	Measure 0097: Medication Reconciliation Post-Discharge (National Committee for Quality Assurance)
Description	The percentage of discharges from January 1–December 1 of the measurement year for patients 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 days total).
Numerator	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days).
Numerator Details	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days). Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. This measure is specified for medical record or administrative data collection. Medical Record Reporting Details: Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meets criteria: • Documentation of the current medications with a notation 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 patient'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. • Documentation of the current medications with evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the patient was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the patient's hospitalization or discharge. • Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days). • Notation that no medications were prescribed or ordered upon discharge. Only documentation in the outpatient medical record meets the intent of the measure, but an outpatient visit is not required. Administrative Reporting Method Details: See value sets provided for administrative codes meeting measure numerator intent.

Denominator	All acute or nonacute inpatient discharges on or between January 1 and December 1 of the measurement year for patients who are 18 years and older.
Denominator Details	To identify an acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year do the following: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 total days), count only the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharges if the last discharge occurs after December 1 of the measurement year. If the admission date and the discharge date for an acute inpatient stay occur between the admission and discharge dates for a nonacute inpatient stay, include only the nonacute inpatient discharge. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. 4. Identify the discharge date for the stay. To identify nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. 4. Identify the discharge date for the stay. Additional guidance for identifying appropriate discharges for inclusion in the eligible population: - If a patient remains in an acute or nonacute care setting through December 1 of the measurement year, a discharge is not included in the measure for this patient, but the organization must have a method for identifying the patient's status for the remainder of the measurement year, and may not assume the patient remained admitted based only on the absence of a discharge before December 1. If the organization is unable to confirm the patient remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date. Additional guidance for identifying the eligible population: Patients in hospice are removed from the eligible population.
Exclusions	No exclusions.
Exclusion	N/A

details	
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Type	Process
Type of Score	Rate/proportion
Data Source	Claims, Electronic Health Records, Paper Medical Records
Level	Health Plan
Setting	Outpatient Services

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