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| **Enable if cohort = 70 and DCDT - ADMDT > 1 day** |
|  |  | **Inpatient Medication Reconciliation** |  |  |
| 1 | emlr | Upon admission or during the 24 hours after admission, is there evidence in the medical record that the prescribing provider’s note included or referenced the Essential Medication List for Review (EMLR) Data Object (DO) for medication reconciliation?1.  Yes2.  No  | 1,2If 1, auto-fill revptmed1 - revptmed6 and revptmed8 = 1; go to revptmed9If 2, go to revptmed1

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| Warning if 1 |

 | The intent of the question is to determine if the facility is utilizing the Essential Medication List for Review (EMLR) Data Object (DO) which is a health summary component enhancement for CPRS used to pull together the components necessary for medication review. The EMLR DO is a complete alphabetical list of the patient’s prescriptions. * Use of the EMLR DO will be recognizable by the codes imbedded:
	+ MRT5 - Allergy Health Summary Component; and
	+ MRR1 - Medication and Supply Health Summary Components (no glossary version) OR
	+ MRT1 - Medication and Supply Health Summary Components (glossary version-preferred for patients).

**NOTE:** Documentation of “Tool 1” or “Tool 5” is NOT acceptable as identifying codes for the EMLR DO. Select “2” (No).* **A prescribing provider is the physician/hospitalist/attending physician/APN/PA responsible for the care of the patient on the inpatient unit.**
* The EMLR Data Object must be imported into the prescribing provider’s note.

**OR** * The note in which the EMLR DO resides must be referenced by the prescribing provider in his/her admission note or progress note during the 24 hours after admission. An addendum to the original note containing the EMLR DO upon admission or during the 24 hours after admission is acceptable.
* If there is documentation of the EMLR DO in a pre-admission H&P (for the current admission) completed within 30 days prior to this admission and the prescribing provider indicates that the EMLR DO was reviewed with the patient/caregiver on admission or within 24 hours after admission and documents there were no changes, or adds any updates to it; this is considered valid documentation for the medication reconciliation.
* If the EMLR DO is used, the Medical Record will include the following introductory paragraph “INCLUDED IN THIS LIST: Alphabetical list of a*ctive outpatient prescriptions dispensed from this VA (local) and dispensed from another VA or DoD facility (remote) as well as inpatient orders (local, pending and active), local clinic medications, locally documented non-VA medications, and local prescriptions that have expired or been discontinued in the past 90 days.*

Use of the EMLR DO by the prescribing provider will result in an auto-fill of yes for the components revptmed1-revptmed6 and revptmed8. **Suggested data sources:**  Progress notes include but are not limited to clinical pharmacy note, ED documentation, EMLR note, H&P, intake note, medication reconciliation note, pre-operative anesthesia note, essential medication list for review note. |

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| 2 | revptmed1revptmed2revptmed3revptmed4revptmed5revptmed6revptmed8revptmed9 | Upon admission or during the 24 hours after admission, is there evidence in the medical record that the prescribing provider’s note included or referenced a medication list for review including the following components?

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| **Medication List Component** | 1, 2If any revptmed1 – revptmed9 = 1, go to ipmedrevIf (all revptmed1 – revptmed9 = 2) and dcdispo = 6 or 7, go out of moduleIf (all revptmed1 – revptmed9 = 2) and dcdispo = 3, 4, or 5, go to trxlist; else if (all revptmed1 – revptmed9 = 2 and dcdispo = 1, 2, or 99, go to dcrxlist |
| 1. 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. Expired VA Prescriptions (see D/D rules) | 1. Yes 2. No |
| 5. Discontinued VA Prescriptions (see D/D rules) | 1. Yes 2. No |
| 6. Pending Medication Orders  | 1. Yes 2. No |
| 8. Inpatient Medications | 1. Yes 2. No |
| 9. Allergies (Remote Facility **AND** Local Facility) | 1. Yes 2. No |

