Group	Intervention	Time	Dollar	Definition	Examples
Ambulatory Care	Added Drug Therapy	20	75	•When unmet healthcare need is addressed by pharmacist.	**Examples:** pharmacist identifies that additional medication for diabetes should be added due to poor glycemic control, add statin after MI, ACEI in CHF, etc.
Ambulatory Care	ADE Prevention-Major	30	2200	•Prevention of an ADE that would likely have been serious and resulted in an increased LOS. •Changes in therapy occurred as a result of clinical skills and not just a computer notice (i.e. duplicate therapy, allergy, or drug interaction notice).	**1)** A Category X medication is ordered for a pregnant patient (this kind of warning does not appear during order entry). **2)** Drug interactions preventing severe adverse reactions such as QT prolongation, seizures, etc. **3)** Discontinuing sleeper agents ordered for patients with respiratory issues. **4)** Dose change based on indication, i.e., Xarelto has different doses depending on the indication. **5)** High dose opioid ordered for an opioid naïve patient.
Ambulatory Care	ADE Prevention-Minor	15	220	A pharmacist prevents a MINOR medication error as part of clinical review or patient care.	**1)** Drug Interactions discovered that could have had non-fatal, non-severe consequences. **2)** Discontinuation of a medication which is found not to be necessary decreasing the potential for side effects. **3)** Increase in a lab value soon after starting a new medication which was then discontinued as a result of a pharmacist intervention.
Ambulatory Care	Chart Review	10	0	•A medication-oriented chart review that did not result in specific interventions, changes, or recommendations. •An intervention resulting from a chart review will be recorded in the appropriate CI category.	
Ambulatory Care	Discontinue Therapy	30	90	•A pharmacist reviews and appropriately discontinues a therapy	Patient is on therapy that is not necessary or not appropriate for patient and is discontinued due to pharmacist intervention.
Ambulatory Care	Dose Optimization	15	112	•A dose adjustment made by pharmacy based on patient-specific evaluation of clearance, such as renal or hepatic function. •The reason for the dose change is to improve efficacy and/or to avoid toxicity. May be a recommendation for dose adjustment or a protocol-driven adjustment per pharmacy. •Requires gathering and evaluating patient-specific clinical information.	Pharmacist recommends or adjusts (per collaborative practice protocol) the dose of blood pressure med for better hypertension control or to reduce hypotension.
Ambulatory Care	Drug Optimization	15	220	Optimizing drug selection for a patient to avoid drug-drug interactions, reduce pill burden, change to generic product, change to different class of medication, etc. in the ambulatory environment	1) Pharmacist recommends changing to combination med to prevent patient from paying 2 copays and taking extra doses. 2) Recommend changing diabetic agents due to better Hgb A1C reduction and more in line with guidelines.
Ambulatory Care	Immunization Indicated	20	75	Recommending or ordering a necessary immunization based upon patient status	Recommend Prevnar/Pneumovax as appropriate
Ambulatory Care	Lab Test Ordered	20	75	Ordering a new or repeat lab test to monitor therapy or assess efficacy	Recommend/Order Hgb A1C for diabetic patient per guidelines/protocol
Ambulatory Care	Med Rec - Outpatient	20	75	Performing medication reconciliation in a clinic setting	
Ambulatory Care	Medication Assistance Enrollment	30	0	•Pharmacy staff coordinates patient assistance programs, enrolls patients in industry programs for copay reduction or starter medication, enrolls patients in REMS required programs	
Ambulatory Care	Medication History Obtained	30	642	•Captures work effort where pharmacist or pharmacy technician collects the official medication history and documents the history in the permanent medical record. •Medication History does not need to include "Reconciliation" of Home Meds. Pharmacists should document "Reconciliation" in other categories as appropriate. •Medication History may occur at any point during the patient stay.	
Ambulatory Care	Patient Education	30	208	A significant contribution to patient, family, and/or caregiver teaching about medications.	
Ambulatory Care	Prescription Coordination	30	0	Facilitating and ensuring medication availability and compliance on the ambulatory side.	

Group	Intervention	Time	Dollar	Definition	Examples
Anticoagulation	Added Drug Therapy	20	75	•When unmet healthcare need is addressed by pharmacist	Pharmacist adds Vitamin K therapy for patient who meets criteria. Pharmacist recommends starting an anticoagulant for patient who is at high risk for stroke, etc.
Anticoagulation	ADE Prevention-Major	30	2200	•Prevention of an ADE that would likely have been serious and resulted in an increased LOS. •Changes in therapy occurred as a result of clinical skills and not just a computer notice (i.e. duplicate therapy, allergy, or drug interaction notice).	Drug interaction prevented or dosing adjustment made that if not changed could have resulted in severe adverse reactions bleed, coagulopathy, stroke, etc.
