



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 0554

De.2. Measure Title: Medication Reconciliation Post-Discharge (MRP)

Co.1.1. Measure Steward: National Committee for Quality Assurance

De.3. Brief Description of Measure: The percentage of discharges during the first 11 months of the measurement year (e.g., January 1–December 1) for patients 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.

1b.1. Developer Rationale: The intent of this measure is to reduce complications resulting from drug interactions, omissions, or duplications in elderly patients after discharge from an inpatient facility. Communication between the inpatient facility and the patient's primary caregiver is often delayed and incomplete, which may result in duplication of medications or the administration of medications with potentially harmful interactions (Williams 1990). Numerous evaluations have established that medication reconciliation is an effective tool to reduce preventable adverse drug events, which is associated with 1 of 5 injuries or deaths. (Pronovost 2003, IHI 2011) In one study, the percentage of patients affected by adverse drug events fell from 36.9% to 9.3% with the use of medication reviews (IOM 2011). This intervention may also ease the financial burden that medication errors place on the medical system; a study utilizing a pharmacist-led medication review concluded that there was a \$230 decrease in cost per patient (Gillespie 2009).

- Williams EI and Filton F. General practitioner response to elderly patients discharged from hospital. *BMJ*. 1990; 300:159-161.
- Pronovost P, Weast B, Schwarz M, et al. Medication Reconciliation: A Practical Tool to Reduce the Risk of Medication Errors. *J Crit Care*. 2003 Dec;18(4):201-5.
- Institute for Healthcare Improvement (IHI). Reconcile Medications at All Transition Points: Reconcile Medications in Outpatient Settings. Available at: <http://www.ihl.org/knowledge/Pages/Changes/ReconcileMedicationsatAllTransitionPoints.aspx>. Accessed December 2011.
- Committee on Quality Health Care in America. Institute of Medicine. To err is human: building a safer health system. Washington, D.C: National Academy Press. 2002.
- Gillespie U, Alassaad A, Henrohn D, et al. A Comprehensive Pharmacist Intervention to Reduce Morbidity in Patients 80 Years or Older. *Arch Intern Med*. 2009;169:894-900.

S.4. Numerator Statement: Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge.

S.7. Denominator Statement: Acute or nonacute inpatient discharge during the first 11 months of the measurement year (e.g., January 1 to December 1) for patients who are 66 years and older as of the end of the measurement year.

S.10. Denominator Exclusions: N/A

De.1. Measure Type: Process

S.23. Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records

S.26. Level of Analysis: Health Plan, Integrated Delivery System

IF Endorsement Maintenance – Original Endorsement Date: Aug 05, 2009 **Most Recent Endorsement Date:** Aug 10, 2012

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form 0554_Evidence_MSF5.0_Data.doc

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)

The intent of this measure is to reduce complications resulting from drug interactions, omissions, or duplications in elderly patients after discharge from an inpatient facility. Communication between the inpatient facility and the patient's primary caregiver is often delayed and incomplete, which may result in duplication of medications or the administration of medications with potentially harmful interactions (Williams 1990). Numerous evaluations have established that medication reconciliation is an effective tool to reduce preventable adverse drug events, which is associated with 1 of 5 injuries or deaths. (Pronovost 2003, IHI 2011) In one study, the percentage of patients affected by adverse drug events fell from 36.9% to 9.3% with the use of medication reviews (IOM 2011). This intervention may also ease the financial burden that medication errors place on the medical system; a study utilizing a pharmacist-led medication review concluded that there was a \$230 decrease in cost per patient (Gillespie 2009).

