



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 sub criterion 1b).

Brief Measure Information

NQF #: 0097

Corresponding Measures:

De.2. Measure Title: Medication Reconciliation Post-Discharge

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

De.3. Brief Description of Measure: The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.

1b.1. Developer Rationale: The intent of this measure is to address a critical component of handoffs between inpatient and outpatient providers, reconciliation of medication lists. Incomplete or delayed communication between the inpatient facility and a patient's primary caregiver may result in duplication or omission of medications or the administration of medications with potentially harmful interactions. Timely reconciliation of the discharge medication list and the outpatient medical record medication list will reduce complications resulting from drug errors, interactions, omissions, or duplications in patients after discharge from an inpatient facility.

S.4. Numerator Statement: 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.

S.6. Denominator Statement: All discharges from an in-patient setting for patients who are 18 years and older.

S.8. Denominator 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.

De.1. Measure Type: Process

S.17. Data Source: Claims, Electronic Health Records, Paper Medical Records

S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System

IF Endorsement Maintenance – Original Endorsement Date: May 01, 2007 **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 sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[0097_2_Evidence_FINAL.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

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., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

The intent of this measure is to address a critical component of handoffs between inpatient and outpatient providers, reconciliation of medication lists. Incomplete or delayed communication between the inpatient facility and a patient's primary caregiver may result in duplication or omission of medications or the administration of medications with potentially harmful interactions. Timely reconciliation of the discharge medication list and the outpatient medical record medication list will reduce complications resulting from drug errors, interactions, omissions, or duplications in patients after discharge from an inpatient facility.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. 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 include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

Health Plan Level:

The following data are extracted from HEDIS data collection for Medicare Special Needs Health Plans and reflect the most recent years of measurement for this measure. Performance data is summarized at the health plan level and described by mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at the 10th, 25th, 50th, 75th and 90th percentile. Data is stratified by year. At the time of data collection this measure was reported for all adults 65 years. Future years of reporting will include all adults age 18 and older and be stratified by age group.

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH
2010	31.1%	21.1%	8.3%	15.7%	26.1%	44.3%	59.6%
2011	30.3%	22.5%	0.0%	14.8%	24.7%	40.3%	63.5%
2012*	26.2%	22.2%	2.4%	8.5%	19.4%	39.7%	57.1%
2013	36.6%	21.1%	9.4%	19.2%	34.7%	52.8%	62.1%

*Change in specification led to decreased performance. Trend should be interpreted with caution.

In 2013, nearly 1.9 million Special Needs Plan beneficiaries were included in plans that reported HEDIS measures. Data is summarized at the health plan level for all Special Needs Plans submitting data for this measure for 2013. Patients included in the HEDIS data include a diverse representation of ages, race and diagnoses. The table below shows the average number of eligible patients per health plan and the standard deviation of that average across health plans.

Year	N Plans	Avg Eligible Population per Plan	SD
2010	316	678.3	1,262.7
2011	294	703.9	1,277.4
2012	334	629.9	1,190.6
2013	353	655.9	1,246.9

Physician Level:

The following data are extracted from Physician Quality Reporting System (PQRS) and reflect claims data for services provided from January 1, 2013 through December 31, 2013. Currently PQRS is a pay-for-reporting incentive program that allows providers to

choose which quality measures to report on. In 2013, of 392,308 eligible providers, only 1.6% chose to report on this measure. Therefore, the performance rates below are reflective of less than two percent of Medicare providers. At the time of data collection this measure applied to adults 65 years and older. In 2015, the measure was revised to reflect all adults 18 and older. For the next year of quality measurement reporting, the physician level performance will be reported for the 18-64, and 65+ age groups.

Performance data is summarized at the physician level and described by mean, 10th, 25th, 50th, 75th and 90th percentile.

Performance Rate for all Reporting Providers for 2013

Mean | 10th | 25th | 50th | 75th | 90th

96.3% | 92.3% | 100% | 100% | 100% | 100%

The following data (also extracted from PQRS) show the average performance rates for several years prior to 2013.

Average performance rates from 2010-2012

2010 | 91.3%

2011 | 95.9%

2012 | 96.4%

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.

