



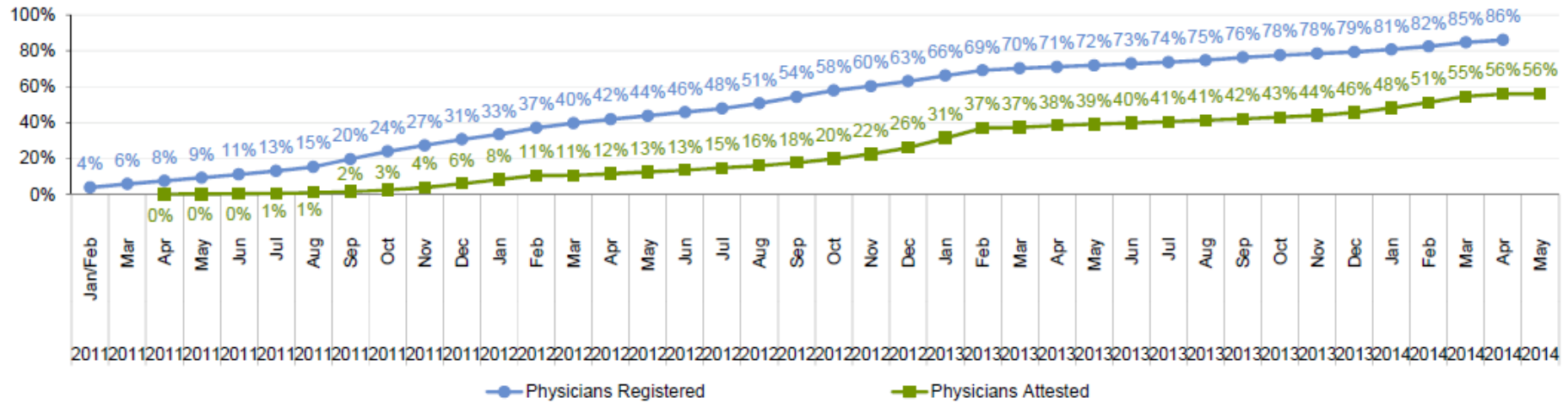
# Meaningful Use

## Medication Reconciliation

August 2014

# Physicians Attesting

**Exhibit 6. Physicians Registered and Attested For Medicare/Medicaid Incentives**



Source: CMS and Wells Fargo Securities, LLC estimates

# Regulation

## Medication Reconciliation

### Objective

The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

### Measure

The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

### Exclusion

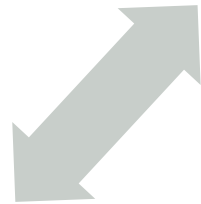
Any EP who was not the recipient of any transitions of care during the EHR reporting period.

**Medication Reconciliation** – The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

**Relevant Encounter** – An encounter during which the EP performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the EP. Essentially an encounter is relevant if the EP judges it to be so. (Note: Relevant encounters are not included in the numerator and denominator of the measure for this objective.)

**Transition of Care** – The movement of a patient from one clinical setting (inpatient, outpatient, physician office, home health, rehab, long-term care facility, etc.) to another or from one EP to another. At a minimum, transitions of care include first encounters with a new patient and encounters with existing patients where a summary of care record (of any type) is provided to the receiving provider. The summary of care record can be provided either by the patient or by the referring/transiting provider or institution.

# Transition of Care



Transition  
in

Transition  
Out

**Medication Reconciliation  
Requirement**

**Summary of Care Document  
Requirement**

# Attestation Worksheet

14	<p><b>Objective:</b> The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.</p> <p><b>Measure:</b> The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.</p> <p><b>Exclusion:</b> Any EP who was not the recipient of any transitions of care during the EHR reporting period.</p>						
	<table border="1"> <tr> <td data-bbox="426 522 1311 579">Does this exclusion apply to you?</td> <td data-bbox="1311 522 1667 579">Yes <input type="radio"/> No <input type="radio"/></td> </tr> <tr> <td data-bbox="426 579 1311 658"> <b>Numerator:</b> Number of transitions of care in the denominator where medication reconciliation was performed.         </td> <td data-bbox="1311 579 1667 658"> <input type="text"/> </td> </tr> <tr> <td data-bbox="426 658 1311 775"> <b>Denominator:</b> Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.         </td> <td data-bbox="1311 658 1667 775"> <input type="text"/> </td> </tr> </table>	Does this exclusion apply to you?	Yes <input type="radio"/> No <input type="radio"/>	<b>Numerator:</b> Number of transitions of care in the denominator where medication reconciliation was performed.	<input type="text"/>	<b>Denominator:</b> Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.	<input type="text"/>
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<b>Numerator:</b> Number of transitions of care in the denominator where medication reconciliation was performed.	<input type="text"/>						
<b>Denominator:</b> Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.	<input type="text"/>						

# Actual Screen Print

## Questionnaire: (13 of 17)

(\*) Red asterisk indicates a required field.

