patient is being seen by multiple providers in the same day) * The medication list components must be titled as noted above or description must be sufficient to map to component (e.g., Active VA Prescriptions at other VAMCs is sufficient for Remote Active VA Prescriptions). Documentation of recently expired and discontinued medications anytime during a range of 90 – 180 days is acceptable. * In order to select “1”, there **must** be documentation upon admission or during the 24 hours after admission that the clinical staff reviewed the patient’s list of medications and/or a medication list for review **with the patient/caregiver**. * If the documentation does NOT indicate that the patient/caregiver was involved in the review of the medication list, enter“2” for each component. For example, physician noted, “Medication list reviewed. No changes noted.”   Cont’d next page  **Med review cont’d**   * If a medication list component is present and section is blank [e.g., Non-VA medications: (blank)], consider the component was reviewed and enter “1.”   **Note:** For surgical care cases that have surgery on the day of admission, documentation of the patient’s list of medications and/or a medication list for review 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:**  Progress notes include but are not limited to clinical pharmacy note, ED documentation, H&P, intake note, medication reconciliation note, pre-operative anesthesia note, essential medication list for review. | |
| 2 | nomedadm | Upon admission or during the 24 hours after admission, did a member of the health care team document the patient was not taking any medications upon admission?  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 | | **If a health care team member explicitly documents that the patient was not currently taking any medications upon admission, enter value 1.**  Health care team member may include but is not limited to: physician/ resident/fellow physician/APN/PA,RN, LPN, pharmacist, pharmacy technician or other health care team member who by virtue of educational background AND approved credentialing, privileging, and/or scope of practice, has been determined by the facility to be capable of performing medication reconciliation. |

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| 3 | noptlist  mrec42 | 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:**  Progress notes include but are not limited to clinical pharmacy note, ED documentation, H&P, medication reconciliation note, intake note, nursing note pre-operative anesthesia clinic visit note |
| 4 | noptlist2  mrec42 | Upon admission or during the 24 hours after admission, did a member of the health care team 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 documentation by a health care team member 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 in a ‘good faith effort’ to contact the patient’s caregiver is required.**  Health care team member may include but is not limited to: physician/ resident/fellow physician/APN/PA,RN, LPN, pharmacist, pharmacy technician or other health care team member who by virtue of educational background AND approved credentialing, privileging, and/or scope of practice, has been determined by the facility to be capable of performing medication reconciliation.  **ED documentation prior to admission is acceptable.**  **Suggested data sources:**  Progress notes include but are not limited to clinical pharmacy note, ED documentation, H&P, medication reconciliation note, intake note, nursing note, pre-operative anesthesia clinic visit note |

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| 5 | noptlist3  mrec42 | Upon admission or during the 24 hours after admission, did a member of the health care team document at least two attempts to obtain the patient’s medication list from a referring facility?  3. Yes  4. No  5. 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 a member of the health care team 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:**  Progress notes include but are not limited to clinical pharmacy note, ED documentation, H&P, medication reconciliation note, intake note, nursing note, pre-operative anesthesia clinic visit note, interfacility transfer notes, telephone encounter note |
|  |  | **Discharge Medication Reconciliation** |  |  |
| 6 | trxlist | At the time of discharge/transition in care, 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 CPRS.  Methods for transmitting the written list of reconciled medications include, but are not limited to: FedEx, CPRS access.  **Suggested data sources:** Discharge/Transfer summary, Medication Reconciliation note |

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| 7 | dcrxlist  mrec21  mrec34 | 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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| 8 | medsame2  mrec34 | 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 | **For the purposes of this question, it is necessary to compare medications only.** Disregard items such as alcohol pads, syringes, glucometer test strips, etc.  **In order to answer accurately, it is necessary to do a careful and thorough comparison of the medication list in the discharge instructions and the medication list in the discharge summary.**   * **If discharge medications are contained in more than one discharge document (**e.g., physician discharge instructions, pharmacy discharge instructions, nursing discharge instructions, discharge summary)**, the discharge medications list must be the same in all documents in order to select “1.”** * If the discharge medications are not listed in the discharge summary, but there is a reference to the document that contains the information, select “1.” **Example:** In reference to discharge medications the Discharge summary states, “Please see Pharmacy Discharge Instructions” or “Please refer to Nursing Discharge Note.” This is acceptable to select “1.”   \*Note: Discharge instructions and discharge summary/documentation should ALWAYS be accompanied with the discharge medication list when furnished to patients or other health care teams respectively.   * If the discharge medications are not listed on the discharge instructions given to the patient, select “2.” * If the discharge medications in the discharge summary, (or the document that is referenced in the discharge summary), are not the same as the discharge instructions given to the patient, select “2”.   **Suggested data sources:** Discharge summary, Discharge instructions given to the patient, Pharmacy discharge instructions |

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| **Discharge Disposition (DCDISPO: What was the patient’s discharge disposition on the day of discharge?) Reference Information:**  1. Home   * Assisted Living Facilities (ALFs) – includes assisted living care at nursing home/facility * Court/Law Enforcement – includes detention facilities, jails, and prison * Home – includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, and homeless shelters * Home with Home Health Services * Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization   2. Hospice – Home (or other home setting as listed in #1 above)  3. Hospice – Health Care Facility   * General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities   4. Acute Care Facility   * Acute Short Term General and Critical Access Hospitals * Cancer and Children’s Hospitals * Department of Defense and Veteran’s Administration Hospitals   5. Other Health Care Facility   * Extended or Immediate Care Facility (ECF/ICF) * Long Term Acute Care Hospital (LTACH) * Nursing Home or Facility including Veteran’s Administration Nursing Facility * Psychiatric Hospital or Psychiatric Unit of a Hospital * Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital * Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed * Transitional Care Unit (TCU) * Veteran’s Home   6. Expired  7. Left Against Medical Advice/AMA  99. Not documented or unable to determine |