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- Pronovost P, Weast B, Schwarz M, et al. Medication Reconciliation: A Practical Tool to Reduce the Risk of Medication Errors. J Crit Care. 2003 Dec;18(4):201-5.
- Institute for Healthcare Improvement (IHI). Reconcile Medications at All Transition Points: Reconcile Medications in Outpatient Settings. Available at: <http://www.ihl.org/knowledge/Pages/Changes/ReconcileMedicationsatAllTransitionPoints.aspx>. Accessed December 2011.
- Committee on Quality Health Care in America. Institute of Medicine. To err is human: building a safer health system. Washington, D.C: National Academy Press. 2002.
- Gillespie U, Alassaad A, Henrohn D, et al. A Comprehensive Pharmacist Intervention to Reduce Morbidity in Patients 80 Years or Older. Arch Intern Med. 2009;169:894-900.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

Medicare

Measurement Year: 2010; 2009; 2008

N: 279; 282; 303

MEAN: 31.8; 34.1; 33.1

STDEV: 21.7; 21.6; 19.7

STDERR: 1.3; 1.28; 1.13

MIN: 0; 0; 0

MAX: 97.3; 95.8; 98.6

P10: 7.89; 6.33; 4.14

P25: 15.8; 18.8; 21.9

P50: 27.3; 32.6; 31.7

P75: 44.7; 47; 44.9

P90: 62.7; 64.6; 57.4

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the

literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

Section 1b.2 references data from the most recent three years of measurement for this measure. The data in section 1b.2 includes percentiles, mean, min, max, standard deviations and standard errors.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*

The measure is not stratified to detect disparities. NCQA has participated with IOM and others in attempting to include information on disparities in measure data collection. However, at the present time, this data, at all levels (claims data, paper chart review, and electronic records), is not coded in a standard manner, and is incompletely captured. There are no consistent standards for what entity (physician, group, plan, employer) should capture and report this data. While "requiring" reporting of the data could push the field forward, it has been our position that doing so would create substantial burden with inability to use the data because of its inconsistency. At the present time, we agree with the IOM report that disparities are best considered by the use of zip code analysis which has limited applicability in most reporting situations. At the health plan level, for HEDIS health plan data collection, NCQA does have extensive data related to our use of stratification by insurance status (Medicare, Medicaid and private-commercial) and would strongly recommend this process where the data base supporting the measurement includes this information. However, we believe that the measure specifications should NOT require this since the measure is still useful where the data needed to determine disparities cannot be ascertained from the data available.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

N/A

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.

Implementing routine medication reconciliation after discharge from an inpatient facility is an important step in ensuring the continuity of patient care. Estimates suggest that 46% of medication errors occur on admission or discharge from a hospital (Pronovost 2003). Elderly patients possess several factors, including chronic conditions and increased drug utilization, which makes them particularly prone to adverse drug events resulting from multiple care settings (Marcum 2010).

Hospital medication records for admitted patients are often incomplete. A comparison of medication histories maintained by the hospital for admitted patients with community pharmacy records revealed that the hospital's records omitted 26% of the medications in use. This study also found that 61% of all patients had one or more drugs that were not registered with the hospital. As a result, patients are discharged from the hospital without being continued on some of their chronic medications, possibly inadvertently (Lau 2000). Significant changes can occur to a patient's medications during hospitalization; a study by Beers et al. found that 45% of all discharge medications were initiated during hospitalization (1989).

The process of resolving discrepancies in a patient's medication list reduces the risk of adverse drug interactions being overlooked and helps physicians minimize the duplication and complexity of the patient's medication regimen (Wenger 2004). This in turn may increase patient adherence to the medication regimen and reduce hospital readmission rates. A study by Gillespie et al utilized a randomized pharmacist-led medication review process of hospitalized patients and demonstrated a subsequent 16% reduction in all visits to the hospital and a 47% reduction in visits to the emergency department (Gillespie 2009).

