Documentation of Current Medications in the Medical Record

**eMeasure Title**
Documentation of Current Medications in the Medical Record

**eMeasure Identifier**
68  
**eMeasure Version number**
6.1.000

**NQF Number**
0419  
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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, herbs, 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 et al. (2007) reveal that it is in fact in outpatient settings where more fatal adverse drug events (ADEs) 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
## 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).


## 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

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

Table of Contents
- Population Criteria
- Data Criteria (QDM Variables)
- Data Criteria (QDM Data Elements)
- Supplemental Data Elements
- Risk Adjustment Variables

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