|  |
| --- |
| **Enable if cohort = 70 and DCDT - ADMDT > 1 day** |
|  |  | **Inpatient Medication Reconciliation** |  |  |
| 1 | revptmed1revptmed2revptmed3revptmed4revptmed5revptmed6revptmed8revptmed9 | Upon admission or during the 24 hours after admission, is there evidence in the medical record of a medication list for review note related to the admission that included all of the following components?

|  |  |
| --- | --- |
| **Medication List Component** | 1, 2If any revptmed1 – revptmed9 = 1, go to ipmedrev; else If (all revptmed1 – revptmed9 = 2) and dcdispo = 1, 2, or 99, go to dcrxlist; else go to end |
| 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. Any Pending Medication Orders  | 1. Yes 2. No |
| 8. Inpatient Medications | 1. Yes 2. No |
| 9. Allergies (both Remote Facility **AND** Local Facility) | 1. Yes 2. No |

  | **This question is intended to determine if all of the components of the medication list for review, including remote and local facility allergies, were presented in an admission note upon admission or within 24 hours after admission.** * **Only one note may be considered as the medication list for review.**
* Any health care team member can document the note containing the medication list and document that the list was reviewed. If multiple notes contain medication lists, look for the list that is most complete (i.e., contains the greatest number of medication list components).

**Acceptable Documentation:** * A provider or other team member’s progress note, or separate progress note solely generated for medication reconciliation (e.g., any medication list developed by the facility that contains all of the components for review).
* Essential Medication List for Review (EMLR) Data Object (DO); an alphabetical list of the patient’s prescriptions often found with MRT1, MRR1, or tool 1 and MRT5 or tool 5 (allergy health summary component) prior to the list.
* An addendum to a note containing a medication list for review upon admission or during the 24 hours after admission.
* Documentation of the components of the medication list 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 documents updates.

**Example of Acceptable Documentation**: 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). A 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.” **Cont’d next page****The medication list 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, but MUST not include prescriptions expired more than 180 days.
* **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 but MUST not include prescriptions expired more than 180 days.
* **Any Pending Medication Order(s)**
* **Inpatient Medication(s**)**:** as available/relevant at the time the inpatient medication list is generated.
* **Allergies (Remote Facility AND Local Facility)**
	+ In order to select “yes” for revptmed9, both Remote Facility AND Local Facility Patient Allergies must be documented.
	+ To select value “1” or “yes” for No known Drug Allergies (NKDA), minimum documentation should read: Allergies: Remote Facility - NKDA AND Local Facility – NKDA.

**Cont’d next page*** + If the site is using the EMLR DO, and the MRT5 or tool 5 indicates “No Records Found” or “No Data Found” or a WARNING (e.g., Remote Data from HDR not available; Connection to Remote Data Currently Down/Data Not Available; No Remote Allergy/ADR Data available for this patient), Remote Allergies have been addressed. Local Allergies must still be addressed separately.

**Additional Guidance**:* If the facility has developed a template/logic to capture the components of the medication list to be automatically generated in a progress note, a paragraph preceding the list may be used to identify which medication components were included for review. Medications from each component must be listed within the progress note either directly or via notation in a preceding paragraph.
* **If the medication list does not include a component and the component is listed in a statement preceding the medication list, select value “1” for the component.**

**Example** **of preceding paragraph:** *A list of active outpatient prescriptions dispensed from this local VA and dispensed remotely from another VA or DoD facility as well as any pending medication 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.* * For example, 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 value “1” for inpatient medications.
* **If there is not a proceeding statement or paragraph, each component must be included to select value “1”**
* **Example of no preceding paragraph**: The most complete list presented in an admission note with no preceding paragraph

**Cont’d next page**documented lists the patient’s active prescriptions, remote VA medications, non-VA medications, and pending medication orders. Based on this documentation, select value “1” for active and remote prescriptions, non-VA medications, and pending medication orders. Select value “2” for those not documented in the note (i.e., allergies (Remote Facility AND Local Facility), expired and discontinued prescriptions). **Suggested data sources:**  Progress notes including but not limited to clinical pharmacy note, EMLR DO note, H&P, intake note, medication reconciliation note, pre-operative anesthesia note |
| 2 | 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 = 1, 2, or 99, go to dcrxlist, else go to end  | * 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 DO note, medication reconciliation notes, telephone encounter notes |
|  |  | **Discharge Medication Reconciliation** |  |  |
| 3 | dcrxlist  | At the time of discharge, is there documentation that a written list of 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 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 4 | 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 |