NATIONAL QUALITY FORUM

Medication Reconciliation Harmonization

CSAC Informational Update

October 23-24, 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
  - *Charged Patient Safety Standing Committee to explore issues further*
- Good opportunity to talk about our processes for related and competing measures more generally

Definitions: Competing and Related Measures

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)

Harmonization 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 in NQF Portfolio

	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	2988: MedRec for Patients Receiving Care at Dialysis Facilities
Steward	NCQA	CMS	NCQA	Brigham and Women´s Hospital	CMS / HSAG	Kidney Quality Care Alliance
Numerator	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.	The Numerator statement for 2017 Claims/Registry Specification: Eligible clinician attests to documenting, updating, or reviewing a patient´s current medications using all immediate resources available on the date of the encounter. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency, and route of administration. 2018 eMeasure Specification: Eligible professional or eligible clinician attests to documenting, updating or reviewing the patient´s current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications´ name, dosages, frequency and route of administration.	At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record	For each sampled inpatient in the denominator, the total number of unintentional medication discrepancies in admission orders plus the total number of unintentional medication discrepancies in discharge orders.	Number of patients for whom a designated Prior to Admission (PTA) medication list was generated by referencing one or more external sources of medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization when the admission date is Day 0.	Number of patient-months for which medication reconciliation was performed and documented by an eligible professional during the reporting period. The medication reconciliation MUST: • Include the name or other unique identifier of the eligible professional; AND • Include the date of the reconciliation; AND • Address ALL known home medications (prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and medical marijuana); AND • Address for EACH home medication: Medication name(1), indication(2), dosage(2), frequency(2), route of administration(2), start and end date (if applicable)(2), discontinuation date (if applicable)(2), reason medication was stopped or discontinued (if applicable)(2), and identification of individual who authorized stoppage or discontinuation of medication (if applicable)(2); AND • List any allergies, intolerances, or adverse drug events experienced by the patient. 1. For patients in a clinical trial, it is acknowledged that it may be unknown as to whether the patient is receiving the therapeutic agent or a placebo. 2. "Unknown" is an acceptable response for this field.

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Denominator	All discharges from an in-patient setting for patients who are 18 years and older.	The 2017 Claims and Registry denominator statement is as follows: "All visits for patients aged 18 years and older." The 2018 eMeasure denominator statement is as follows: "All visits occurring during the 12 month reporting measurement period for patients aged 18 years and older."	All patients 66 and older as of the end (e.g., December 31) of the measurement year.	The patient denominator includes a random sample of all potential adults admitted to the hospital. Our recommendation is that 25 patients are sampled per month, or approximately 1 patient per weekday. So, for example, if among those 25 patients, 75 unintentional discrepancies are identified, the measure outcome would be 3 discrepancies per patient for that hospital for that month.	All patients admitted to an inpatient facility from home or a non-acute setting.	Total number of patient-months for all patients permanently assigned to a dialysis facility during the reporting period.
Exclusions	The following exclusions are applicable to the Health Plan Level measure. - Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. - If the discharge is followed by a readmission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the patient was transferred.	The 2017 Claims and Registry version provides the following as a denominator exception: A patient is not eligible if the following reason is documented: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status. The 2018 eMeasure includes the following denominator exception: Medical Reason: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.	Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.	Patients that are discharged or expire before a gold standard medication list can be obtained.	The measure applies two exclusion criteria to ensure that it is feasible to complete the medication reconciliation process on admission to the IPF: 1. Patients transferred from an acute care setting 2. Patient admissions with a length of stay less than or equal to 2 days	In-center patients who receive <7 hemodialysis treatments in the facility during the reporting month.

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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.	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	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	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
Setting	Outpatient	Outpatient	Inpatient/Hospital, Outpatient Services, Post-Acute Care	Hospital	Inpatient/Hospital	Post-Acute Care

NQF-endorsed Medication Reconciliation Measures: Review of Evidence

- No clinical guidelines cited
- Several individual studies that have demonstrated a decrease in medication errors when medication reconciliation is implemented
- Several articles on adverse drug events in the various care settings
- 2012 systematic review on Hospital-Based Medication Reconciliation Practices*
  - *Reduction of medication discrepancies and ADEs and successful interventions include: intensive pharmacy staff involvement and targeting intervention to "high risk" patient population.*

*Mueller SK, Sponsler KC, Kripalani S, Schnipper JL. Hospital-Based Medication Reconciliation Practices: A Systematic. *Arch Intern Med.* Jun 25 2012:1-13.

Medication Reconciliation Harmonization: Considerations

- What would be included in standardized specifications?
  - *What would be reconciled?*
    - » All prescriptions, OTCs, herbals, vitamins
    - » Name, dosages, frequency, route
  - *How often does it need to be done?*
  - *Who would do it? (e.g., pharmacist, MDs)*
  - *Who needs it done? (e.g., all patients, stratify for certain groups)*
  - *What would trigger it? (e.g., "visit", phone refill)*
  - Where should it be done?
  - What terminology coding should be used (e.g., SNOMED, LOINC, RXNorm)?

Medication Reconciliation Harmonization: Considerations

- Is there evidence to inform these factors?
  - *Does it differ across settings, patient populations, or conditions?*
- What might differ depending on care setting, data source, level of analysis?

Medication Reconciliation Harmonization : Considerations

- Where should medication reconciliation measurement go in the future?
  - *Outcome measures, adverse events?*
  - *What is the ideal future state of measurement with respect to medication reconciliation?*
  - *What research might be needed to support future quality measurement in this area?*
- How can we best harmonize existing med rec measures?
- What is the role of the committee in making clinical recommendations (i.e., how to do med rec in the absence of clear literature)?
- How should NQF involve developers in harmonization efforts?

Medication Reconciliation Harmonization: Patient Safety Standing Committee Discussion

- Patient Safety Web Meeting-Sept 12, 2018
- Participation by:
  - *Patient Safety Committee and expert reviewers*
  - *1 Behavioral Health Committee member*
  - *2 developers*

Patient Safety Committee Discussion: Key Themes

- Important items to consider in standardized specifications:
  - *Timing and frequency of medication reconciliation;*
  - *Who is involved in the medication reconciliation process;*
  - *Location of the medication reconciliation;*
  - *Consideration of risk factors such as high-risk medications and patient risk factors; and*
  - *Is it a "checkbox" medication reconciliation or is there a methodology for how medication reconciliation is documented and reported?*
- Importance of interoperable health information systems.
- Importance of moving towards outcome measures.
- Some necessary specifications in certain measures cannot be harmonized.

CSAC Discussion Questions

- What is a reasonable approach to harmonization, especially when evidence is lacking for some measures in this area?
- What is NQF's role in providing harmonization guidance for measures that involve complex interventions and multiple attributes?
- What kind of guidance should NQF give developers and how should that be delivered?
- Noting that process and structure measures are valuable in assessing medication reconciliation more holistically, does CSAC agree with the importance of moving towards outcome measures in this topic area?

Next Steps

- NQF staff to provide Committee with a comparison of attributes across each of the medication reconciliation measures.
- Committee to review where variations amongst the medication reconciliation measures occur and continue discussion regarding harmonization.
- Developers will be encouraged to continue participating in on-going discussions.