Meaningful Use

Medication Reconciliation

August 2014

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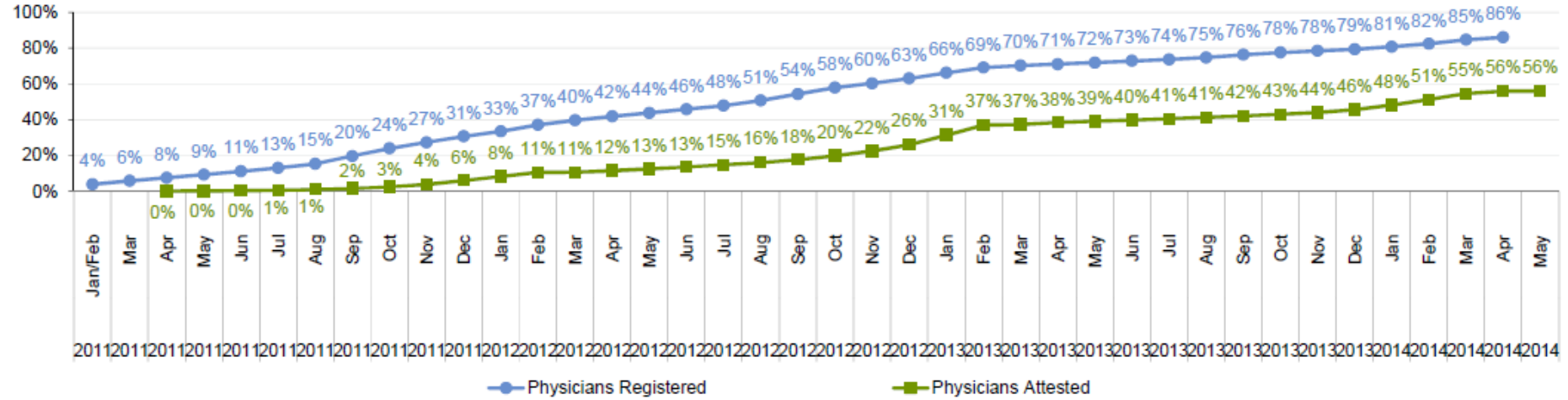
Physicians Attesting

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



Source: CMS and Wells Fargo Securities, LLC estimates

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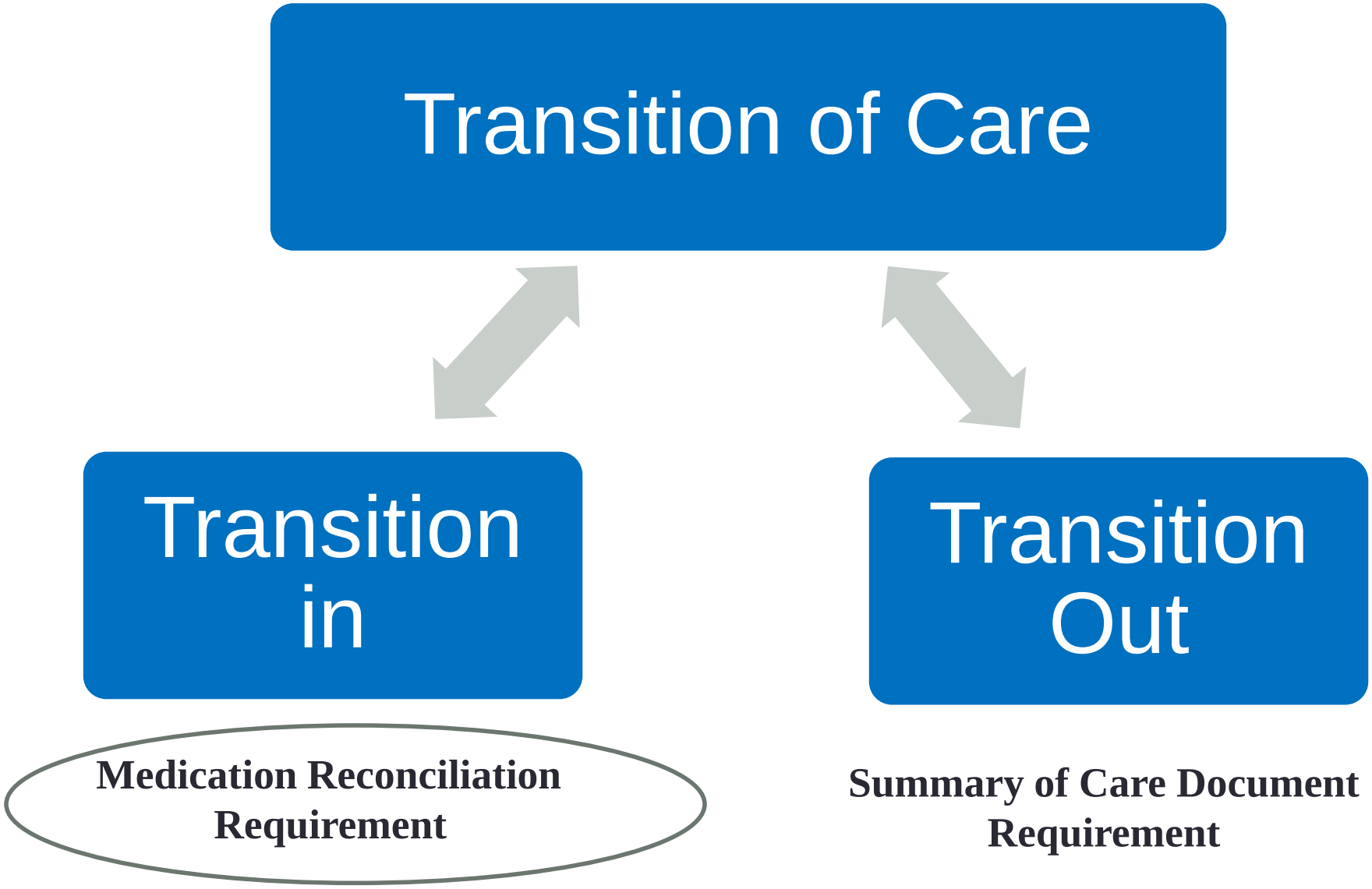
Regulation

