2017 CMS Web Interface

CARE-1 (NQF 0097): Medication Reconciliation Post-Discharge

Measure Steward: NCQA

Contents

INTRODUCTION

There are a total of 15 individual measures (including one composite consisting of two measures) included in the 2017 CMS Web Interface targeting high-cost chronic conditions, preventive care, and patient safety. The measures documents are represented individually and contain measure specific information. The corresponding coding documents are posted separately in an Excel format.

The Measure Documents are being provided to allow group practices and Accountable Care Organizations (ACOs) an opportunity to better understand each of the 15 individual measures included in the 2017 CMS Web Interface data submission method. Each Measure Document contains information necessary to submit data through the CMS Web Interface.

Narrative specifications, supporting submission documentation, and calculation flows are provided within each document. Please review all of the measure documentation in its entirety to ensure complete understanding of these measures.

WEB INTERFACE SAMPLING INFORMATION

BENEFICIARY SAMPLING

For more information on the sampling process and methodology please refer to the *2017 Web Interface Sampling Document*, available at CMS.gov.

NARRATIVE MEASURE SPECIFICATION

THIS MEASURE DOES NOT HAVE A CORRESPONDING eCQM

DESCRIPTION:

The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record

IMPROVEMENT NOTATION:

No Corresponding eCQM

INITIAL POPULATION:

No Corresponding eCQM

DENOMINATOR:

All discharges from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years of age and older seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care.

DENOMINATOR EXCLUSIONS:

Not Available

DENOMINATOR EXCEPTIONS:

Not Available

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.

NUMERATOR EXCLUSIONS:

Not Available

DEFINITION:

Medication Reconciliation – A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. Documentation in the outpatient medical record must include evidence of medication reconciliation and the date on which it was performed. Any of the following evidence meets criteria: (1) Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in meds since discharge, same meds at discharge, discontinue all discharge meds), (2) Documentation of the patient's current medications with a notation that the discharge medications were reviewed, (3) Documentation that the provider "reconciled the current and discharge meds," (4) Documentation of a current medication list, a discharge medication list and notation that the appropriate practitioner type reviewed both lists on the same date of service, (5) Notation that no medications were prescribed or ordered upon discharge.

GUIDANCE:

This denominator is based on discharges followed by an office visit, not patients. Patients may appear in the denominator more than once if there was more than one discharge followed by an office visit in the performance period.

SUBMISSION GUIDANCE

PATIENT CONFIRMATION

Establishing patient eligibility for reporting requires the following:

- Determine if the patient's medical record can be found
  - If you can locate the medical record select "Yes"

  OR

  - If you cannot locate the medical record select "No - Medical Record Not Found"

  OR

  - Determine if the patient is qualified for the sample
    - If the patient is deceased, in hospice, moved out of the country or was enrolled in HMO select "Not Qualified for Sample", select the applicable reason from the provided drop-down menu, and enter the date the patient became ineligible

Guidance *Patient Confirmation*

If "No – Medical Record Not Found" or "Not Qualified for Sample" is selected, the patient is completed but not confirmed. The patient will be "skipped" and another patient must be reported in their place, if available. The Web Interface will automatically skip any patient for whom "No – Medical Record Not Found" or "Not Qualified for Sample" is selected in all other measures into which they have sampled.

If "Not Qualified for Sample" is selected and the date is unknown, you may enter the last date of the measurement period (i.e., 12/31/2017).

The Measurement Period is defined as January 1 – December 31, 2017.

NOTE:

- *In Hospice: Select this option if the patient is not qualified for sample due to being in hospice care at any time during the measurement period (this includes non-hospice patients receiving palliative goals or comfort care)*
- *Moved out of Country: Select this option if the patient is not qualified for sample because they moved out of the country any time during the measurement period*
- *Deceased: Select this option if the patient died during the measurement period*
- *HMO Enrollment: Select this option if the patient was enrolled in an HMO at any time during the measurement period (i.e., Medicare Advantage, non-Medicare HMOs, etc.)*

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient is qualified for the measure
  - If the patient is qualified for the measure select "Yes"

  OR

  - If there is an "other" CMS approved reason for patient disqualification from the measure select "No - Other CMS Approved Reason"

Guidance ***Denominator***

CMS Approved Reason may only be selected when approved by CMS. To request a CMS Approved Reason, you would need to provide the patient rank, measure, and reason for request in a Quality Payment Program Service inquiry. A CMS decision will be provided in the resolution of the inquiry. Patients for whom a CMS Approved Reason is selected will be "skipped" and another patient must be reported in their place, if available.