John Doe

Tax Identifier: XXX-XX- XXXX (SSN)

NPI:

Program Year: 2014

**Objective:** The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

**Measure:** The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

**EXCLUSION:** Any EP who was not the recipient of any transitions of care during the EHR reporting period. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

\*Does this exclusion apply to you?

Yes  No

\***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.

- This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- This data was only extracted from patient records maintained using certified EHR technology.

Complete the following information:

**Numerator** The number of transitions of care in which the patient is transitioned into the care of the EP included in the denominator where the EP performs medication reconciliation during the EHR reporting period.

**Denominator** The number of transitions of care in which the patient is transitioned into the care of the EP during the EHR reporting period.

\*Numerator: 1 \*Denominator: 1

# Where is the Med List used?



## Information Requirements for Summary of Care

### Information Requirements for Summary of Care Measure

- Patient name
- Referring or transitioning provider's name and office contact information (EP only)
- Procedure
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking Status
- Functional Status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field, including goals and instructions\*\*
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Reason for referral
- Current problem list (EPs may also include historical problems at their discretion)\*\*
- **Current medication list\*\***
- **Current medication allergy list\*\***

\*\*Required Fields



Enter information into certified EHR technology



Withhold any information provider determines could cause possible harm



Verify presence of elements; Problem List, Medication List, and Medication Allergy List



Create C-CDA



Provide summary of care record when patient is transferred to another setting of care or referred to another provider





# Where is the Med List used?



## Information Requirements for Clinical Summary

### Information Requirements for Clinical Summary Measure

- Patient name
- Provider's name and office contact information
- Date and location of the visit
- Reason for the office visit
- Current problem list
- Current medication list
- Current medication allergy list
- Procedures performed during the visit
- Immunizations or medications administered during the visit
- Vital signs taken during the visit (or other recent vital signs)
- Laboratory test results
- List of diagnostic tests pending
- Clinical instructions
- Future appointments
- Referrals to other providers
- Future scheduled tests
- Demographic information maintained within certified electronic health record technology (CEHRT) (sex, race, ethnicity, date of birth, preferred language)
- Smoking status
- Care plan field(s), including goals and instructions
- Recommended patient decision aids (if applicable to the visit)



Enter information into certified EHR technology at the time of the office visit



Withhold any information provider determines could cause possible harm



Provide modified information in clinical summary to patient (either online or on paper) within one (1) business day





# Where is the Med List used?



## Information Requirements for Patient Access

### Information Requirements for Clinical Summary Measure

- Patient name
- Provider's name and office contact information
- Current and past problem list
- Procedures
- Laboratory test results
- **Current medication list and medication history**
- **Current medication allergy list and medication allergy history**
- Vital signs (height, weight, blood pressure, BMI growth charts)
- Smoking status
- Demographic Information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field(s), including goals and instructions
- Any known care team members including the primary care provider (PCP) of record

Unless the information is not available in certified HER technology (CEHRT), is restricted from disclosure due to any federal, state, or local law regarding the privacy of a person's health information, including variations due to the age of the patient, or the provider believes that substantial harm may arise from disclosing particular health information in this manner.



Enter information into certified EHR technology as it becomes available



Withhold from online disclosure any information provider determines could cause possible harm



Make modified information available to patient online within four (4) business days



# eClinical Works – at Check In

Appointment on Monday, December 29, 2014

Encounters Find Logs Referrals Orders

Facility: Med Onc NRD - Charlevoix

Date: 12/29/2014 Provider: Riddle, Andrew J

Claim Providers Resource: Riddle, Andrew J

Start Time: 11:00 AM End Time: 11:30 AM  New Pt

Patient: ZZZZZzTest,Kelly Sel Info Hub Elgib Sts

DOB: 11/17/1966 Tel: 231-499-3746 E-mail: kbator@mhc.net W

Visit Type: [Dropdown]

Visit Status:  PEN (Pending) Reason: [Dropdown]  Transition of care

Diagnosis: [Dropdown]

Open Cases: [Dropdown] Case Manager: N

Billing Notes: [Text Area]

General Notes: [Text Area]

**Co-pay / Claim changes for this visit only**

Change co-pay for this visit [Text Box]

Non-billable visit

Step 1: From the appointment template or the Chief Complaint area of the progress note put a check in the Transition of Care box.

