Data Exchange for Quality Measures Implementation Guide

30-Day Medication Reconciliation Post-Discharge Use Case Update

August, 2018
SUMMARY

- Payers and providers need common transport tools to share the data required to complete medication reconciliation at all transitions care, for care management plans, during medication changes.

- Proof of 30 day medication reconciliations is increasingly required for value based care incentives. Providers and care coordinators face the challenge of collecting accurate and complete patient medication records across care settings.

- Today’s manual and adhoc processes are costly and will not scale.

- Vendors like Surescripts and others are actively leveraging FHIR resources to improve partners access to patient medication history by unlocking existing silos of this critical data from vendor, healthcare operations systems and provider EHRs.
• Complete a medication reconciliation post discharge within 30 days of inpatient stay.
• Medication Reconciliation Post-Discharge (MRP) may be completed by physician, clinical pharmacist or registered nurse in an outpatient setting.
• Reconciliation of discharge medication list against most recent medication list in the outpatient medical record.
• Completion of reconciliation must be documented in the patient’s outpatient medical record.
• Patients 18+ years of age
• Patients who die during the measurement year are excluded
• Patients who are readmitted during the 30-Day post-discharge period are excluded
Definition of 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

*from NQF, 2017 #46 NQF #0097: Medication Reconciliation
Current Workflow

Patient seen by PCP. Medication List A

Patient Admission to Hospital. Medication List B

Medications are held, added, discontinued during hospital course

Patient Discharged from Hospital. Discharge Medication List C

Pharmacist/RN MRP (Optional)

List is then communicated to outpatient provider

Patient encounter with PCP/RN. List C reconciled with List A. Reconciled Medication List D

MRP documentation & attestation

MRP reporting to payer

Measure Reporting
FHIR Profile Perspectives

- Base FHIR Resources
- Existing FHIR Profiles
  - US Core Profiles - us-core-patient, us-core-location
  - QI-Core Profiles
  - HEDIS Profiles - build.fhir.org/ig/cqframework/hedis-ig
  - Da Vinci may further constrain an existing profile for other Da Vinci Use Cases
- DEQM Level Profiles
  - Leverage QI-Core Profiles and apply to current and future measure developers
- Da Vinci FHIR Profiles
  - Profiled for use across multiple Da Vinci use cases
- Use case level profile
  - Created as needed to support the use case when one of the above does not meet requirements
This Implementation Guide is prepared as a U.S. Realm Specification with support from the Clinical Quality Framework (CQF) initiative, which is a public-private partnership sponsored by the Centers for Medicare & Medicaid Services (CMS) and the U.S. Office of the National Coordinator (ONC) to harmonize standards for clinical decision support and electronic clinical quality measurement. While this Implementation Guide is for electronic clinical quality improvement, the Quality Improvement Core (QICore) is intended to be usable for multiple use cases across domains, and much of the content is likely to be usable outside the U.S. Realm.

http://build.fhir.org/ig/cqframework/qi-core/
Use of QI-Core Profile

**Pros**
- Based on Quality Data Model (QDM) requirements that quality measures use to express their criteria and therefore aligned between the QDM and FHIR
- Based on US Core
- HEDIS Profiles use QI-Core
- QI-Core profiles subject to 3-4 rounds of balloting and review – curated
- In the US Realm, allows usage in quality measures and clinical decision support use cases
- Our usages would spur additional adoption
- Provides feedback to QI-Core for improvement
- We can use a subset of QI-Core profiles without adopting all of them
- We would not have to create some of our DV profiles
- Uses Must Support

**Cons**
- Imposes additional requirements (constraints) on the data and therefore the implementation
  - Can be mitigated by feedback from implementers so that profiles can be updated
  - Need to support additional extensions in QI-Core profiles
- STU3 and R4 transition
  - R4 QI-Core profiles dependent on R4 US Core update
- Still need review mapping to make sure QI-Core supports our use case data requirements
DEQM IG Structure

• General Guidance and Definitions
  • Background
  • Scope
  • Data flows
  • Instructions for implementers
  • Privacy, Security, and Consent
    • Address consent when there is patient specific data – does BAA cover consent vs non-PHI
    • Terms of use
• Relationship to other IGs
• Profiles and Extensions
  • Da Vinci/US Realm profiles for ALL measures using this IG – Measure, Measure Report
  • MRP use case specific profiles
• Operations
  • General explanation of operations
    • Submit, collect, pub/sub
  • MRP use case specific example of $submit-data operations
  • Address consent for MRP – Covered by BAA between payer and provider
• Terminology
• Capability Statement
• Use Case Example
  • MRP Use Case background, usage, etc
Relationship of DEQM IG and Other IGs

- **DEQM IG** provides framework for quality measure exchange in the US Realm
- **MRP use case** is an example of using the framework
  - measure-mrp used in the $submit-data operation will refer
- **HEDIS IG**
  - [http://build.fhir.org/ig/cqframework/hedis-ig/](http://build.fhir.org/ig/cqframework/hedis-ig/)
  - Will need to define measure-mrp instance with CQL
- **QI-Core IG**
  - [http://build.fhir.org/ig/cqframework/qi-core/index.html](http://build.fhir.org/ig/cqframework/qi-core/index.html)
  - Since QI-Core is dependent on US-Core, QI-Core will need to wait until R4 US-Core is available (plan is early 2019)
Managing Versioning of IG

• DEQM IG will be based on the R4 ballot guidance for backwards compatibility to STU3

• R4 Resource/profile
  • Use base R4 resources
  • Create Da Vinci (US Realm) profiles on base resources
  • “Anticipate” and Create “US Core” profiles/extensions on Patient, Encounter and Location
    • Harmonize with US-Core when their profiles are created post-R4 final ballot (early 2019)

• STU3 Resource/profile gaps
  • Create profiles with extensions to match R4 profiles (e.g. add location extension to STU3 Observation profile

• R4 Operations
  • Submit/collect/pub-sub operations will be in base FHIR operations

• STU3 Operations
  • Create custom operations as operationDefinition for MRP or broader?