N/A

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 maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Health Plan Reporting:

NCQA does not currently collect performance data stratified by race, ethnicity, or language. Escarce et al. have described in detail the difficulty of collecting valid data on race, ethnicity and language at the health plan level (Escarce, 2011). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity, in order to assess the presence of health care disparities. The HEDIS Health Plan Measure Set contains two measures that can assist with stratification to assess health care disparities. The Race/Ethnicity Diversity of Membership and the Language Diversity of Membership were designed to promote standardized methods for collecting these data. These measures follow Office of Management and Budget and Institute of Medicine guidelines for collecting and categorizing race/ethnicity and language data. In addition, NCQA's Multicultural Health Care Distinction Program outlines standards for collecting, storing and using race/ethnicity and language data to assess health care disparities. Based on extensive work by NCQA to understand how to promote culturally and linguistically appropriate services among plans and providers, we have many examples of how health plans have used HEDIS measures to design quality improvement programs to decrease disparities in care.

Escarce JJ, Carreón R, Veselovskiy G, Lawson EH. Collection of race and ethnicity data by health plans has grown substantially, but opportunities remain to expand efforts. Health Aff (Millwood). 2011;30(10):1984-1991. - See more at: <http://www.ajmc.com/publications/issue/2012/2012-7-vol18-n7/exploring-health-plan-perspectives-in-collecting-and-using-data-on-race-ethnicity-and-language/4#sthash.23sL3Luc.dpuf>

Physician Level Reporting:

CMS does not currently report performance data stratified by different variables in the PQRS program, where the measure is in use.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

While there is no evidence on disparities in receiving medication reconciliation, there is evidence that disparities in health outcomes may be explained by a patients' inability to afford prescription medications. Studies have documented particularly low adherence

rates among the poor and ethnic minorities within the U.S. (Cobaugh et al. 2008). Income inadequacy is a strong predictor for not filling prescription medications. One study that looked at racial disparities in the quality of medication use in older adults found that 28 percent of blacks could not purchase their medication due to cost compared to 12 percent of whites (Roth et al. 2009). Medication reconciliation post-discharge may be particularly important for patients with poor adherence to their medications, so the prescriber can evaluate what the patient is taking and reinforce which medications are most needed to improve their health.

Cobaugh, D.J., E. Angner, C.I. Kiefe, M.N. Ray, C.L. Lacivita, N.W. Weissman, K.G. Saag, J.J. Allison. 2008. Effect of racial differences on ability to afford prescription medications. American Journal of Health-System Pharmacy: AJHP: Official Journal Of The American Society Of Health-System Pharmacists. 65, no. 22: 2137-43.

Roth, M. T., Esserman, D. A., Ivey, J. L., & Weinberger, M. Racial disparities in the quality of medication use in older adults: baseline findings from a longitudinal study. Journal of general internal medicine 2009; 25, 228-234.

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 sub criteria 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. Non-Condition Specific(check all the areas that apply):

Care Coordination, Safety : Medication

De.7. 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

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.)

<http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/geriatrics-ws.pdf>

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped 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)

This is not an eMeasure 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)

No data dictionary Attachment:

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

- Revised the time period for the numerator from 60 days to 30 days to harmonize measures
- Adjusted eligible population by expanding the age range to include patients 18 years and older. These changes will encourage medication reconciliation among all adults who were discharged from an inpatient facility and provides an opportunity to measure care coordination post-discharge as well as patient safety.
- Adjusted the specification to add examples of medication reconciliation. This change provides more clarity about the type of documentation that counts as evidence of medication reconciliation.
- Added administrative codes (CPT-II) for transitional care visits newly developed under Medicare
- Combined physician level (#0097) and health plan level (#0554) measures into a single NQF submission

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) **DO NOT** include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

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.

S.5. 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, time period for data collection, 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 (S.14).

This measure is specified for medical record or administrative data collection.

Medical Record Numerator Details:

- Documentation in the outpatient medical record must include evidence of medication reconciliation between the inpatient medication list and the medication list in the outpatient medical record, 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

Administrative:

Medication Reconciliation CPT Codes:

- 99495: Transitional care management services with the following required elements: (1) communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, (2) medical decision making of at least moderate complexity during the service period and (3) face-to-face visit, within 14 calendar days of discharge.
- 99496: Transitional care management services with the following required elements: (1) communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, (2) medical decision making of high complexity during the service period and (3) face-to-face visit, within 7 calendar days of discharge.
- 1111F: Discharge med/current med merge

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

All discharges from an in-patient setting for patients who are 18 years and older.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, 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 target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The denominator for this measure is identified by administrative codes, which are specific to the level of reporting. The denominator for both levels of reporting is based on episodes, not patients. If patients have more than one discharge, include all discharges between January 1 and December 1 of the measurement year. This measure is stratified by age group so three denominator groups are identified for each level of reporting: Patients age 18-64, Patients age 65+ and all patients.