Checked when patients are transitioned in. Adds patient to the denominator

# eClinical Works – Provider/Nurse

The screenshot shows a software window titled "Chief Complaints (ZZZZZzTest, Kelly - 12/29/2014 11:00 AM, Dialysis)". The window has a menu bar with "Pt. Info", "Encounter", "Physical", and "Hub". Below the menu bar is a toolbar with various icons for medical actions. The main area is titled "Chief Complaint(s)" and contains a toolbar with "Browse ...", "+ Add", "- Remove", and a checked checkbox for "Transition of care". Below this is a table with two columns: "Sl No" and "Complaint". The table is currently empty. At the bottom right of the window, there is a button labeled "Medication Reconciliation".

Chief Complaint(s)    Browse ...    + Add    - Remove     Transition of care

Sl No	Complaint
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Medication Reconciliation ▶

# eClinical Works

Current Medication | Past Rx History | External Rx History | Add Medication |  Verified  Rx Name Only | Drug Interaction | Cancel

T Taking | N Not Taking | D Discontinued | U Unknown Status

Apply Status from Prior Visit

T Taking

Medication	Start Date	Stop Date	Notes	Source	Mark all as:
Lipitor 10 MG Tablet 1 tablet Once a day	04/24/2014	Stop Date	Notes	Falchney, John D	T N U D
Cervical collar Vista as directed	05/21/2014	Stop Date	Notes	Falchney, John D	T N U D
Commode OTC Miscellaneous as directed	06/23/2014	Stop Date	this is a test to see if we can		T N U D
Norco	Start Date	Stop Date	Notes		T N U D
Amoxicillin	Start Date	Stop Date	Notes		T N U D
Telbivudine	Start Date	Stop Date	Notes	Source	T N U D
Lamisil 250 MG Tablet 1 tablet Once a day	Start Date	Stop Date	Notes	Source	T N U D
Unknown					T N U D
Lipitor	Start Date	Stop Date	Notes	Source	T N U D

Chief Complaints | Past Medical History

Step 2: Review and mark medications as Verified

Adds to the numerator

# Next Gen – 2011 Certified Code

Medications  No medications [Comment](#)

Transition from another site [Reconcile](#)

[Vitamins & Supplements](#)  Meds Reviewed

# Next Gen – 2014 Certified Code

The screenshot displays a software interface with a top navigation bar containing 'Intake', 'Histories', 'SOAP', 'Finalize', and 'Checkout'. Below this is a secondary menu with 'Office Services', 'Lab order detail', 'Tobacco Usage', 'My Plan', 'Procedures', 'TB Skin Test', and 'Document Library'. A 'Care Guidelines' section is visible with a 'Global Days' link and a 'Panel Control' area with 'Toggle', 'Cycle', and refresh icons.

The main section is titled 'Medications' and includes a 'Patient status' row with several checkboxes: 'Transitioning into care', 'Summary of care received', 'No medications', and 'Medications reconciled'. The 'Transitioning into care' and 'Medications reconciled' checkboxes are circled in red. A blue arrow points from the text 'Add to the denominator' below to the 'Transitioning into care' checkbox. Another blue arrow points from the text 'Add to the numerator' below to the 'Medications reconciled' checkbox.

Medication	Sig Description
amoxicillin 500 mg tablet	take 1 tablet by oral route every 12 hours
Cardura 2 mg Tab	take 1 tablet (2MG) by oral route every day

Add to the denominator

Add to the numerator

# Key Take Aways

- Complete list of medications
- Must check Transition of Care (adds to the denominator)
- Must check Meds Reviewed/Reconciled/Verified
- eCw: The patient has to have an office visit with the provider. Telephone encounters do not count. Appointment scheduled with provider
- Must understand how your EHR handles Med Rec.



# Questions

