



# Medication Reconciliation Cluster Workgroup



Co-Chairs: Mary Ann Kliethermes  
David A. Medvedeff





# MRCG 2009 Members



- Alicia Destefano
- Chris Cook
- Cindy Hart
- Noni Bodkin
- Rebecca Chater
- Richard McLeod
- Spencer Harpe
- Terri Smith Moore
- Ajit Dhavle
- Christopher Dezii
- James Lett
- James Owen
- Karen Farris
- Steve Riddle
- Kari Trapskin
- Tom Clark
- Shelly Spiro
- Vic Spain
- Maria Cannito



# MRCG 2009 Charges



- **Concept Paper**
  - Development of a demonstration project
  - Purpose to validate and test the five 2009 Medication Reconciliation Measures
- **Develop a more defined Medication Reconciliation Proposed Measure**
  - measure for transitions of care
  - targeted population
  - Simple process measure



# Medication Reconciliation for High Risk Patients



<b>Measure Description/ Definition:</b>	Percent of high risk patients with a new prescription or renewal of a prescription for whom their medications were reconciled
<b>Definitions</b>	<p><u>High Risk is a Medicare Part D Beneficiary</u></p> <ul style="list-style-type: none"><li>•on 8 or more chronic medications <i>or</i></li><li>•receiving an oral high risk medication as defined by ISMP</li></ul> <p><u>Transitions of Care</u></p> <ul style="list-style-type: none"><li>•Hospital, LTC, community based organizations</li><li>•New prescription or renewal (not refill) of a continuing medication</li></ul>
<b>Rationale:</b>	Elderly patients on multiple medications most at risk during transitions of care



# Medication Reconciliation for High Risk Patients



<b>Data Source:</b>	Pharmacy level data initially Med Reconciliation documentation and transmit-ability high on HIT interoperability agenda
<b>Denominator Description:</b>	Number of high risk patients with a new prescription or renewal of a prescription within a specified period of time
<b>Numerator Description:</b>	Number of high risk patients with a new prescription or renewal of a prescription for whom their medications were reconciled



# Concept Paper



**TITLE:** MTM based Medication Reconciliation  
Post Hospital Discharge

**PURPOSE:** To develop a Model for testing the process and for which the PQA approved medication reconciliation measures could be applied.



# Concept Paper



**Hypothesis:** Collaboration between insurer, acute medical care and community pharmacy in providing medication reconciliation within 7 days of discharge will result in improved outcomes.

**Primary Aim:** Evaluate process of collaboration utilizing PQA Medication Reconciliation Measure Set in providing medication reconciliation post discharge through a community pharmacy based MTM service

**Secondary Aim:** Evaluate 30 day outcomes

- Hospitalizations
- ADE's
- Patient and provider satisfaction



# Concept Paper



## **Methods/Design:**

- Acute care (hospital LTC) to ambulatory/community MTMP
- Over 2 years with intervention within 7 days of discharge and patient follow up at 30 days, 3 and 6 months
- Study subjects (one of the following categories)
  - 8 or more chronic medications on admission
  - High-risk medication or dx for high risk medication
  - Conditions with high readmission rates
  - MTM services referral
- Sample size – value in both small and large projects



# Concept Paper



## **Methods/Design:**

- Data collected
  - Admission and discharge dates and reasons or dx
  - Medications 60 days prior to admission and at discharge
  - Demographics
  - PCP
  - Re-hospitalizations and reasons, medications on re-admission
  - PQA Medication Reconciliation set results
  - Pharmacies used and MTM provider



# Concept Paper



- **Data source** - Recommend partnering with HIT initiatives such as NCPDP-HL-7 work group on the health record and hospital and community pharmacy system vendors

(yet to be determined)

- **Evaluation and Analysis**
- **Support Needs and Costs**
- **Impact**