Health Plan Level:

Administrative:

- An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.
- Stratify the denominator by age group based on age as of December 31 of the measurement year: Patients 18-64 years of age; Patients 65 years of age and older; All Patients 18 years of age and older.

Physician Level:

- Patients who were discharged from an acute or nonacute inpatient facility on or between January 1 and December 1 of the measurement year and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care. Codes to identify visit with on-going care provider are below.
- Stratify the denominator by age group based on age on the date of encounter: Patients 18-64 years of age; Patients 65 years of age and older; All Patients 18 years of age and older.

CPT encounter codes for visit with Ongoing Care Provider:

90791, 90792, 90832, 90834, 90837, 90839, 90845, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0402, G0438, G0439

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

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.

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, 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.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – 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.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. 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.14. Calculation Algorithm/Measure Logic (Diagram or 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; time

period for data, aggregating data; risk adjustment; etc.)

Step 1: Determine the eligible population. The eligible population is all the patients aged 18 years and older.

Step 2: Determine number of patients meeting the denominator criteria as specified in section S.9 above. The denominator includes all patients discharged from an inpatient facility. Patients may be counted more than once in the denominator if they had more than one discharge during the measurement year. Stratify the patients by age groups.

Step 3: Determine the number of patients who meet the numerator criteria as specified in section S.6 above. The numerator includes all patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.

Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2 for each age strata.

S.15. Sampling *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A

S.16. Survey/Patient-reported data *(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)*

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*

If other, please describe in S.18.

Claims, Electronic Health Records, Paper Medical Records

S.18. Data Source or Collection Instrument *(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)*

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Health Plan Level:

- This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan patients. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Maintenance Organizations via NCQA's online data submission system.

Physician Level:

- This measure is based on administrative claims to identify the eligible population and medical record documentation collected in the course of providing care to health plan patients to identify the numerator. In the PQRS program, this measure is coded using CPT and CPT Category II codes specific to quality measurement.

S.19. Data Source or Collection Instrument *(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*

No data collection instrument provided

S.20. Level of Analysis *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*

Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System

S.21. Care Setting *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*

Outpatient Services

If other:

S.22. 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.)*

N/A

2. Validity – See attached Measure Testing Submission Form

0097_3_Testing_Health_Plan_Level_FINAL-635641004034460092.docx, 0097_3_Testing_Provider_Level_FINAL-635641004297003043.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

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) Update this field for **maintenance of endorsement**.

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. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).
This measure is not currently specified as an eMeasure for use in the CMS Meaningful Use program. However, health plans and providers that use an electronic health record to capture medication reconciliation use that data to report on this measure.

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. Please also complete and attach the NQF Feasibility Score Card.

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. Required for maintenance of endorsement. Describe difficulties (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 instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

Health Plan Level:

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

In addition to the HEDIS Audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system is vital to the regular re-evaluation of NCQA measures.

Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the scientific soundness and feasibility of the measure.

Physician Level:

Feedback on use of this measure in CMS PQRS program has been positive with few questions raised by participating clinicians to the CMS vendor. NCQA works with the CMS vendor to review any questions or issues raised with the measure on a bi-weekly basis.

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).

Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

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.

Specific Plan for Use	Current Use (for current use provide URL)
Quality Improvement (Internal to the specific organization)	<p>Public Reporting Physician Quality Reporting Systems (PQRS) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/</p> <p>Payment Program Physician Quality Reporting Systems (PQRS) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/</p> <p>Regulatory and Accreditation Programs HEDIS ACO http://www.ncqa.org/Programs/Accreditation/AccountableCareOrganizationACO.aspx</p>

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

Health Plan Level Use:

CMS MEDICARE PART C SPECIAL NEEDS PLAN REPORTING: Annual performance data on this measures is publically reported by CMS for all Special Needs Plans. In 2013, data was summarized at the national level for all 353 Special Needs Plans representing 1.9 million beneficiaries.

