1. **What is the definition of a high-risk patient?**
   a. Patient populations vary amongst hospitals; therefore, it is the intent to allow each hospital to develop criteria for high-risk patients analogous to the requirements for determining which drugs are high-alert.
   b. Criteria for high-risk patients shall be developed by pharmacists in collaboration with physicians, nurses, and executive management.
   c. Hospitals may consider 30-day readmission data, current literature, key diagnoses (e.g. CHF, Transplant, COPD), number of prescriptions, and categories of prescription medications (e.g. anticoagulants, immunosuppression) when identifying high-risk patient populations.
   d. It is highly recommended that the criteria developed by each institution be approved by the Pharmacy and Therapeutics Committee and/or Medication Safety Committee.
   e. Preliminary criteria of high-risk patients may start with limited populations based on current hospital data and the addition of further criteria may be considered in the future based on their experience.

2. **What is the timeframe for obtaining a list relative to the admission?**
   a. Each hospital shall determine a reasonable timeframe in which a medication history must be obtained.
   b. Hospitals may define circumstances in which additional time is allotted to obtain the list. For example, for patients who are medically unstable, have cognitive impairment and where family and/or caregivers are not available or unable to provide the patient’s medication history, up to 72 hours may be needed to obtain the list.
   c. In situations when the medication list cannot be obtained due to the patient’s condition, cognitive impairment, lack of medication information or patient refusal, the PTA medication list may be documented as “unable to assess.”

3. **What is meant by obtaining an accurate medication list?**
   a. Obtaining an accurate medication list is determining what medications (prescription and non-prescription) the patient is currently taking including dose, frequency and route if the patient/caregiver is able to provide this information.
   b. Additional sources of information that can be used, if available, include a medication list brought in by the patient/family/caregiver, the medication list from the last patient encounter in the electronic medical record, the patient’s physician’s office, electronic prescription data or the patient’s pharmacy.
   c. A best possible medication list obtained using this approach would be considered an accurate medication list since it is based on the information available at the time.
   d. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the Elements of Performance for NPSG.03.06.01.

4. **What happens if a medication error and/or discrepancy results from the medication list?**
   If an error or discrepancy results from the medication list, the existing hospital policy on how to manage medication errors would be followed. This situation would be no different than the current situation since each physician or allied health professional and pharmacist is responsible for
determining if medications listed are appropriate for ordering during the inpatient admission based on patient-specific conditions, diseases, concomitant drugs, etc.

5. **How are technicians trained?**
   a. An established procedure for training and proctoring pharmacy technicians and/or intern pharmacists will be implemented by the hospital pharmacy department.
   b. A standard process to train staff and evaluate competency may include the following elements:
      i. Training manual
      ii. Competency examination
      iii. Proctoring and observation of technicians obtaining medication lists

6. **How often should quality assurance be performed?**
   Each hospital will develop a routine quality assurance program to ensure ongoing competency of staff.

7. **Are medication histories obtained by technician signed by pharmacists?**
   Medication histories or profiles may be transcribed by technicians into the medical record. Note that these lists are not orders until such time that the physician orders the medication. If the medications are ordered during the inpatient admissions, the pharmacist is responsible for reviewing and verifying the orders.

8. **How are interns (pharmacy students) trained?**
   Intern pharmacists are trained to obtain medication histories under the supervision of a pharmacist.

9. **B&P Code § 4118.5(a) indicates the medication profile or list be obtained for high high-risk patients under certain conditions, one of them being “the hospital has more than 100 beds.”** Since “hospital” is not defined or referenced in B&P Code § 4118.5(a), is the definition subject to interpretation and if so, what is the regulatory stance? For the purposes of B&P Code § 4118.5(a), would it be acceptable for organizations to use the definition of “hospital” as defined in California H&S Code § 1250(a)?
   California H&S Code §1250(a) code to define “hospital.” See link for legislative language. [https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1250.&lawCode=HS](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1250.&lawCode=HS)

10. **B&P Code § 4118.5(a) uses the word “admission” but does not define “admission.”** Seeking regulatory stance or interpretation for the word “admission” in the context of B&P Code § 4118.5(a). Per the Code, would a medication profile or list for high-risk patients be required for patients in Observation Status?
    The intended definition of admission is for high-risk patients who are admitted as inpatients; therefore, observation patients should be excluded.