Anticoagulation	ADE Prevention-Minor	15	220	•A pharmacist prevents a MINOR medication error as part of clinical review or patient care.	Change in dose, drug, frequency etc. that prevented a less severe complication such as minor bleeding, or other minor side effect.
Anticoagulation	Discontinue Therapy	30	90	•A pharmacist reviews and appropriately discontinues a therapy	
Anticoagulation	Dose optimization	15	112	•A dose adjustment made by pharmacy •The reason for the dose change is to improve efficacy and/or to avoid toxicity. May be a recommendation for dose adjustment or a protocol-driven adjustment per pharmacy. •Requires gathering and evaluating patient-specific clinical information. •There may be multiple dose adjustments throughout a patient's stay, so this category may be used more than once per patient.	lovenox, rivaroxaban, apixiban, etc. dosing changes
Anticoagulation	Drug Optimization	15	112	•An anticoagulant drug change recommended or made by pharmacy based on avoidance of drug interactions, or more appropriate therapy for the patient.	recommend changing from lovenox to heparin due to renal failure.
Anticoagulation	DVT Prophylaxis indicated	30	640	•Initiation of anticoagulant therapy by pharmacist in a patient at risk for a DVT.	Pharmacist recommends adding DVT prophylaxis
Anticoagulation	Lab Test ordered	30	90	•A pharmacist reviews and appropriately orders a lab	INR, SCr, Hgb/Hct, etc ordered for anticoag monitoring
Anticoagulation	Monitoring Therapy	15	0	•Pharmacist routinely managing and dosing patient's anticoagulant therapy. •May be documented daily •No change in therapy needed to document this, provided a pharmacist is managing consult, reviewing medication list and labs, and writes a note in the chart.	pharmacist reviews and double checks appropriateness of rivaroxaban dosing. May or may not make changes to therapy as a result.
Anticoagulation	Patient Education	30	208	A significant contribution to patient, family, and/or caregiver teaching about anticoagulant medications.	rivaroxaban education provided to patient or caregiver.

Group	Intervention	Time	Dollar	Definition	Examples
Antimicrobial Stewardship	Antibiotic Timeout Review	20	0	•An antimicrobial-oriented chart review that is used to satisfy regulatory requirements of reviewing therapy at facility defined intervals.	
Antimicrobial Stewardship	De-escalation (narrow therapy)	30	90	•After review of culture and sensitivities, an antibiotic with more appropriate spectrum is recommended	**1)** Patient started empirically on levofloxacin for UTI. Culture reveals a pan sensitive E. coli, patient is switched to amoxicillin. **2)** Patient started empirically on Zosyn, Levaquin and vancomycin for HCAP. Culture reveals Pseudomonas aeruginosa, recommend piperacillin or cefepine monotherapy at high doses.
Antimicrobial Stewardship	Discontinue Therapy	30	90	•A pharmacist reviews and appropriately discontinues a therapy	
Antimicrobial Stewardship	Dose optimization	15	112	•A dose adjustment made by pharmacy based on patient-specific evaluation of clearance, such as renal or hepatic function. •The reason for the dose change is to improve efficacy and/or to avoid toxicity. May be a recommendation for dose adjustment or a protocol-driven adjustment per pharmacy. •Requires gathering and evaluating patient-specific clinical information. •There may be multiple dose adjustments throughout a patient's stay, so this category may be used more than	**Examples**: Acyclovir, allopurinol, ampicillin, ampicillin/sulbactam, cefazolin, cefepime, cefoxitin, ceftazadime, fluconazole, levofloxacin, meropenem, metronidazole, pip/tazo, etc.
Antimicrobial Stewardship	Drug Optimization	30	90	•Pharmacist works to optimize antibiotic agent selection appropriate for the patient condition.	**1)** Diabetic patient is started on empiric Vancomycin for suspected staph aureus blood stream infection. The final culture results reveal MSSA and the pharmacist recommends a change to Nafcillin or Ancef to optimize drug therapy. **2)** Patient is being treated with Vancomycin for MRSA bacteremia and the patient's symptoms (fevers, WBC, etc.) have worsened. The pharmacist recommends a change to daptomycin due to the patient's lack of improvement on Vancomycin. **3)** Patient is admitted with suspected pneumonia and is started on empiric Rocephin + Zithromax. Upon review of the patient's history the pharmacist discovers that the patient was admitted from a nursing home and has a history of Pseudomonal pneumonia. Pharmacist recommends change in therapy to an agent cover healthcare acquired pathogens (meropenem, pip/tazo, etc.).