By selecting "No - Other CMS Approved Reason", the patient is only removed from the measure for which the reason was requested, not all Web Interface measures.

SUBMISSION GUIDANCE

DENOMINATOR REPORTING

- Determine if the patient was discharged from an inpatient facility during the measurement period
  - If the patient was not discharged from an inpatient facility on this date select "No"

  OR
  - If the patient was discharged from an inpatient facility on this date select "Yes"

    IF YES
    - Determine if the patient was seen within 30 days following an inpatient facility discharge
      - If the patient was not seen within 30 days following an inpatient facility discharge select "No"

      OR
      - If the patient was seen within 30 days of an inpatient facility discharge select "Yes"

Encounter codes can be found in the 2017 Web Interface CARE Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance ***Denominator***

NOTE:

- ***Synonyms for inpatient facility include:*** *Acute care hospital discharges, psychiatric inpatient discharges, skilled nursing facility discharges or rehabilitation inpatient discharges*
- ***Inpatient discharges*** *will be pre-populated from claims*
- ***This measure is to be reported each time*** *a patient was discharged from any inpatient facility and had an office visit within 30 days of discharge during the measurement period*
- ***"Yes"*** *should be selected if the discharge date documented is within two calendar days before or two calendar days after the prefilled discharge date*

SUBMISSION GUIDANCE

NUMERATOR REPORTING

- Determine if discharge medications were reconciled with the current medication list in the outpatient medical record within 30 days following this inpatient facility discharge
    - If the patient medications were not reconciled with the current medication list in the outpatient medical record within 30 days following this inpatient facility discharge select "No"

    OR

    - If the patient medications were reconciled with the current medication list in the outpatient medical record within 30 days following this inpatient facility discharge select "Yes"

Numerator codes can be found in the 2017 Web Interface CARE Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance ***Numerator***

NOTE:

- *The intent of the measure is to ensure that the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care reviewed the discharge medications from the inpatient facility. If others perform the medication reconciliation there must be documentation that the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care is aware of the review*
- *Medication reconciliation post discharge may be completed during a telehealth encounter*

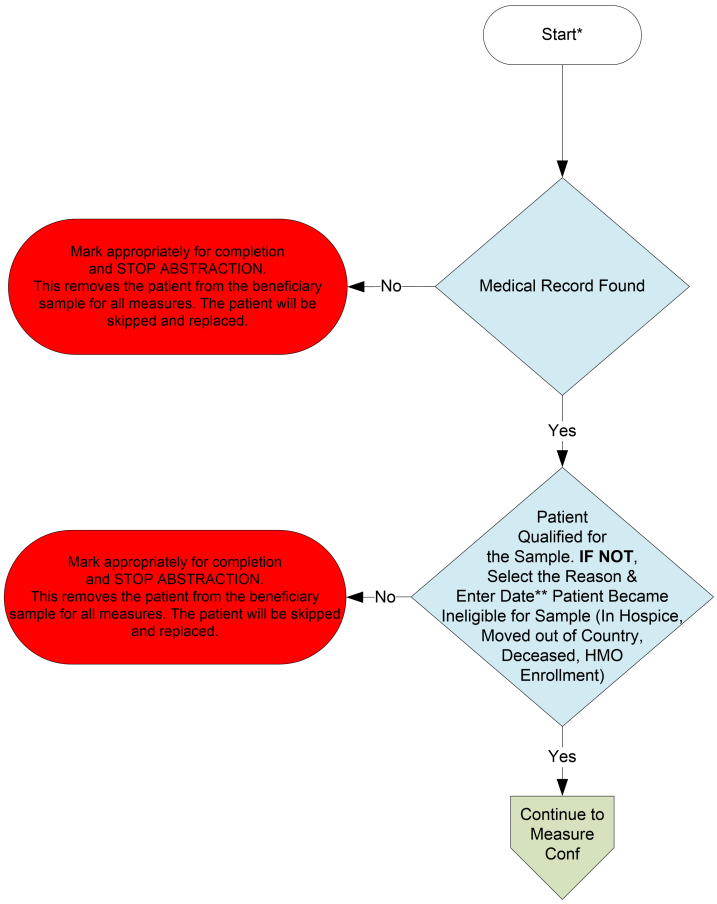
DOCUMENTATION REQUIREMENTS

When submitting data through the CMS Web Interface, the expectation is that medical record documentation is available that supports the action reported in the Web Interface i.e., medical record documentation is necessary to support the information that has been submitted.