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	**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.	
	Does this exclusion apply to you?	Yes ◯ No ◯
	Numerator: Number of transitions of care in the denominator where medication reconciliation was performed.	
	Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.	

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Actual Screen Print

John Doe
Tax Identifier: XXX-XX- XXXX (SSN)
NPI:
Program Year: 2014

Questionnaire: (13 of 17)

(*) Red asterisk indicates a required field.

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?

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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?

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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?

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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

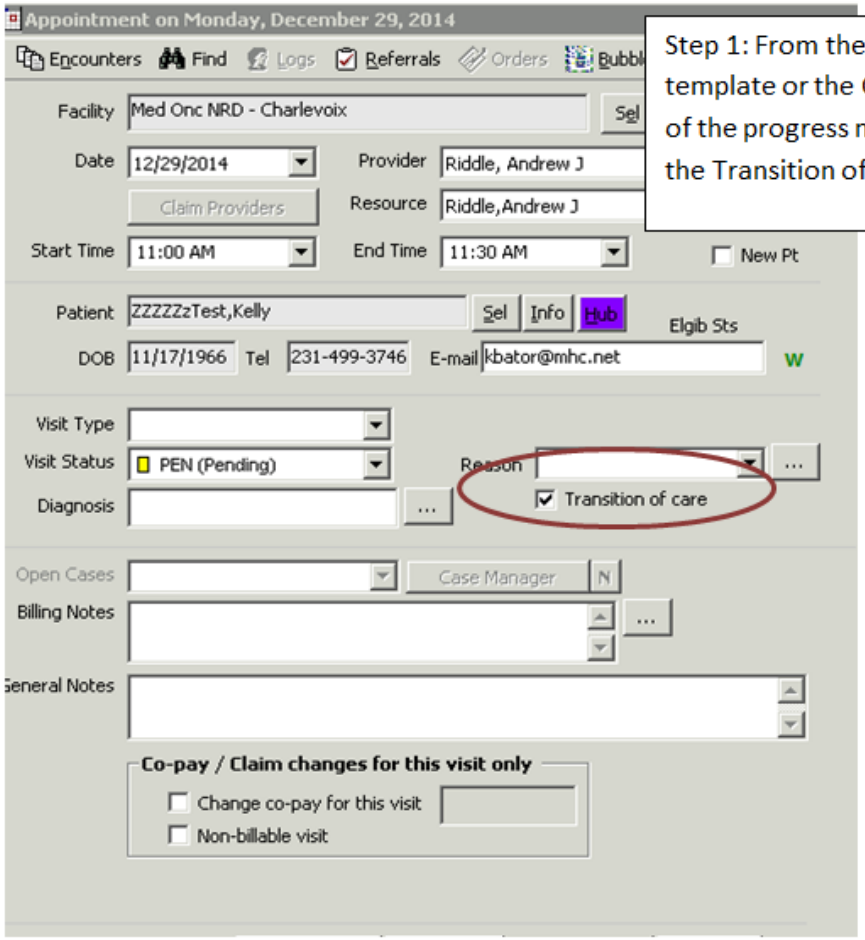
Unless the information is not available in certified HER technology (CEHRT), is restricted from disclosure due to any federal, state, or local law regarding the privacy of a person's health information, including variations due to the age of the patient, or the provider believes that substantial harm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