Antimicrobial Stewardship	Initiate Therapy (Broaden coverage)	30	90	Recognition and ordering of different antibiotic therapy based upon the patients need or worsening indication	Patient who is on Cefazolin, receives a positive C/S for MRSA and pharmacist appropirately recommends starting MRSA coverage with Vancomycin (coverage is broadened).
Antimicrobial Stewardship	Lab Test ordered	30	90	Recognizing and ordering a lab test for monitoring of efficacy or some other need related to antibiotic therapy	Pharmacist recommends or orders monitoring labs (SCr, etc.) or other lab/diagnostic test due to clinical situation and/or drug therapy.
Antimicrobial Stewardship	Penicillin Allergy Skin Testing	90	265	•Pharmacist performs penicillin allergy skin testing	**1)** Patient has stated allergy to penicillin. Pharmacist performs skin test to assess penicillin-based therapy.

Group	Intervention	Time	Dollar	Definition	Examples
Chart-Order Review	Added Drug Therapy	20	75	•When unmet healthcare need is addressed by pharmacist	pharmacist recommends starting a drug therapy to improve patient care
Chart-Order Review	ADE Prevention-Major	30	2200	•Prevention of an ADE that would likely have been serious and resulted in an increased LOS. •Changes in therapy occurred as a result of clinical skills and not just a computer notice (i.e. duplicate therapy, allergy, or drug interaction notice).	**1)** A Category X medication is ordered for a pregnant patient (this kind of warning does not appear during order entry). **2)** Drug interactions preventing severe adverse reactions such as QT prolongation, seizures, etc. **3)** Discontinuing sleeper agents ordered for patients with respiratory issues. **4)** Dose change based on indication, i.e., Xarelto has different doses depending on the indication. **5)** High dose opioid ordered for an opioid naïve patient.
Chart-Order Review	ADE Prevention-Minor	15	220	•A pharmacist prevents a MINOR medication error as part of clinical review or patient care.	**1)** On scheduled electrolyte replacement with no levels ordered for several days. **2)** Discontinuation of a medication which is found not to be necessary decreasing the potential for side effects. **3)** Increase in a lab value soon after starting a new medication which was then discontinued as a result of a pharmacist intervention.
Chart-Order Review	Chart Review	10	0	•A medication-oriented chart review that did not result in specific interventions, changes, or recommendations. •An intervention resulting from a chart review will be recorded in the appropriate CI category.	
Chart-Order Review	Clarify Drug Order	10	0	•Used to clarify allergy reactions, dosage clarifications, abbreviation clarifications, formulary conversions that are not auto substituted.	**1)** You receive an order for Percocet, and an allergy alert to oxycodone appears. You clarify with the patient that the "allergy" is only an upset stomach. **2)** MD orders to restart all home meds on same doses, you clarify with the patient/family/pharmacy what the meds and doses were at home and write the clarification. **3)** An order for Flovent is missing the strength, so you clarify the strength with the patient/physician. **4)** You have a new attending physician who orders Xopenex for his patient not knowing that albuterol is what you have on formulary and the patient has no contraindications, so you call the physician to get the order changed to albuterol.
Chart-Order Review	Discontinue Therapy	30	90	•A pharmacist reviews and appropriately discontinues a therapy	Pharmacist recommends stopping a drug therapy that is reduntant or not indicated based on the patients problem list/condition.
Chart-Order Review	Dose optimization	15	112	•A dose adjustment made by pharmacy based on patient-specific evaluation of clearance, such as renal or hepatic function. •The reason for the dose change is to improve efficacy and/or to avoid toxicity. May be a recommendation for dose adjustment or a protocol-driven adjustment per pharmacy. •Requires gathering and evaluating patient-specific clinical information. •There may be multiple dose adjustments throughout a patient's stay, so this category may be used more than	**Examples**: Acyclovir, allopurinol, ampicillin, ampicillin/sulbactam, cefazolin, cefepime, cefoxitin, ceftazadime, digoxin, dofetilide, enoxaparin, fluconazole, levofloxacin, meperidine, meropenem, metformin, metronidazole, nitroprusside, pip/tazo, procainamide, quinidine
Chart-Order Review	Drug Optimization	20	75	Pharmacist recommends changing to a different medication due to patient specific variables, or to better follow clinical practice guidelines.	Patient with heart failure receiving Atenolol and pharmacist appropriately recommends changing therapy to Metoprolol SR.
Chart-Order Review	DVT Prophylaxis indicated	30	640	•Initiation of anticoagulant therapy by pharmacist in a patient at risk for a DVT.	