Appendix I: Performance Calculation Flow

Patient Confirmation Flow

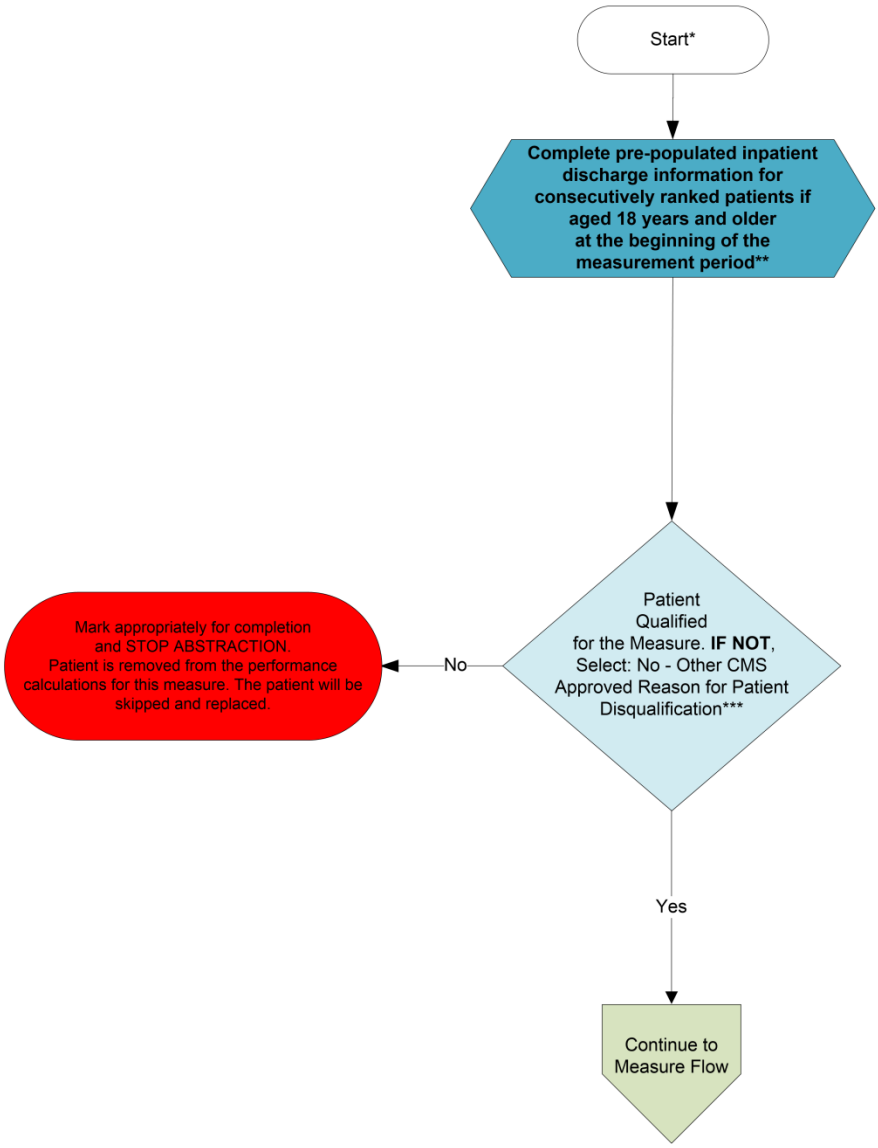
For 2017, confirmation of the “Medical Record Found”, or indicating the patient is “Not Qualified for Sample” with a reason of "In Hospice", "Moved out of Country", "Deceased", or "HMO Enrollment", will only need to be done **once** per patient.



*See the Measure Reporting Document for further instructions on how to report this measure
**If date is unknown, enter 12/31/2017