 | **If the facility is not using the EMLR DO, this question is intended to determine if the components of the medication list were presented in the prescribing provider’s admission note.** **Only one note may be considered as the medication list for review.** **An addendum to the original medication review note containing a medication list for review upon admission or during the 24 hours after admission is acceptable.****Acceptable Documentation:** A medication list contained within the prescribing provider’s note; a medication list within another note with documentation by the prescribing provider that it was the list used for review or reviewed with the patient.**Unacceptable Documentation:** A medication list not included in the prescribing provider’s note and **without** documentation that it was used for review.* **A prescribing provider is the physician/hospitalist/attending physician/APN/PA responsible for the care of the patient on the inpatient unit.**
* The medication list for review must be included in the prescribing provider’s note. **OR**
* The note in which the medication list for review resides must be referenced by the prescribing provider in his/her admission note or progress note during the 24 hours after admission.
* If referencing another note, the prescribing provider must also include any modified or newly prescribed patient medications in that note as well.

**Examples:** * + The nurse imports the list of medication components into her note. The provider states “essential medication list for review contained within Nurse Note dated 03/20/2020 @ 11:00AM was reviewed with the patient/care giver. All outpatient medications will be continued as inpatient except OPT AMLODIPINE BESYLATE 5MG TAB BY MOUTH DAILY FOR HEART/BLOOD PRESSURE; Will prescribe LOPRESSOR 50MG, ONE TAB MOUTH DAILY FOR HEART/BLOOD PRESSURE
	+ A medication list for review is generated prior to admission in a setting from which the patient is intended to be admitted (e.g., ED, Urgent Care, Outpatient Clinic, Observation). The prescribing provider documents in the admission note, e.g., “The patient was seen in the ED and the medication list for review was completed. No changes were made.”
* If there is documentation of the components of the medication list for review in a pre-admission H&P (for the current admission) completed within 30 days prior to this admission and the prescribing provider indicates that medication list was reviewed on admission or within 24 hours after admission and documents there were no changes, or adds any updates to it; this is considered valid documentation for the medication reconciliation
* **In order to select “yes” for revptmed9, both Remote Facility AND Local Facility Patient Allergies must be documented**.
* **If the site is using their own template,** there must be at least one allergy listed or an indication that the patient has no known drug allergies (NKDA) for the Remote and Local Facility. At a minimum the documentation should read: **Allergies: Remote Facility - NKDA AND Local Facility – NKDA.**
* **If the site is using the EMLR DO,** the Allergy Health Summary Component - MRT5 should include Local and Remote VA Allergies and Adverse Drug Reactions (ADRs). If the MRT5 indicates “No Records Found” or “No Data Found” or a warning that data is not available for “Local Allergies”; then at least Local allergies must be addressed separately within the same note as the medication list for review (e.g., patient states he is allergic to Penicillin or has no known drug allergies, etc.).
* The EMLR DO has specific coding designed to report the reasons for the absence of remote allergies or remote medications data,
* WARNING: Remote Data from HDR not available
* WARNING: Connection to Remote Data Currently Down
* WARNING: Connection to Remote Data Not Available
* "No Remote Allergy/ADR Data available for this patient"
* If any of these alerts appear, Remote allergies have been addressed. Local allergies must still be addressed separately.

**The medication list for review includes:*** **Active VA Prescription(s)** *from the local VAMC which generates the list*
* **Remote Active VA Prescription(s)** *from another VAMC or DoD facility.* (Documentation that “Remote Data Down” is acceptable to answer “1” for this component).
* **Non-VA medication(s)** - *not dispensed/administered by the VA and documented in non-VA medication list*
* **Expired VA Prescription(s):**
	+ Must include prescriptions that have expired in the last 90 days.
	+ May include prescriptions that have expired in the last 180 days.
	+ MUST NOT include prescriptions that expired greater than 180 days (e.g., expired VA prescriptions in the last 210 days). \*Sites using objects pulling “MRP – Medication Reconciliation” or “Other meds dispensed in last year” are exempt from this rule.
* **Discontinued VA Prescription(s):**
	+ Must include prescriptions that have been discontinued in the last 90 days.
	+ May include prescriptions that have been discontinued in the last 180 days.
	+ MUST NOT include prescriptions that were discontinued greater than 180 days (e.g., discontinued VA prescriptions in the last 210 days). \*Sites using objects pulling “MRP – Medication Reconciliation” or “Other meds dispensed in last year” are exempt from this rule.
* **Pending Medication Order(s)**
* **Inpatient Medication(s)**
* **Allergies (Remote Facility and Local Facility)**