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

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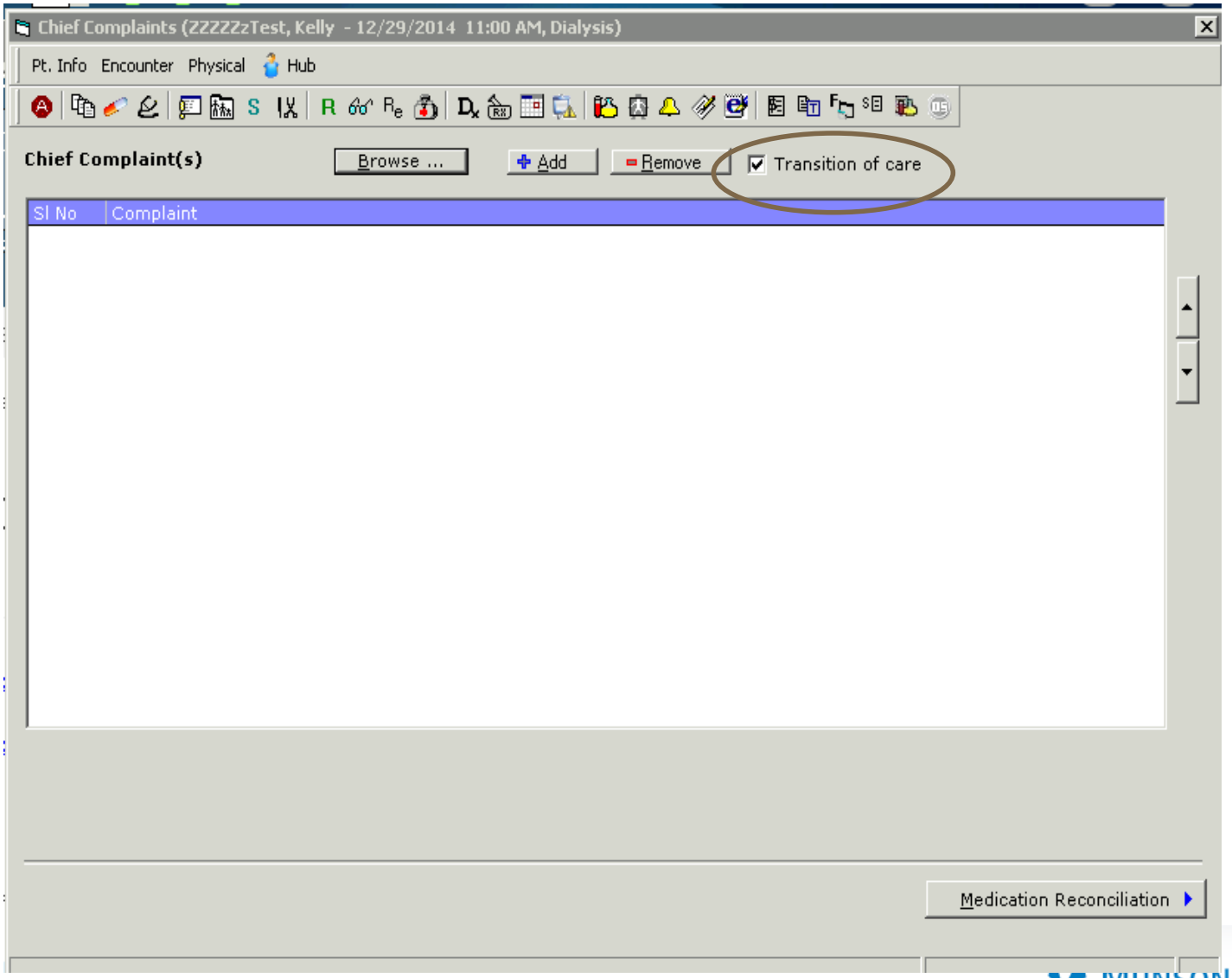
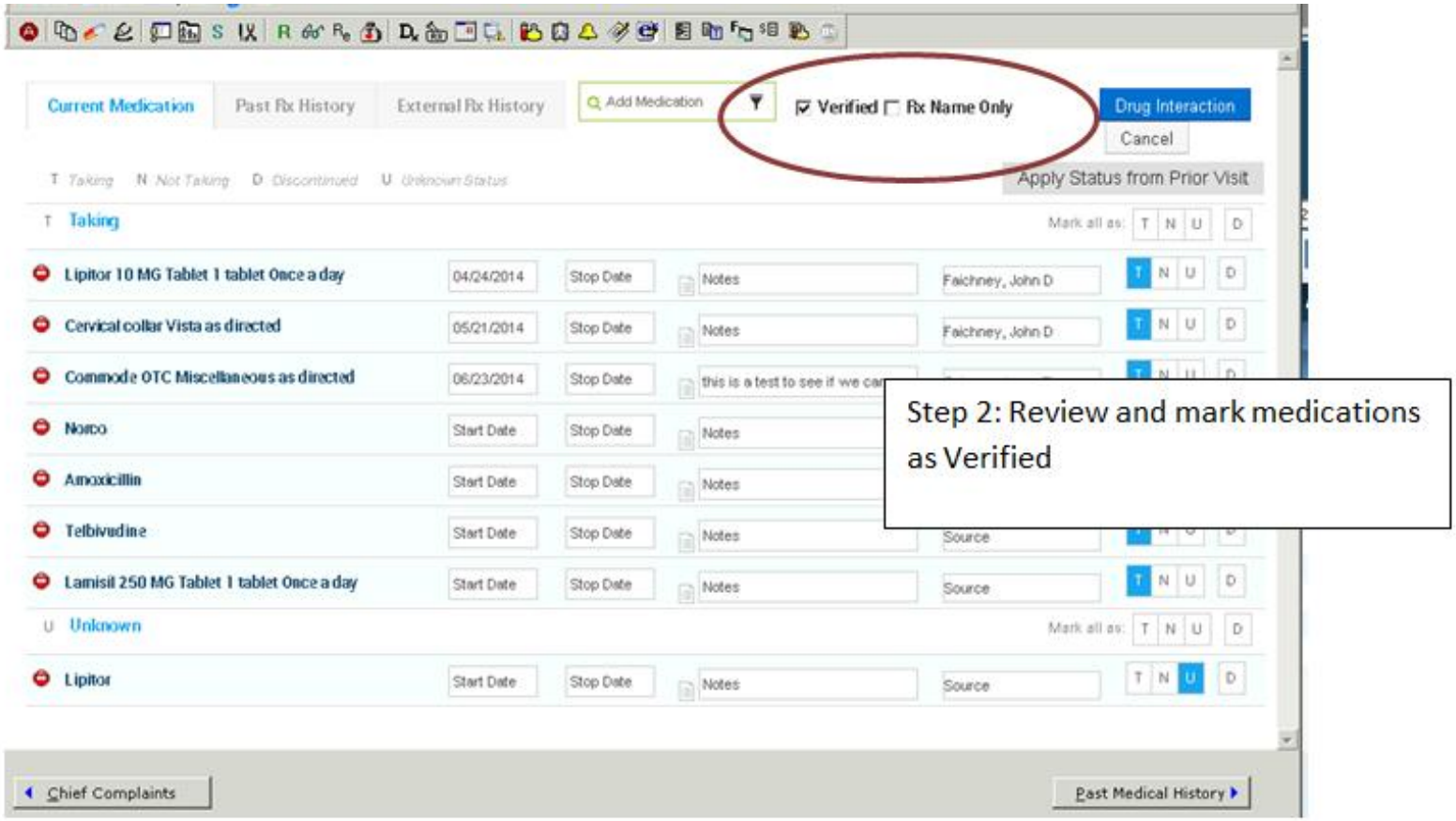
eClinical Works – Provider/Nurse