Measure Confirmation Flow for CARE-1

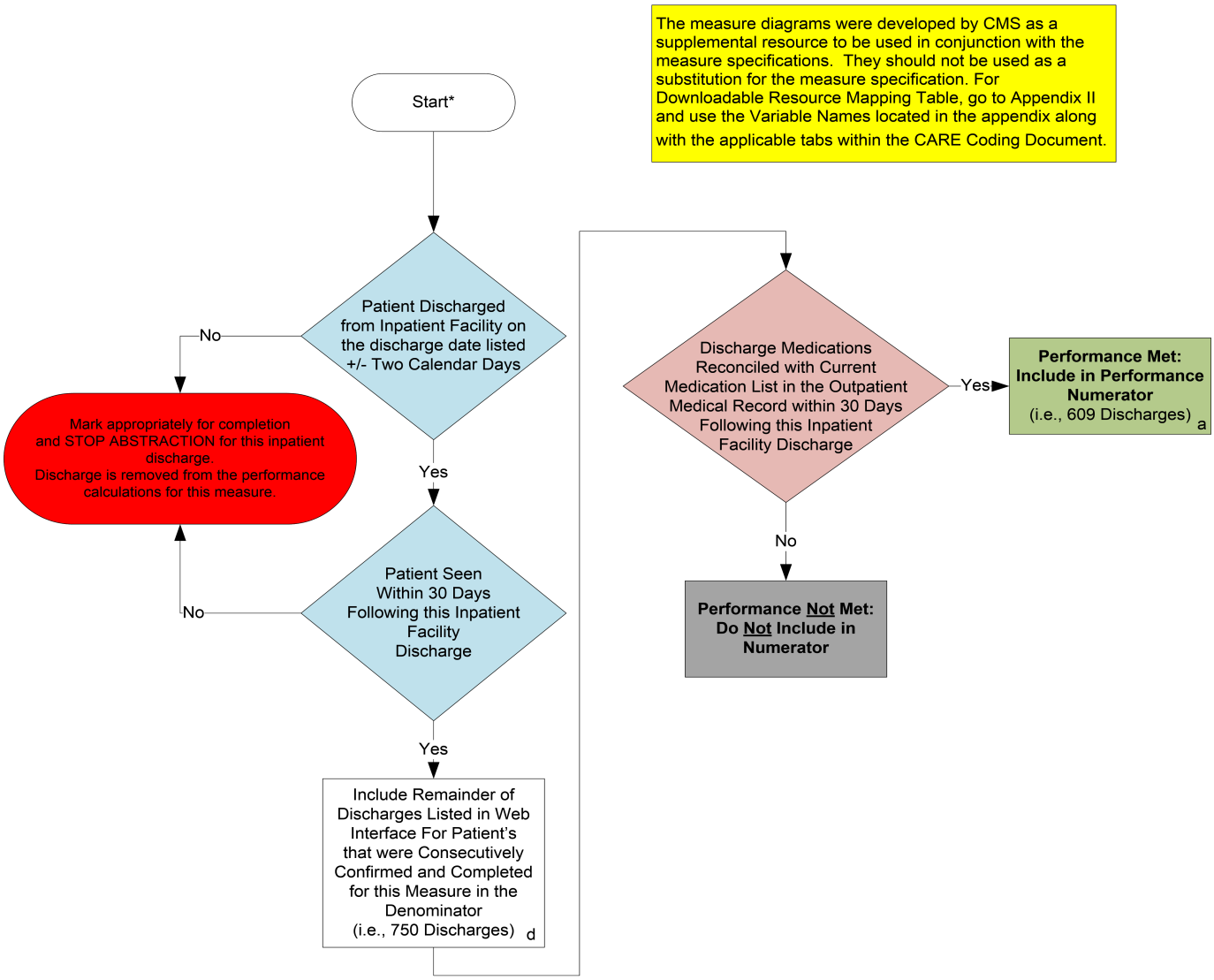
For 2017, measure specific reasons a patient is "Not Confirmed" or excluded for "Denominator Exclusion" or "Other CMS Approved Reason" will need to be done for each measure where the patient appears.



*See the Measure Reporting Document for further instructions on how to report this measure.
**Further information regarding patient selection for specific disease and patient care measures can be found in the Web Interface Sampling Methodology Document. For patients who have the incorrect date of birth listed, a change of the patient date of birth by the abstractor may result in the patient no longer qualifying for the CARE-1 measure. If this is the case, the system will automatically remove the patient from the measure requirements.
***"Other CMS Approved Reason" may only be selected if you have received an approval from CMS in the resolution of a requested Quality Payment Program Service Desk Inquiry at qpp@cms.hhs.gov

Measure Flow for CARE-1

Note: This measure applies to each inpatient discharge



SAMPLE CALCULATION:

Performance Rate=

Performance Met (a = 609 Discharges) / Denominator (d= 750 Discharges) = 609 Discharges / 750 Discharges = 81.20%

CALCULATION MAY CHANGE PENDING PERFORMANCE MET ABOVE

*See the Measure Reporting Document for further instructions on how to report this measure

Patient Confirmation Flow

For 2017, confirmation of the "Medical Record Found", or indicating the patient is "Not Qualified for Sample" with a reason of "In Hospice", "Moved out of Country", "Deceased", or "HMO Enrollment", will only need to be done once per patient. Refer to the Measure Reporting Document for further instructions.

