

Measure #63. Medication Reconciliation for Ambulatory Care

CARE COORDINATION MEASURE MAPPING TABLE

	MEASUREMENT PERSPECTIVE		
	<i>Patient/Family</i>	<i>Health Care Professional(s)</i>	<i>System Representative(s)</i>
CARE COORDINATION ACTIVITIES			
Establish accountability or negotiate responsibility			□
Communicate			
<i>Interpersonal communication</i>			
<i>Information transfer</i>			□
Facilitate transitions			
<i>Across settings</i>			□
<i>As coordination needs change</i>			
Assess needs and goals			
Create a proactive plan of care			
Monitor, follow up, and respond to change			□
Support self-management goals			
Link to community resources			
Align resources with patient and population needs			
BROAD APPROACHES POTENTIALLY RELATED TO CARE COORDINATION			
Teamwork focused on coordination			
Health care home			
Care management			
Medication management			□
Health IT-enabled coordination			

Legend:

- = ≥ 3 corresponding measure items
- = 1-2 corresponding measure items

Medication Reconciliation for Ambulatory Care

Purpose: To measure the percentage of patients aged 65 years and older who were discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days of discharge in the office by the physician providing on-going care who had reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.¹

Format/Data Source: This process requires administrative claims data and data collected from the medical record.¹

Date: Measure released in 2006.¹

Perspective: System Representative(s)

Measure Item Mapping:

This measure maps to the following domains. There are no individual measure items to map.

- **Communicate**
 - Information transfer
 - *Across health care teams or settings*
- **Facilitate transitions**
 - Across settings
- **Monitor, follow up, and respond to change**
- **Medication Management**

Development and Testing: None described in the sources identified.

Link to Outcomes or Health System Characteristics: One study indicated a relationship between hospital readmissions and the quality of discharge communication, although medication management was not determined to be the causal factor.^{2,3}

Logic Model/Conceptual Framework: None described in the sources identified.

Country: United States

Past or Validated Applications*:

- **Patient Age:** Adults, Older Adults
- **Patient Condition:** General Population/Not Condition Specific
- **Setting:** Primary Care Facility, Inpatient Care Facility

*Based on the sources listed below.

Notes:

- Detailed measure specifications are included in the Physician Consortium for Performance Improvement (PCPI) Geriatrics Physician Performance Measurement Set, which is available for download from the American Medical Association website.¹

- Current Procedural Terminology (CPT) service codes are indicated in the measure specifications within the PCPI Geriatrics Physician Performance Measurement Set.¹
- This measure is intended for use in ambulatory care settings only.¹
- An updated version of this measure is forthcoming at the time of this publication.

Sources:

1. American Geriatrics Society, Physician Consortium for Performance Improvement (PCPI), National Committee for Quality Assurance (NCQA). Geriatrics Physician Performance Measurement Set. Chicago, IL: American Medical Association; 2006. Available at: <http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI>
2. William El and Filton F. General practitioner response to elderly patients discharged from hospital. *BMJ*1990; 300:159-161.
3. Wenger NS, Young RT. Quality indicators of continuity and coordination of care for vulnerable elders. *JAGS* 2007; 55(S2):S285-S292.