Chart-Order Review	Renal Dosing Protocol Adjustmemt	15	112	•A dose adjustment made by pharmacy based on patient-specific evaluation of renal function. The reason for the dose change is to improve efficacy and/or to avoid toxicity. May be a recommendation for dose adjustment or a protocol-driven adjustment per pharmacy. • Requires gathering and evaluating patient-specific clinical information. There may be multiple dose adjustments throughout a patient's stay, so this category may be used more than once per patient.	**Examples**: Acyclovir, allopurinol, ampicillin, ampicillin/sulbactam, cefazolin, cefepime, cefoxitin, ceftazadime, digoxin, dofetilide, enoxaparin, fluconazole, levofloxacin, meperidine, meropenem, metformin, metronidazole, nitroprusside, pip/tazo, procainamide, quinidine
Chart-Order Review	Stress Ulcer Prophylaxis Added	20	800	•Initiation of therapy by pharmacist. Includes H2 Blocker or PPI therapy initiated for specific patients at risk for stress ulcers.	
Chart-Order Review	Stress Ulcer Prophylaxis D/C'D	15	94	•A pharmacist review of the patient medication profile and diet orders for non-ICU patients to determine if stress ulcer prophylaxis is no longer needed. If a patient does not meet the criteria for requiring stress ulcer prophylaxis, the pharmacist may recommend discontinuation of the therapy.	Pharmacist reviews patient criteria and determines that PPI therapy is not indicated for SUP or any other indication. Leaves recommendation for provider or discontinues per facility approved protocol.

Group	Intervention	Time	Dollar	Definition	Examples
Chemotherapy	ADE Prevention-Major	30	2200	•Prevention of an ADE that would likely have been serious and resulted in an increased LOS. •Changes in therapy occurred as a result of clinical skills and not just a computer notice (i.e. duplicate therapy, allergy, or drug interaction notice).	Pharmacist catches chemotherpy dosing error that could have led to major toxicity.
Chemotherapy	ADE Prevention-Minor	15	220	•A pharmacist prevents a MINOR medication error as part of clinical review or patient care.	Pharmacist intervenes due to abnormal labs or drug-drug interaction, etc. that could have lead to less severe adverse event for the patient.
Chemotherapy	Chemotherapy Order Review	20	270	•Used when chemotherapy order is received and reviewed for protocol, accuracy of doses, organ dysfunction, BSA calculation, hydration, lifetime doses. •Additional categories should be utilized when interventions are made (e.g. antiemetics ordered as a result of this review.)	
Chemotherapy	Consult Antiemetic Therapy Dose & Monitor	15	52	•For initial review or ordering of antiemetics for a chemotherapy patient; or, •May be used for review of physician-ordered antiemetics and recommendations for changes; or, •Antiemetic therapy follow-up.	
Chemotherapy	Dose Optimization	15	112	•A dose adjustment made by pharmacy based on patient-specific evaluation of clearance, such as renal or hepatic function. •The reason for the dose change is to improve efficacy and/or to avoid toxicity. May be a recommendation for dose adjustment or a protocol-driven adjustment per pharmacy. •Requires gathering and evaluating patient-specific clinical information. •There may be multiple dose adjustments throughout a patient's stay, so this category may be used more than once per patient.	Pharmacist recommends change in chemotherapy dosing due to patient diagnosis, clinical situation, or lab/clearance factors. Could also be a dose optimization due to rounding to whole vial size and preventing inappropriate drug waste.
Chemotherapy	Drug Optimization	20	75	Pharmacist recommends changing to a different medication due to patient specific variables, or to better follow clinical practice guidelines.	Change or addition to chemo therapy recommendation based on clinical review of the patient, diagnosis, etc.
Chemotherapy	Patient Education	60	1300	•Chemotherapy Teaching using checklist or similar supporting method: A significant contribution to patient, family, and/or caregiver teaching about inpatient and/or discharge medications.	
Chemotherapy	Rasburicase Fixed Dose	20	5051	•Rasburicase is indicated for initial management of plasma uric acid (UA) levels in pediatric and adult patients with leukemia, lymphoma, and solid tumor malignancies who are receiving anti-cancer therapy expected to result in tumor lysis and subsequent elevation of plasma uric acid. •Standard dosing is 0.2 mg/kg. Alternative dosing 4.5 mg or fixed dose of Rasbuicase has been studied.	
Chemotherapy	Rasburicase Reduced Weight-based Dose	20	2165	•Another option is a single dose of 0.15mg/kg for the therapeutic use of Rasburicase (versus standard dosing 0.2mg/kg). Studies have shown that lower weight-based dosing and single doses of Rasburicase versus daily dosing for 5 days is effective for prevention and management of uric acid levels in adult patients with or at risk for tumor lysis syndrome.	