eClinical Works



Adds to the numerator

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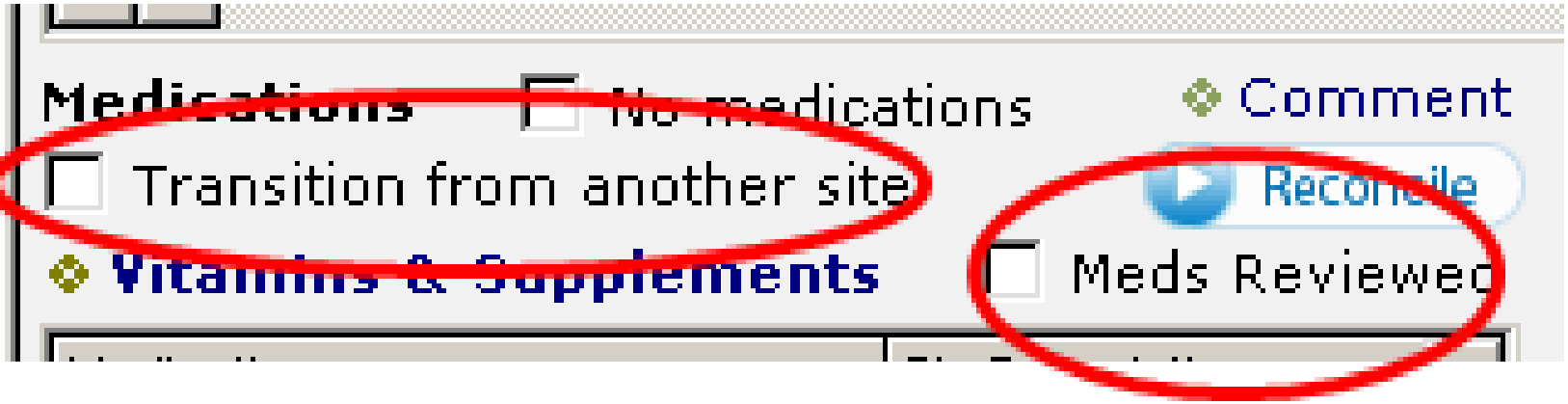
Next Gen – 2011 Certified Code



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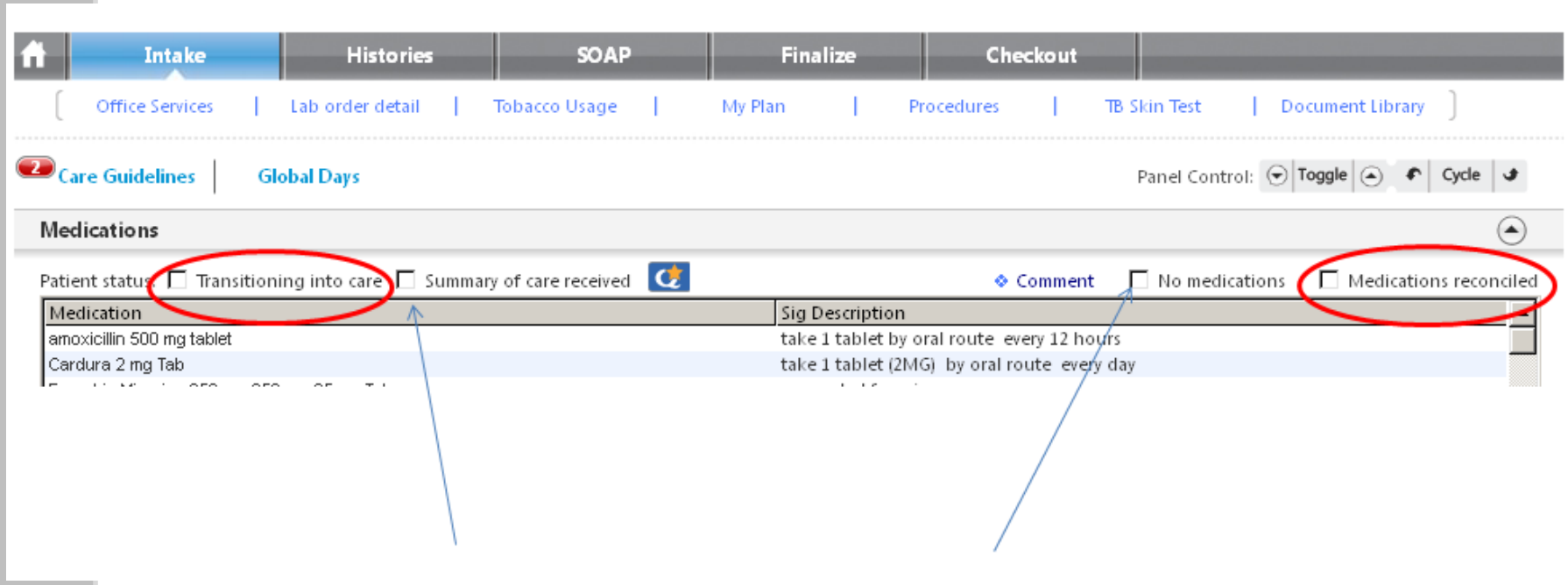
Next Gen – 2014 Certified Code



Add to the denominator

Add to the numerator

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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.

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Questions