NATIONAL QUALITY FORUM

Medication Reconciliation Harmonization

June 5, 2018

Context

- Fall 2017 Behavioral Health SC discussion about medication reconciliation
  - Desire for greater alignment in measure specifications
- April 2018 CSAC meeting
  - *Medication reconciliation is a general topic*
  - *Which is best?*
    - » Narrowly focused measures (e.g., med rec for a specific patient group) **OR**
    - » Broader measure that includes most patients

Good opportunity to talk about our processes for related and competing measures more generally

Definitions

At the conceptual level:

Competing Measures	Related Measures
Same measure focus **AND** Same target population	Same measure focus **OR** Same target population
	↓
	Harmonize if possible (align specifications)

NQF's Process for Evaluating Related and Competing Measures

- Prior to the evaluation meeting
  - *NQF staff identify related/competing (R/C) measures*
    - » Should happen at/before start of project
  - *NQF staff notify developers of R/C measures*
    - » Developers should develop and share a plan for harmonization
    - » NQF is supposed to help facilitate discussions between developers
  - *NQF staff include R/C measures in Preliminary Analysis*

NQF's Process for Evaluating Related and Competing Measures

- During evaluation meeting
  - *SCs evaluate against Criteria 1-4: Measures must be recommended as being suitable for endorsement*
  - *Consider competing measures: Ask SC to identify a superior measure OR justify why multiple measures needed*
    - » If multiple competing measures are justified, then consider if they should be harmonized
  - *Consider related measures*
    - » Can the target populations be combined? If not, justify why different measures are needed, then ask:
    - » Can the measures be harmonized?
      - *If yes, provide recommendations for how*
      - *If no, justify differences*

Identifying Superior ("best in class") Measures

- Weigh strengths and weaknesses across all criteria
- All else equal, preference is for measures that:
  - *Are specified for the broadest application*
  - *Address disparities in care when appropriate*
  - *Are based on data from electronic sources*
  - *Use EHR data*
  - *Are freely available*
  - *Are used in at least one accountability application*
  - *Have widest use (e.g., settings, number of entities reporting)*
  - *Have greatest improvement*
  - *Benefits outweigh unintended negative consequences to patients*

NQF's Process for Evaluating Related and Competing Measures

- Challenges of the process
  - *Time-consuming to identify and document details of R/C measures from various sources*
  - *Inconsistency between projects*
    - » Identifying R/C measures
    - » Presenting to SCs (if, how, when)
  - *Effective evaluation harder If R/C measures evaluated by different Standing Committees*
  - *NQF's only "stick" is to withhold endorsement*

Exemplar: Flu shot measures

- 2008: Steering Committee identified standard measure specifications
  - *Who is included in/excluded from the target denominator population*
  - *Who is included in the numerator population*
  - *Time windows for measurement and vaccinations*
  - *Exclusions*
- 2012: Population Health Steering Committee strongly recommended the development of a universal influenza immunization measure
- 2017: Health and Well-Being Standing Committee
  - *Evaluated and endorsed eight flu measures*
    - » Most harmonized to NQF's standardized specifications
    - » SC reiterated the need for a single, standardized measure

Related Medication Reconciliation Measures

	0097: MedRec Post-Discharge	0419e: Documentation of Current Medications in the Medical Record	0553: Care for Older Adults (COA) – Medication Review	2456: MedRec: Number of Unintentional Medication Discrepancies per Patient	3317: MedRec on Admission	0293: Medication Information	2988: MedRec for Patients Receiving Care at Dialysis Facilities
Steward	NCQA	CMS	NCQA	Brigham and Women´s Hospital	CMS / HSAG	U of Minnesota Rural Health	Kidney Quality Care Alliance
Measure Focus	Reconciliation of discharge medication list with current outpatient medical record medication list	Eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter	Medication review of all a patient's medications, including prescription medications, OTC medications by a prescribing practitioner or clinical pharmacist	Total number of unintentional medication discrepancies in admission orders + total number of unintentional medication discrepancies in discharge orders	Reconciliation of Prior to Admission medication list (referencing external sources) by end of Day 2 of hospitalization.	Communication of medical record documentation to receiving transfer facility within 60 minutes of departure from originating facility	Patients receive medication reconciliation upon visit to dialysis facility. .
Population	Patients ages 18 +	Patients ages 18 +	Patients ages 66 +	Random sample of adults admitted to the hospital	All inpatient psychiatric admissions	All ages	Dialysis patients
Data Source	Claims, Electronic Health Records, Paper Medical Records	Claims, Electronic Health Records, Registry Data	Claims, Electronic Health Records, Paper Medical Records	Electronic Health Data, Electronic Health Records, Instrument-Based Data, Other, Paper Medical Records	Paper Medical Records	Claims, Electronic Health Data, Paper Medical Records	Electronic Health Records, Other
Level of Analysis	Clinician: individual Clinician: group Health Plan Integrated Delivery System	Clinician: individual Clinician: group	Health Plan Integrated Delivery System	Facility	Facility	Facility	Facility
Setting	Outpatient	Outpatient	Inpatient/Hospital, Outpatient Services, Post-Acute Care	Hospital	Inpatient/Hospital	Inpatient/Hospital	Post-Acute Care

Medication Reconciliation: Issues to Consider

- What would be included in standardized specifications?
  - *What would be reconciled?*
    - » All prescriptions, OTCs, herbals, vitamins, etc.
    - » Name, dosages, frequency, route
  - *How often does it need to be done?*
  - *Who would do it? (e.g., pharmacist, MDs, etc.)*
  - *Who needs it done? (e.g., all pts? Stratify for certain groups?)*
  - *What would trigger it? (e.g., "visit", phone refill, etc.)*
  - Where should it be done?
- Is there any evidence to inform the above?
  - *Does it differ across settings, patient populations, or conditions?*
- What might differ depending on care setting, data source, level of analysis?