eMeasure Title	**Documentation of Current Medications in the Medical Record**		
eMeasure Identifier (Measure Authoring Tool)	68	**eMeasure Version number**	6.1.000
NQF Number	0419	**GUID**	9a032d9c-3d9b-11e1-8634-00237d5bf174
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	Centers for Medicare & Medicaid Services (CMS)		
Measure Developer	Quality Insights of Pennsylvania		
Endorsed By	National Quality Forum		
Description	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.		
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Measure Scoring	Proportion		
Measure Type	Process		
Measure Item Count	Occurrence A of Encounter, Performed: Medications Encounter Code Set		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Maintaining an accurate and complete medication list has proven to be a challenging documentation endeavor for various health care provider settings. While most of outpatient encounters (2/3) result in providers prescribing at least one medication, hospitals have been the focus of medication safety efforts (Stock et al., 2009). Nassaralla et al. (2007) caution that this is at odds with the current trend, where patients with chronic illnesses are increasingly being treated in the outpatient setting and require careful monitoring of multiple medications. Additionally Nassaralla etal. (2007) reveal that it is in fact in outpatient settings where more fatal adverse drug events (ADE) occur when these are compared to those occurring in hospitals (1 of 131 outpatient deaths compared to 1 in 854 inpatient deaths). In the outpatient setting, adverse drug events (ADEs) occur 25% of the time and over one-third of these are considered preventable (Tache et al., 2011). Particularly vulnerable are patients over 65 years, with evidence suggesting that the rate of ADEs per 10,000 person per year increases with age; 25-44 years old at 1.3; 45-64 at 2.2, and 65 + at 3.8 (Sarkar et al., 2011). Another vulnerable group are chronically ill individuals. These population groups are more likely to experience ADEs and subsequent hospitalization. A multiplicity of providers and inadequate care coordination among them has been identified as barriers to collecting complete and reliable medication records. Documentation of current medications in the medical record facilitates the process of medication review and reconciliation by the provider, which are necessary for reducing ADEs and promoting medication safety. The need for provider to provider coordination regarding medication records, and the existing gap in implementation, is highlighted in the American Medical Association's (AMA) Physician's Role in Medication Reconciliation (2007), which states that "critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes" (p.7). This is because clinical decisions based on information that is incomplete and/or inaccurate are likely to lead to medication error and ADEs. Weeks et al. (2010) noted similar barriers and identified the utilization of health information technology as an opportunity for facilitating the creation of		

	universal medication lists.
Clinical Recommendation Statement	The Joint Commission's 2015 Ambulatory Care National Patient Safety Goals guide providers to maintain and communicate accurate patient medication information. Specifically, the section "Use Medicines Safely NPSG.03.06.01" states the following: "Maintain and communicate accurate patient medication information. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected to reconcile current and newly ordered medications and to safely prescribe medications in the future." (Joint Commission, 2015, retrieved at: http://www.jointcommission.org/assets/1/6/2015_NPSG_AHC1.PDF). The National Quality Forum's 2010 update of the Safe Practices for Better Healthcare, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care (p. 40).
Improvement Notation	Higher score indicates better quality
Reference	American Medical Association (2007). The physician's role in medication reconciliation: Issues, strategies and safety principles. Retrieved from https://bcpsqc.ca/documents/2012/09/AMA-The-physician%e2%80%99s-role-in-Medication-Reconciliation.pdf
Reference	Stock, R., Scott, J., & Gurtel, S. (2009). Using an Electronic Prescribing System to Ensure Accurate Medication Lists in a Large Multidisciplinary Medical Group. The Joint Commission Journal on Quality and Patient Safety; 35(5), 271-277.
Reference	Nassaralla, C.L., Naessens, J.M., Chaudhry, R., et al. (2007). Implementation of a medication reconciliation process in an ambulatory internal medicine clinic. Quality and Safety in Health Care 2007; (16), 90-94.
Reference	Sarkar, U., Lopez, A., Maselli, J.H., Gonzalez, R. (2011). Adverse Drug Events in U.S. Adult Ambulatory Medical Care. Health Services Reserach, 46(5), 1517-1533.
Reference	Weeks, D.L., Corbette, C.F., Stream, G. (2010). Beliefs of Ambulatory Care Physicians about Accuracy of Patient Medication Records and Technology-Enhanced Solutions to Improve Accuracy. Journal for Healthcare Quality; 32(5), 12-21.
Reference	The Joint Commission (2015). Ambulatory Care National Patient Safety Goals. Retrieved from http://www.jointcommission.org/assets/1/6/2015_NPSG_AHC1.PDF
Reference	National Quality Forum (2010). Safe Practices for Better Healthcare - 2010 Update. Retrieved from http://www.qualityforum.org/Projects/Safe_Practices_2010.aspx
Reference	Tache, S.V., Sonnichsen, A., & Ashcroft, D.M. (2011). Prevalence of Adverse Drug Events in Ambulatory Care: A Systematic Review. The Annals of Pharmacotherapy, 45(7-8), 977-989. doi: 10.1345/aph.1P627.
Definition	Current Medications: Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route. Route: Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical).
Guidance	This measure is to be reported for every encounter during the measurement period. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. This list must include all prescriptions, over-the-counter (OTC) products, herbals, vitamins, minerals, dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration. This measure should also be reported if the eligible professional documented the patient is not currently taking any medications. By reporting the action described in this measure, the provider attests to having documented a list of current medications utilizing all immediate resources available at the time of the encounter.
Transmission Format	TBD
Initial Population	All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period
Denominator	Equals Initial Population
Denominator Exclusions	None
Numerator	Eligible professional attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration
Numerator	Not Applicable

Exclusions	
Denominator Exceptions	Medical Reason: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

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Population Criteria

- **Initial Population =**
  - AND: Age>= 18 year(s) at: "Measurement Period"
  - AND: "Occurrence A of Encounter, Performed: Medications Encounter Code Set" during "Measurement Period"
- **Denominator =**
  - AND: Initial Population
- **Denominator Exclusions =**
  - None
- **Numerator =**
  - AND: "Procedure, Performed: Current Medications Documented SNMD" during "Occurrence A of Encounter, Performed: Medications Encounter Code Set"
- **Numerator Exclusions =**
  - None
- **Denominator Exceptions =**
  - OR: "Procedure, Performed not done: Medical or Other reason not done" for "Current Medications Documented SNMD" during "Occurrence A of Encounter, Performed: Medications Encounter Code Set"
- **Stratification =**
  - None

Data Criteria (QDM Variables)

- None

Data Criteria (QDM Data Elements)

- "Encounter, Performed: Medications Encounter Code Set" using "Medications Encounter Code Set Grouping Value Set (2.16.840.1.113883.3.600.1.1834)"
- "Procedure, Performed: Current Medications Documented SNMD" using "Current Medications Documented SNMD SNOMEDCT Value Set (2.16.840.1.113883.3.600.1.462)"
- "Procedure, Performed not done: Medical or Other reason not done" using "Medical or Other reason not done SNOMEDCT Value Set (2.16.840.1.113883.3.600.1.1502)"

Supplemental Data Elements

- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity CDCREC Value Set (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer SOP Value Set (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race CDCREC Value Set (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex AdministrativeGender Value Set (2.16.840.1.113762.1.4.1)"

Risk Adjustment Variables

- None

Measure Set	CLINICAL QUALITY MEASURE SET