1. Start Patient Confirmation Flow.

2. Check to determine if Medical Record can be found.
    a. If no, Medical Record not found, mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
    b. If yes, Medical Record found, continue processing.

3. Check to determine if Patient Qualified for the sample.
    a. If no, the patient does not qualify for the sample, select the reason why and enter the date (if date is unknown, enter 12/31/2017) the patient became ineligible for sample. For example; In Hospice, Moved out of Country, Deceased, HMO Enrollment. Mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
    b. If yes, the patient does qualify for the sample; continue to the Measure Confirmation Flow for CARE-1.

Measure Confirmation Flow for CARE-1

For 2017, measure specific reasons a patient is "Not Confirmed" or excluded for "Denominator Exclusion" or "Other CMS Approved Reason" will need to be done for each measure where the patient appears. Refer to the Measure Reporting Document for further instructions.

1. Start Measure Confirmation Flow for CARE-1. Complete pre-populated discharge information for consecutively ranked patients aged 18 years and older at the beginning of the measurement period. Further information regarding patient selection for specific disease and patient care measures can be found in the Web Interface Sampling Methodology Document. For patients who have the incorrect date of birth listed, a change of the patient date of birth by the abstractor may result in the patient no longer qualifying for the CARE-1 measure. If this is the case, the system will automatically remove the patient from the measure requirements.

2. Check to determine if the patient qualifies for the measure (Other CMS Approved Reason).
    a. If no, the patient does not qualify for the measure select: No – Other CMS Approved Reason for patient disqualification. Mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced. "Other CMS Approved Reason" may only be selected if you have received an approval from CMS in the resolution of a requested Quality Payment Program Service Desk Inquiry at QPP Service Desk. Stop processing.
    b. If yes, the patient does qualify for the measure, continue to the CARE-1 measure flow.

Measure Flow for CARE-1

Note: This measure applies to each patient discharge

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used as a substitution for the measure specifications. For Downloadable Resource Mapping Table, go to Appendix II and use the Variable Names located in the appendix along with the applicable tabs within the CARE Coding Document.

1. Start processing 2017 CARE-1 (NQF 0097) Flow for the patients that qualified for sample in the Patient Confirmation Flow and the Measure Confirmation Flow for Care-1.

2. Check to determine if the patient was discharged from an inpatient facility on the listed discharge date (plus or minus two calendar days).
    a. If no, the patient was not discharged from an inpatient facility on the listed discharge date (plus or minus two calendar days), mark appropriately for completion and stop abstraction for this discharge.
    b. If yes, the patient was discharged from an inpatient facility on the listed discharge date (plus or minus two calendar days), continue processing.

3. Check to determine if the patient was seen in the office/clinic within 30 days following this inpatient facility discharge.
    a. If no, the patient was not seen in the office/clinic within 30 days following this inpatient facility discharge, mark appropriately for completion and stop abstraction for this discharge.
    b. If yes, the patient was seen in the office/clinic within 30 days following this inpatient facility discharge, this discharge will be included in the denominator for performance rate calculations. Note: Include remainder of discharges listed in the Web Interface for patients that were consecutively confirmed and completed for this measure in the denominator. For the sample calculation in the flow these discharges would fall into the 'd' category (eligible denominator, i.e. 750 discharges). Continue processing.

4. Check to determine if the discharge medications were reconciled with the current medication list in the outpatient medical record within 30 days following this inpatient facility discharge.
    a. If no, the discharge medications were not reconciled with the current medication list in the outpatient medical record within 30 days following this inpatient facility discharge, performance is not met and should not be included in the numerator. Stop processing.
    b. If yes, the discharge medications were reconciled with the current medication list in the outpatient medical record within 30 days following this inpatient facility discharge, performance is met and this discharge will be included in the numerator. For the sample calculation in the flow these discharges would fall into the 'a' category (numerator, i.e. 609 discharges). Stop processing.

Sample Calculation

Performance Rate Equals
Performance Met is category 'a' in the measure flow (609 discharges)
Denominator is category 'd' in measure flow (750 discharges)
609 (Performance Met) divided by 750 (Eligible Denominator) equals a performance rate of 81.20 percent
Calculation May Change Pending Performance Met

Appendix II: Downloadable Resource Mapping Table

Each data element within this measure's denominator or numerator is defined as a pre-determined set of clinical codes. These codes can be found in the 2017 Web Interface CARE Coding Document.