ACCOUNTABLE CARE ORGANIZATION ACCREDITATION: This measure is used in NCQA's ACO Accreditation program, that helps health care organizations demonstrate their ability to improve quality, reduce costs and coordinate patient care. ACO standards and guidelines incorporate whole-person care coordination throughout the health care system.

Physician Level Use:

Physician Quality Reporting System: This measure is used in the Physician Quality Reporting System (PQRS) which is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). Eligible professionals who satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer) receive these payment incentives and adjustments.

4a1.2. 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?)

N/A

4a1.3. 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.)

We are considering expanding this measure to reporting by all Medicare Advantage Plans. If the measure use is expanded we will consider publically reporting rates in the following programs:

STATE OF HEALTH CARE ANNUAL REPORT: This measure would be publically reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2012 the report included measures on 11.5 million Medicare Advantage beneficiaries in 455 Medicare Advantage health plans, 99.4 million members in 404 commercial health plans, and 14.3 million Medicaid beneficiaries in 136 plans across 50 states.

QUALITY COMPASS: This measure would be used in Quality Compass which is an indispensable tool used for selecting a health plan, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

4a2.2.2. Summarize the feedback obtained from those being measured.

4a2.2.3. Summarize the feedback obtained from other users

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

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.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (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.)

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.

N/A

4b2. 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).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

No unintended negative consequences were identified during testing. No unintended negative consequences have been reported since this measure's implementation.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

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)

0419 : Documentation of Current Medications in the Medical Record

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

2456 : Medication Reconciliation: Number of Unintentional Medication Discrepancies per Medication Per Patient

2988 : Medication Reconciliation for Patients Receiving Care at Dialysis Facilities

3317 : Medication Reconciliation on Admission

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

5a. Harmonization of Related Measures

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 harmonized to the extent possible?

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 details.

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.)

This measure assesses medication reconciliation between a discharge medication list and an outpatient medication list conducted post hospital discharge by an ongoing care provider and documented in the outpatient record. The denominator for this measure is all patients 18+ discharged from an inpatient facility to the community.

Related Measures:

Measure 0553 is conducted at health plan level. This measure assesses annual outpatient medication review by a prescribing practitioner or clinical pharmacist among all patients aged 66+. A hospital discharge is not required to meet denominator criteria

therefore the measure has a different target population than measure 0097 and is not a competing measure.

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 only focused on the reconciliation of medications that were prescribed during the inpatient stay and looks to see if the patient themselves receive this reconciled list at discharge. This measure does not address whether a reconciled medication list is documented in the outpatient medical record. Therefore the measure focus is different from measure 0097, which focuses on whether or not a patients' discharge medications were reconciled with their current medications in the outpatient setting.

Measure 2456 is conducted at the hospital/acute facility level. This measure assesses the quality of the medication reconciliation process in the hospital by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. This process is completed by a trained pharmacist who at the time of admission, compares the admission orders to the preadmission medication list to look for discrepancies and identify which discrepancies were unintentional using brief medical record review. This measure does not address whether a reconciled medication list is documented in the outpatient medical record after discharge. Therefore the measure focus is different from measure 0097.

Measure 0419 is conducted at the provider level. This measure looks at the percentage of visits for all patients 18+ for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. The list must include all known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary supplements AND must contain the medications' name, dosage, frequency and route of administration. This measure only looks for documentation of current medications and is not focused on reconciling medications after a discharge. The measure has a different target population and measure focus and is therefore not competing.

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.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance

Co.2 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955-1728-

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

Co.4 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955-1728-

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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Lynne Rothney-Kozlak, Rothney-Kozlak Consulting, LLC
Natan Szapiro, Independence Blue Cross

An expert panel was used to assess face validity of the measure. The panel consists of 33 members, whose specialties include internal medicine, geriatrics, anesthesia, orthopedic surgery, physical medicine & rehabilitation, neurology, palliative medicine, urology, geriatric psychiatry, emergency medicine, nephrology, radiation oncology, ophthalmology, medical epidemiology, methodology, hospital medicine, family medicine, and bioethics.

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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2006

Ad.3 Month and Year of most recent revision: 09, 2014

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? 06, 2016

Ad.6 Copyright statement: © 2006 by the National Committee for Quality Assurance

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