**If the facility has developed a template/logic that allows the essential components of the medication list for review to be automatically generated in a progress note, a paragraph preceding the list (similar to the EMLR DO introductory paragraph above) may be used to identify which medication components were included for review.** * **Example:** *A list of active outpatient prescriptions dispensed from this local VA and dispensed remotely from another VA or DoD facility as well as local, pending and active inpatient orders, local clinic medications, locally documented non-VA medications, and local prescriptions that have expired or been discontinued in the past 90 days has been generated below. If the list for review does not include a component, then it was not applicable to this patient.*

**If the medication list for review does not include a component and the component is listed in a statement preceding the medication list for review, select “1” for the component.** **Examples:** * The patient’s active, pending, non-VA, and remote medications as well as prescriptions that have been expired or discontinued in the past 6 months were: [list of medications documented]. There are no remote medications in the medication list; but you may select “1” for Remote Medications as it was noted above the medication list.
* On admission there were no inpatient medications at that time but if Inpatient Medications are listed in the statement preceding the medication list for review select “1” for Inpatient Medications.

**Suggested data sources:**  Progress notes including but not limited to clinical pharmacy note, EMLR note, H&P, intake note, medication reconciliation note, pre-operative anesthesia note |

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| 3 | ipmedrev | Upon admission or during the 24 hours after admission, is there documentation the available medication list components were reviewed with the patient/caregiver?3. Yes4. No: There is no documentation that the available essential medication list components were reviewed with the patient/caregiver5. Documentation the patient/caregiver refused or was unable to participate in review of essential medication list components | 3,4,5If dcdispo = 6 or 7, go out of moduleIf dcdispo = 3, 4, or 5, go to trxlist; else go to dcrxlist | * If there is documentation that the health care team member reviewed the available medication list components **with the patient/caregiver**, select “3”.
* Documentation may be in the same note as the medication list for review; the EMLR DO, or in a separate note.
* If the documentation does NOT indicate that the patient/caregiver was involved in the review of the medication list, select “4.” For example, physician noted, “Medication list reviewed. No changes noted.”
* If there is documentation that the patient and/or caregiver refused or was unable to participate in review of the medication list components, select “5.” For example, physician notes, “Patient is obtunded and cannot confirm medications.”

**Suggested data sources:**  Progress notes (clinic notes), clinical pharmacy notes, EMLR note, medication reconciliation notes, telephone encounter notes |
|  |  | **Discharge Medication Reconciliation** |  |  |
| 4 | 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. Yes2. No3. Documented medications were not prescribed at discharge | 1,2,3If 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 |
| 5 | 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. Yes2. No3. Documented medications were not prescribed at discharge | 1,2,3If 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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| 6 | medsame2 | Were the medications listed on the patient’s discharge instructions the same as the medications listed in the discharge summary?1. Yes2. 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,** **all discharge documentation with medications included need to be reviewed.  If it states the list was discussed with and/or given to the patient/caregiver then it must match the discharge summary.** **It is necessary to do a careful and thorough comparison of the medication list in the discharge instructions given to the patient 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 but not limited to: Inpatient Rehabilitation Facility/Hospital, Rehabilitation Unit of a Hospital , Chemical Dependency/Alcohol Rehabilitation Facility
* Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
* Transitional Care Unit (TCU)
* Veteran’s Home

6. Expired7. Left Against Medical Advice/AMA99. Not documented or unable to determine |