1c.4. Citations for data demonstrating high priority provided in 1a.3

- Pronovost P, Weast B, Schwarz M, et al. Medication Reconciliation: A Practical Tool to Reduce the Risk of Medication Errors. J Crit Care. 2003;18(4):201-5.
- Marcum ZA, Handler SM, Boyce R, et al. Medication Misadventures in the Elderly: A Year in Review. Am J Geriatr Pharmacother. 2010; 8(1):77-83.
- Lau HS, Florax C, Porsius AJ, De Boer A. The completeness of medication histories in hospital medical records of patients admitted to general internal medicine wards. Br J Clin Pharmacol. 2000;49(6):597-603.
- Beers MH, Dang J, Hasegawa J, Tamai IY. Influence of hospitalization on drug therapy in the elderly. J Am Geriatr Soc. 1989;37(8):679-83.
- Wenger NS and Young R. Working paper: Quality Indicators of Continuity and Coordination of Care for Vulnerable Elder Persons. Rand: August 2004.
- Gillespie U, Alassaad A, Henrohn D, et al. A Comprehensive Pharmacist Intervention to Reduce Morbidity in Patients 80 Years or Older. Arch Intern Med. 2009;169:894-900.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Cross Cutting Areas (check all the areas that apply):

Care Coordination, Safety : Medication Safety

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

No HQMF specs Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment:

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)
IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the

calculation algorithm.

Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge.

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

Denominator: The first 11 months of the measurement year (e.g., January 1–December 1)

Numerator: On or within 30 days after discharge.

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

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, on or within 30 days after discharge.

ADMINISTRATIVE

Medication reconciliation (Medication Reconciliation Value Set) conducted by prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge.

- See corresponding Excel document for the Medication Reconciliation Value Set

MEDICAL RECORD

Documentation in the medical record must include evidence of medication reconciliation, and the date when it was performed. The following evidence meets criteria:

- Notation that medications prescribed or ordered upon discharge were reconciled with the current medications (in the outpatient record) by the appropriate practitioner type, OR
- A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications conducted by an appropriate practitioner type (the organization must be able to distinguish between the patient's discharge medications and the patient's current medications). OR
- Notation that no medications were prescribed or ordered upon discharge

Only documentation in the outpatient chart meets the intent of the measure, but an in-person, outpatient visit is not required

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

Acute or nonacute inpatient discharge during the first 11 months of the measurement year (e.g., January 1 to December 1) for patients who are 66 years and older as of the end of the measurement year.

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Populations at Risk : Dual eligible beneficiaries, Populations at Risk : Individuals with multiple chronic conditions, Senior Care

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

An acute or nonacute inpatient discharge during the first 11 months of the measurement year (e.g., January 1 to December 1). The denominator is based on discharges, not patients. Patients may appear more than once in the denominator. If patients have more than one discharge, include all discharges during the first 11 months 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.

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the first 11 months of the measurement year (e.g., December 1).

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

N/A

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

N/A

S.12. Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*

N/A

S.13. Risk Adjustment Type *(Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)*

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*

N/A

S.15. Detailed risk model specifications *(must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)*

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications *(if not provided in excel or csv file at S.2b)*

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*

Better quality = Higher score

S.18. Calculation Algorithm/Measure Logic *(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)*

Step 1: Identify the eligible population: Adults age 66 years of age and older as of the end of the measurement year (e.g., December 31).

Step 2. Identify the denominator: All acute or nonacute inpatient discharges for the eligible population between January 1 and December 1 of the measurement year. Note an individual may be counted in the denominator more than one time if they had more than one discharge during the time frame. Discharges followed by a readmission or direct transfer to an acute or nonacute facility within the 30-day follow-up period do not count towards the denominator. Instead count only the readmission discharge or the discharge from the facility to which the patient was transferred. If the readmission discharge or discharge from the transfer facility occurs after December 1 of the measurement year it does not count toward the denominator.

Step 3. Identify the numerator: Discharges which were followed by a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge.

Step 4. Calculate the rate: Numerator/Denominator

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

[Administrative claims](#), [Electronic Clinical Data](#), [Paper Medical Records](#)

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

[NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System \(IDSS\).](#)

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

[URL](#)

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

[Health Plan](#), [Integrated Delivery System](#)

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

[Ambulatory Care : Clinician Office/Clinic, Pharmacy](#)

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

[0554_MeasureTesting_MSF5.0_Data.doc](#)

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure,

lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)
If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

Some data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

NCQA is working on developing EHR specified measures to capture this information.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

NCQA's multi-stakeholder advisory panels examined an analysis of the measure after its first year of reporting. The measure was deemed appropriate for public reporting. NCQA has processes to ensure coding and specifications are clear and updated when needed.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (*e.g., value/code set, risk model, programming code, algorithm*).