Group	Intervention	Time	Dollar	Definition	Examples
CHI Initatives	Avoid/Discontinue General-Agent Not Listed	20	0	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	
CHI Initatives	Avoid/Discontinue 4-Factor PCC (Kcentra)	30	2265	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	**1)** A pharmacist recommends alternative therapy in place of Kcentra during a non-life-threatening hemorrhage or INR reversal prior to procedure. Elevated INR may or may not be associated with vitamin K antagonist therapy. **2)** A pharmacist receives an order for Kcentra to reverse INR for a planned procedure ≥ 6 hours in the future in a patient who is able to receive 10-15 ml/kg of fresh frozen plasma (FFP). The pharmacist recommends FFP. **3)** A physician writes an order for KCentra in a patient with a GI bleed on Plavix and aspirin. The pharmacist recommends platelets be used, as the patient is not currently taking an anticoagulant which would inhibit clotting factors. **4)** A PA-C orders KCentra in a patient with an INR of 1.2. The pharmacist recommends alternative treatment, as KCentra has little utility in patients with subtherapeutic INRs.
CHI Initatives	Avoid/Discontinue Acetaminophen IV (Ofirmev)-MUE	20	24	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	Pharmacist contacts provider and prevents Ofirmev/IV Acetaminophen order from being started. Provider instead orders oral, or rectal acetaminophen or other agent.
CHI Initatives	Avoid/Discontinue Alvimopan (Entereg)-MUE	20	264	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	
CHI Initatives	Avoid/Discontinue Calcitonin (Miacalcin)-MUE	20	4222	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	
CHI Initatives	Avoid/Discontinue Cangrelor (Kangreal)-MUE	20	693	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	
CHI Initatives	Avoid/Discontinue Dexmedetomidine (Precedex)	20	8	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	
CHI Initatives	Avoid/Discontinue Epoetin alpha	20	507	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	
CHI Initatives	Avoid/Discontinue Ertapenem (Invanz)-MUE	20	100	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	
CHI Initatives	Avoid/Discontinue Leuprorelin (Lupron Depot) 22.5mg	20	3699	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	
CHI Initatives	Avoid/Discontinue leuprorelin (Lupron Depot) 7.5mg	20	1133	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	
CHI Initatives	Avoid/Discontinue Pegfilgrastim (Neulasta) 6 mg	20	4669	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	
CHI Initatives	Avoid/Discontinue Regadenoson (Lexiscan)-MUE	20	199	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	
CHI Initatives	Avoid/Discontinue Sugammadex (Bridion)-MUE	20	88	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	
CHI Initatives	Avoid/Discontinue TPN	20	350	•Pharmacist reviews a medication profile or ordered therapy for patient and makes a recommendation to hold, stop, or replace an expensive or inappropriate therapy.	

Group	Intervention	Time	Dollar	Definition	Examples
Core Measure Review	Acute MI Measures Review	15	0	Used for pharmacist documentation of review of Core Measure criteria according to CMS guidelines and facility defined process	
Core Measure Review	Heart Failure Measures Review	15	0	Used for pharmacist documentation of review of Core Measure criteria according to CMS guidelines and facility defined process	
Core Measure Review	Pneumonia Measures Review	15	0	Used for pharmacist documentation of review of Core Measure criteria according to CMS guidelines and facility defined process	
Core Measure Review	Sepsis Measures Review	15	0	Used for pharmacist documentation of review of Core Measure criteria according to CMS guidelines and facility defined process	
Core Measure Review	Stroke Measures Review	15	0	Used for pharmacist documentation of review of Core Measure criteria according to CMS guidelines and facility defined process	
Core Measure Review	Vaccination Measures Review	15	0	Used for pharmacist documentation of review of Core Measure criteria according to CMS guidelines and facility defined process	
Core Measure Review	VTE Measures Review	15	0	Used for pharmacist documentation of review of Core Measure criteria according to CMS guidelines and facility defined process	
Drug Information	Drug Info Major >/=20 min	30	100	Formal, extensive written or verbal consults taking more than 20 minutes to complete. May be requested by physician, nurse, patient, or generated by the pharmacist.	
Drug Information	Drug Info Minor <20 min	10	20	For drug info consults taking less than 20 minutes.	

Group	Intervention	Time	Dollar	Definition	Examples
Emergency Pharmacy	Added Drug Therapy	20	75	•When unmet healthcare need is addressed by pharmacist	pharmacist recommends starting a drug therapy to improve patient care in the Emergency Department
Emergency Pharmacy	ADE Prevention-Major	30	2200	•Prevention of an ADE that would likely have been serious and resulted in an increased LOS. •Changes in therapy occurred as a result of clinical skills and not just a computer notice (i.e. duplicate therapy, allergy, or drug interaction notice).	**1)** Drug interactions preventing severe adverse reactions such as QT prolongation, seizures, etc. 2**)** Discontinuing sleeper agents ordered for patients with respiratory issues. 3**)** Dose change based on indication, i.e., Xarelto has different doses depending on the indication. 4**)** High dose opioid ordered for an opioid naïve patient.
Emergency Pharmacy	ADE Prevention-Minor	15	220	•A pharmacist prevents a MINOR medication error as part of clinical review or patient care.	Change in dose, drug, frequency etc. that prevented a less severe complication such as minor bleeding, or other minor side effect that would have likely occurred.
Emergency Pharmacy	Chart Review	10	0	•A medication-oriented chart review that did not result in specific interventions, changes, or recommendations.	
Emergency Pharmacy	Code Blue / Rapid Response	25	0	•To be used for active participation in a code Blue. This applies to neonatal codes as well.	
Emergency Pharmacy	Discontinue Therapy	30	90	•A pharmacist reviews and appropriately discontinues a therapy	
Emergency Pharmacy	Dose optimization	15	112	•A dose adjustment made by pharmacy based on patient-specific evaluation of clearance, such as renal or hepatic function. •The reason for the dose change is to improve efficacy and/or to avoid toxicity. •There may be multiple dose adjustments throughout a patient's stay, so this category may be used more than once per patient.	
Emergency Pharmacy	Drug Info Major >/=20 min	30	100	•For form, extensive written or verbal consults taking more than 20 minutes to complete. May be requested by physician, nurse, patient, or generated by the pharmacist.	
Emergency Pharmacy	Drug Info Minor <20 min	10	20	•For drug info consults taking less than 20 minutes.	
Emergency Pharmacy	DVT Outpt Rx by Pharmacist	45	5082	•Initial assessment of patient with a new active DVT in the ED (or inpatient setting appropriate for discharge). •The pharmacist activates the protocol, screens patient for inclusion/exclusion criteria and whether patient is appropriate for outpatient treatment for DVT (either LMWH or oral therapy), orders appropriate therapy for initial treatment as well as outpatient treatment and coordinates outpatient follow-up as necessary (referral to anticoagulation clinic if appropriate). •This protocol includes education for the patient prior to discharge.	Pharmacist is consulted to manage DVT/PE treatment to prevent admission for inpatient management. May include referral to anticoagulation clinic for management, prescribing of most cost effective anticoagulant agent to ensure patient access to DVT/PE treatment as an outpatient, etc.
Emergency Pharmacy	ED Discharge Culture Review - Change Therapy	30	90	•Pharmacist actively participates in the review of cultures collected in the ED and needs to alter, initiate, or discontinue therapy based upon the culture result. This includes conducting the necessary follow-up and initiating the modification	Pharmacist reviews discharge cultures and finds that a patient was placed on antibiotic which is not appropriate given culture and sensitivity results. Pharmacist contacts provider, patient, pharmacy to get the patient placed on an appropriate agent.
Emergency Pharmacy	ED Discharge Culture Review - Therapy Appropriate	30	0	•Pharmacist actively participates in the review of cultures collected in the ED and no change to therapy or follow-up is needed	Pharmacist reviews discharge cultures but no change in therapy is required.
Emergency Pharmacy	Med Rec - Admission	20	75	•Pharmacist actively participates in the admission reconciliation process and completes the appropriate reconciliation documents. •The focus is assuring appropriate continuity of care, prevention of omitted meds, and addressing any unmet needs of the patient. •Pharmacist may document actual medication errors & ADEs prevented in the other Med Rec categories in addition to this category.	**1)** Review home med list and contacts provider to resume/order the appropriate meds
Emergency Pharmacy	Medication History obtained	30	642	Used this category when pharmacist or technician collects complete medication history and records in the permenent medical record. This activity replaces the physician or nurse having to complete this activity and improves accuracy of home med list and reduces potential for adverse events due to inaccurate reconciliation of home medications.	Pharmacist or Technician collects complete medication history of patient so meds are as accurate as possible for provider to reconcile.
Emergency Pharmacy	Patient Education	30	208	•General: A significant contribution to patient, family, and/or caregiver teaching about inpatient and/or discharge medications.	
Emergency Pharmacy	Rapid Sequence Intubation	30	100	Participation in RSI or Procedural sedation. This could include recommendations, implementation, administration of medications as appropriate	
Emergency Pharmacy	STEMI Management	10	20	Participation in STEMI or as members of the STEMI team. This could include recommendations, implementation, administration of medications as appropriate	
Emergency Pharmacy	Sepsis Measures Review	15	0	Participation in Code Sepsis or as members of the Sepsis team. This could include recommendations, implementation, administration of medications as appropriate.	
Emergency Pharmacy	Stroke/TPA Management	30	100	Participation in Stroke/TPA workup or as members of the Stroke team. This could include recommendations, implementation, dosing, contraindications checklist, or administration of medications as appropriate	

Group	Intervention	Time	Dollar	Definition	Examples
IV-PO	Acetaminophen	10	98	Changing any drug from IV to oral route per protocol or recommendation	Pharmacist converts Ofirmev/IV Acetaminophen to oral or other route.
IV-PO	Allopurinol	10	5626	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Ampicillin / Sulbactam	10	17	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Azithromycin	10	5	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Ciprofloxacin	10	6	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Clindamycin	10	23	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Digoxin	10	3	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Doxycycline	10	68	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Ethacrynicacid	10	3516	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Famotidine	10	4	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Fluconazole	10	8	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Lacosamide	10	92	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Levetiracetam	10	13	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Levofloxacin	10	4	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Levothyroxine	10	177	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Linezolid	10	122	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Metoclopramide	10	7	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Metronidazole	10	7	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Minocycline	10	572	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Multivitamin	10	17	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Mycophenolate	10	467	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Other(Anti-Infective)	10	0	Changing any drug from IV to oral route per protocol or recommendation	Change an antibiotic not listed
IV-PO	Other(NonAnti-Infective)	10	0	Changing any drug from IV to oral route per protocol or recommendation	Change another agent not listed
IV-PO	Pantoprazole	10	6	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Rifampin	10	138	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Sulfamethoxazole/Trimethoprim	10	93	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Tacrolimus	10	342	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Thiamine	10	14	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	ValproicAcid	10	14	Changing any drug from IV to oral route per protocol or recommendation	
IV-PO	Voriconazole	10	88	Changing any drug from IV to oral route per protocol or recommendation	

Group	Intervention	Time	Dollar	Definition	Examples
Pharmacy Consult-Protocol	Consult Aminoglycoside Dose & Monitor	30	100	•Initiating therapy per protocol or recommending therapy for aminoglycosides. •May include additional entries for follow up when dose adjustments or labs above routine are required	Pharmacy to dose Aminoglycoside orders
Pharmacy Consult-Protocol	Consult Pain Management Dose & Monitor	30	600	•Evaluating, ordering, or following-up for pharmacy dosing of pain medications for a patient	**1)** Includes orders such as “PCA Per Pharmacy”, “Pain Meds Per Pharmacy” **2)** Includes use of reversal agents are used. **3)** Neonatal Abstinence Syndrome (NAS) Management: Evaluation and provision of daily recommendations by the NICU pharmacist to the medical team regarding opioid dosing to prevent withdrawal symptoms in the neonate. The pharmacist shall work in conjunction with the nurse and healthcare team to determine the Modified Finnegan score and appropriate treatment plan based on the established protocol and other patient-specific factors.
Pharmacy Consult-Protocol	Consult Pharmacy to Dose & Monitor	15	112	•A dose adjustment made by pharmacy based on patient-specific evaluation of clearance, such as renal or hepatic function. •The reason for the dose change is to improve efficacy and/or to avoid toxicity. May be a recommendation for dose adjustment or a protocol-driven adjustment per pharmacy. •Requires gathering and evaluating patient-specific clinical information.	Any Rx to Dose order for various drug not applicable to other pharmacy consult categories.
Pharmacy Consult-Protocol	Consult PPN Dose & Monitor	15	30	•Writing or review of peripheral parenteral nutrition for a patient	Rx to dose PPN
Pharmacy Consult-Protocol	Consult TPN Dose & Monitor	40	120	•Initial consult for “TPN per pharmacy” orders. •Follow up after initial consult. Or may be monitoring patients on TPN being ordered by physician.	Rx to dose TPN order
Pharmacy Consult-Protocol	Consult Vancomycin Dose & Monitor	30	100	•Evaluating, ordering, following-up for pharmacy dosing of vancomycin for a patient	Rx to dose Vancomycin,
Pharmacy Consult-Protocol	Consult Warfarin Dose & Monitor	15	185	•Initial assessment, dosing, INR order/evaluation of a specific patient on warfarin. Note written in the chart detailing complete assessment. •Follow up of initial warfarin assessment. •Pharmacist routinely managing and dosing patient’s warfarin therapy. May be documented daily. No change in therapy needed to document this, provided a pharmacist is managing consult, reviewing medication list and labs, and writes a note in the chart.	Use for Rx to dose Warfarin orders
Pharmacy Consult-Protocol	Heparin Per Weight-Based Protocol	20	177	•Instructions including adjustments based on lab values. •This is a one-time entry.Initial provision of dosing	Pharmacy provides dosing/titration worksheet for nursing and ensures appropriate management of Heparin infusion therapy.
Pharmacy Consult-Protocol	Renal Dosing Protocol Adjustmemt	15	112	•A dose adjustment made by pharmacy based on patient-specific evaluation of renal function. The reason for the dose change is to improve efficacy and/or to avoid toxicity. May be a recommendation for dose adjustment or a protocol-driven adjustment per pharmacy. • Requires gathering and evaluating patient-specific clinical information. There may be multiple dose adjustments throughout a patient’s stay, so this category may be used more than once per patient.	Use for Renal Dosing Protocol Adjustments that are made per faciltiy defined protocol. If physician is contacted for change recommend using Dose Optimization intervention.

Group	Intervention	Time	Dollar	Definition	Examples
Transitions of Care	Added Drug Therapy	20	75	•When unmet healthcare need is addressed by pharmacist	pharmacist recommends starting a drug therapy that was ommitted or that would improve patient care following a transition of care.
Transitions of Care	ADE Prevention-Major	30	2200	•Prevention of an ADE that would likely have been serious and resulted in an increased LOS. •Changes in therapy occurred as a result of clinical skills and not just a computer notice (i.e. duplicate therapy, allergy, or drug interaction notice).	**1)** Drug interactions identified and drug therapy adjusted to preventing severe adverse reactions such as QT prolongation, seizures, etc. **2)** Ommitted meds discovered or meds continued that shouldn't be continued at home that could have lead to severe adverse event. Ex: Rivaroxaban continued from hospital list and Apixaban continued from home list identified and appropriate agent discontinued and patient educated on which to continue at home 3**)** Dose change based on indication, i.e., Xarelto has different doses depending on the indication. 4**)** High dose opioid ordered for an opioid naïve patient.
Transitions of Care	ADE Prevention-Minor	15	220	•A pharmacist prevents a MINOR medication error as part of clinical review or patient care.	Change in dose, drug, frequency etc. that prevented a less severe complication such as minor bleeding, or other minor side effect that would have likely occurred due to error during transition of care
Transitions of Care	Chart Review	10	0	•A medication-oriented chart review that did not result in specific interventions, changes, or recommendations. •An intervention resulting from a chart review will be recorded in the appropriate CI category.	
Transitions of Care	Discontinue Therapy	30	90		
Transitions of Care	Med Rec - Admission	20	75	•Pharmacist actively participates in the admission medication reconciliation process and completes the appropriate reconciliation documents. •The focus is assuring appropriate continuity of care, prevention of omitted meds, and addressing any unmet needs of the patient. •Pharmacist may document actual medication errors & ADEs prevented in the other Med Rec categories in addition to this category.	**1)** Review home med list and contacts provider to resume/order the appropriate meds
Transitions of Care	Med Rec - Discharge	20	75	•Pharmacist actively participates in the discharge reconciliation process and completes the appropriate reconciliation documents. •The focus is assuring appropriate continuity of care, prevention of omitted meds, and addressing any unmet needs of the patient. •Pharmacist may document actual medication errors & ADEs prevented in the other Med Rec categories in addition to this category	**1)** Review inpatient medications and previous home medications. Ensure patient is discharged on appropriate therapy for use at home.
Transitions of Care	Med Rec - Outpatient	20	75		
Transitions of Care	Med Rec - Transfer	20	75	•Pharmacist actively participates in the transfer reconciliation process and completes the appropriate reconciliation documents. •The focus is assuring appropriate continuity of care, prevention of omitted meds, and addressing any unmet needs of the patient. •Pharmacist may document actual medication errors & ADEs prevented in the other Med Rec categories in addition to this category	**1)** Review medications on transfer of care to ensure inappropriate medications are discontinued, and any home medications are resumed when appropriate
Transitions of Care	Medication Assistance enrollment	30	0	•Pharmacy staff coordinates patient assistance programs, enrolls patients in industry programs for copay reduction or starter medication, enrolls patients in REMS required programs	**1)** Pharmacy enters patient info into MedData system or enrolls patient in an REMS program
Transitions of Care	Medication History obtained	30	642	•Pharmacist or pharmacy technician collects and documents the official medication history or manages medication reconciliation during admission, transfer, discharge. Interventions will be captured in the subintervention categories, not the general CI.	
Transitions of Care	Patient Education	30	208	A significant contribution to patient, family, and/or caregiver teaching about inpatient and/or discharge medications.	
Transitions of Care	Prescription Coordination	30	0	Facilitating and ensuring medication availability and compliance after a transition of care.	
Transitions of Care	Skilled Bed Drug Regimen Review	30	0		