*CARE-1: Medication Reconciliation Post-Discharge			
Measure Component/Excel Tab	Data Element	Variable Name	Coding System(s)
Denominator/Encounter Codes	Hospital Discharge	HOSP_DIS_CODE	C4 SNM
	Office Visit	ENCOUNTER_CODE	C4 HCPCS SNM
Numerator/Numerator Codes	Medications Reconciled	MED_RECON_CODE	C4 SNM

**For EHR mapping, the coding within CARE-1 is considered to be all inclusive*

Appendix III: Measure Rationale and Clinical Recommendation Statements

RATIONALE:

Medications are often changed while a patient is hospitalized. Continuity between inpatient and on-going care is essential.

CLINICAL RECOMMENDATION STATEMENTS:

Medication reconciliation post-discharge is an important step to catch potentially harmful omissions or changes in prescribed medications, particularly in elderly patients that are prescribed a greater quantity and variety of medications (Leape, 1991). Although the magnitude of the effect of medication reconciliation alone on patient outcomes is not well studied, there is agreement among experts that potential benefits outweigh the harm (Coleman, 2003; Pronovost, 2003; IOM, 2002; IOM, 2006). Medication reconciliation post-discharge is recommended by the Joint Commission patient safety goals (Kienle, 2008), the American Geriatric Society (Coleman, 2003), Society of Hospital Medicine (Kripalani, 2007; Grennwald, 2010), ACOVE (Assessing Care of Vulnerable Elders; Knight, 2001), and the Task Force on Medicines Partnership (2005). Additionally, measurement of medication reconciliation post-discharge has been cited by the National Quality Forum and the National Priorities Partnership as a measurement priority area (NQF, 2010)

No trials of the effects of physician acknowledgment of medications post-discharge were found. However, patients are likely to have their medications changed during a hospitalization. Estimates suggest that 46% of medication errors occur on admission or discharge from a hospital (Pronovost, 2003). Therefore, medication reconciliation is a critical piece of care coordination post-discharge for all individuals who use prescription medications. Prescription medication use is common among adults of all ages, particularly older adults and adults with chronic conditions. On average, 82% of adults in the U.S. are taking at least one medication (prescription or nonprescription, vitamin/mineral, herbal/natural supplement); 29% are taking five or more. Older adults are the biggest consumers of medications with 17-19% of people 65 and older taking at least ten medications in a given week (Slone Survey, 2006).

One observational study showed that 1.5 new medications were initiated per patient during hospitalization, and 28% of chronic medications were canceled by the time of hospital discharge. Another observational study showed that at one week post-discharge, 72% of elderly patients were taking incorrectly at least one medication started in the inpatient setting, and 32% of medications were not being taken at all. One survey study faulted the quality of discharge communication as contributing to early hospital readmission, although this study did not implicate medication discontinuity as the cause. (ACOVE)

Implementing routine medication reconciliation after discharge from an inpatient facility is an important step to ensure medication errors are addressed and patients understand their new medications. The process of resolving discrepancies in a patient's medication list reduces the risk of these 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.

First, a medication list must be collected. It is important to know what medications the patient has been taking or receiving prior to the outpatient visit in order to provide quality care. This applies regardless of the setting from which the patient came — home, long-term care, assisted living, etc. The medication list should include all medications (prescriptions, over-the-counter, herbals, supplements, etc.) with dose, frequency, route, and reason for taking it. It is also important to verify whether the patient is actually taking the medication as prescribed or instructed, as sometimes this is not the case.

At the end of the outpatient visit, a clinician needs to verify three questions:

1) Based on what occurred in the visit, should any medication that the patient was taking or receiving prior to the visit be discontinued or altered?
2) Based on what occurred in the visit, should any prior medication be suspended pending consultation with the prescriber?

3) Have any new prescriptions been added today?

These questions should be reviewed by the physician who completed the procedure, or the physician who evaluated and treated the patient.

- If the answer to ***all three questions*** is "no," the process is complete.
- If the answer to ***any question*** is "yes," the patient needs to receive clear instructions about what to do — all changes, holds, and discontinuations of medications should be specifically noted. Include any follow-up required, such as calling or making appointments with other practitioners and a timeframe for doing so Institute for Healthcare Improvement (IHI)

Appendix IV: Use Notices, Copyrights, and Disclaimers