• Need to determine how to align DEQM IG with other IGs which it depends
• Post of parameters and not a bundle
• Implementation of the operations in HAPI
• Ruler – HAPI RI of Clinical Reasoning
• How to transfer to HSPC
  • Task in HSPC JIRA for implementing CQF Rules
    • Bryn is knowledgable

• Using the
  POST [base]/Measure/measure-mrp/$submit-data
Operation, the provider system
Measure subscription

- Aggregator subscribes to a data provider system
- When measure data is created in the provider system, a notification is sent to the aggregator
- Aggregator performs $\text{collect-data}$ on provider system
- Need an example
Back-up Slides
Current Flow of Events and Triggers

- Payer receives notification of patient discharge
- Payer consults with physician to discover if MRP already completed
  - If not, then payer receives discharge medication list from PCP/Physician or Hospital
    - After medication list received from PCP/Physician or Hospital entity the payer converse with member to complete MRP (has to be in person or by phone)
    - After MRP is completed PCP is faxed with instructions to include in the chart
      - Goal is to reduce promote patient wellness and reduce re-admissions risk by optimizing medication regimen and transition to home.
      - Plan submits CPT 1111F code after Anthem Staff completed Medical Record Review
  - If MRP already completed, then Payer educates the physician on completing and submitting CPT 1111F.
• Preconditions
  • Discharge medications available to physician/RN via current methods (paper/fax/CDA)
  • Most recent outpatient medication list (pre-discharge) available to physician/RN in EHR

• Patient – Provider Encounter (face to face?, over-the-phone)
  • Patient confirms that they are on the medications on their discharge med list
    • Deviation – Patient given prescription at discharge but Rx is not filled
    • Deviation – Patient fills discharge medication prescription, but stops due to side effect or non-adherence
    • Deviation – Patient fills discharge medication and completes the medication (e.g. antibiotic) prior to encounter
  • Provider performs MRP
  • Provider documents MRP in clinical notes
  • Provider attests that MRP was performed
  • Provider attests that MRP was NOT performed and includes Reason
Preconditions

• Provider is aware that patient is within 30-Day post-discharge window
  • Via electronic notification (like ADT or fax)
  • Received a transition of care document (CCD, discharge summary,
  • Via notification by the payer
  • Via an encounter with the patient
• Discharge and outpatient medications lists are available to the provider either electronically or in paper form
• Supporting documentation in the EHR (based on measure requirements)
• Provider knows patient’s health plan information (attribution of patient-payer relationship)
  • In order to send attestation or make it available to a payer
• Provider has an EHR system capable of supporting Da Vinci use case
• HEDIS quality measure is collected for Medical Part C
  • HEDIS is measuring the rate of MRP completion only by admission
    • Numerator is number of MRP completed by servicers within 30 days of discharge and Denominator is based on episodes (discharge to 30 days later), not on members who may appear more than once in the sample

• **Documentation in the medical record** must include evidence of medication reconciliation and the date when it was performed and by whom (identifiers vary by actor). Any of the following meets criteria:
  • Documentation that the provider reconciled the current and discharge medications.
  • Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
  • Documentation of the member’s current medications with a notation that the discharge medications were reviewed.
  • Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
  • Notation that no medications were prescribed or ordered upon discharge.
  • Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.
• Provider enters a procedure order (i.e. similar to a lab order) for “Medication Reconciliation” into the outpatient EHR

• In the order user interface, Provider documents
  • Date of inpatient discharge
  • Attestation that MRP was performed
  • Acknowledgement that required medical documentation is present (see Post Conditions)

• Provider signs the attestation

• System creates a Task or Observation resource that includes the attestation information

• Provider sends MRP information to payer
**Scope**

**In-Scope**
- Measure rules
- Patients on commercial health plans, Medicare and Medicaid
- 30-Day period after an inpatient discharge
- Provider EHR interactions
  - Outpatient
  - PCP, Specialists, inpatient prescriber who does the outpatient follow-up
- Attestation process
- Face-to-face and non-face-to-face patient-provider interactions
- MRD with NO patient interaction (i.e. with the med lists only).
- Provider requirements based on MRD measure (i.e. workflow done by a medical assistant)

**Out-of-Scope**
- Self-Pay patients
- >30-Days post discharge
- Workflow steps that occur outside the provider EHR (e.g. Payer’s pharmacist MRD)
- Death?
- Electronic ADT (future use case)
- Electronic exchange of inpatient discharge medications
- Electronic reconciliation (comparison) of the discharge and outpatient medications
- Current claims process for attestation
- Audit of the clinical record electronically (future)
- Readmission and MRD requirements