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported

within 6 years of initial endorsement in addition to performance improvement.

Planned	Current Use (for current use provide URL)
Public Reporting	
Quality Improvement with Benchmarking (external benchmarking to multiple organizations)	
Quality Improvement (Internal to the specific organization)	

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may

vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications (. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

- 1) information practices and control procedures
- 2) sampling methods and procedures
- 3) data integrity
- 4) compliance with HEDIS specifications
- 5) analytic file production
- 6) reporting and documentation

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0097 : Medication Reconciliation

0553 : Care for Older Adults (COA) – Medication Review

0646 : Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications completely harmonized?

No

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

See 5b.1 for more information.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Measure 0554 is conducted at the health plan level. This measure assesses medication reconciliation by a RN or prescribing practitioner within 30 days of hospital discharge. The denominator for this measure is all patients 65+ discharged from the hospital. All patients regardless of ambulatory care visit are included in the denominator.

Related Measures:

Measure 0553 is conducted at health plan level. This measure assesses annual outpatient medication review by a prescribing practitioner and is not driven by a hospital discharge. The denominator for this measure is all patients aged 65+.

Measure 0097 is conducted at the physician level. This measure assesses medication reconciliation post hospital discharge which occurs during an outpatient visit with a physician. The denominator for this measure is all patients 65+ discharged from the hospital with an ambulatory care visit within 60 days of discharge. Patients without a visit to an ambulatory care visit are not included in the denominator.

Measure 0646 is conducted at the facility level. This measure assesses whether the patient received a reconciled medication list at the time of discharge. The denominator for this measure is all patients, regardless of age, discharged from the hospital. This measure is not dependent on an ambulatory care provider reconciling the medication list.

Additive value of related measures:

The AMA and NCQA have worked together to assess how the three medication reconciliation measures can be harmonized and continue to address performance gaps at different levels of care. Care-coordination measures by nature must address care across levels of accountability. The three medication reconciliation measures submitted to NQF for re-endorsement address measure reconciliation at three levels of accountability and across three points of care. Together all three measures represent shared accountability for medication reconciliation across facilities, health plans and physicians.

Defining the process of medication reconciliation (this will determine the numerator)

- Patients should be educated about changes to medication list (Measure #646)
- Outpatient record should be updated as appropriate with the discharge medication list and reviewed for potential harm (Measure #0554)
- The physician responsible for patient care should review the discharge medication list for appropriateness over the long-term treatment of the patient and their multiple conditions (Measure #0097)

What is the point of care for medication reconciliation (this will determine the denominator)?

- At discharge (Measure #646)
- Within 30 days of discharge (Measure #0554)
- At outpatient follow-up visit within 60 days of discharge (Measure #0097)

Evidence of performance gap and relation to risk of adverse events

- Many medication errors occur during times of transition, when patients receive medications from different prescribers who lack access to patients' comprehensive medication list. Providing patients with a comprehensive, reconciled medication list at each care transition (eg, inpatient discharge) may improve patients' ability to manage their medication regimen properly and reduce the number of medication errors. (Measure #0646).
- Geriatric patients in particular are more likely to have multiple comorbid conditions and be receiving multiple medications, making them more at risk of having an adverse medication event. Therefore there is a need to have a higher level of reconciliation for these patients. (Measures #0554 and #0097).

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required

attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

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Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance

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Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2010

Ad.3 Month and Year of most recent revision:

Ad.4 What is your frequency for review/update of this measure? Approximately every 3 years, sooner if the clinical guidelines have changed significantly.

Ad.5 When is the next scheduled review/update for this measure?
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Ad.8 Additional Information/Comments: