CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) MEASURES GROUP OVERVIEW

2015 PQRS OPTIONS FOR MEASURES GROUPS:

2015 PQRS MEASURES IN COPD MEASURES GROUP:

#47 Care Plan
#51 Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation
#52 Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy
#110 Preventive Care and Screening: Influenza Immunization
#111 Pneumonia Vaccination Status for Older Adults
#130 Documentation of Current Medications in the Medical Record
#226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

INSTRUCTIONS FOR REPORTING:

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

  G8898: I intend to report the COPD Measures Group

- Report the patient sample method:
  20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2015).

- Patient sample criteria for the COPD Measures Group are patients aged ≥ 18 years with a specific diagnosis of COPD accompanied by a specific patient encounter:

  One of the following diagnosis codes indicating COPD:
  ICD-9-CM [for use 1/1/2015 – 9/30/2015]: 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 493.20, 493.21, 493.22, 496
  ICD-10-CM [for use 10/1/2015 - 12/31/2015]: J41.0, J41.1, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9

  Accompanied by:

  One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

- Report a numerator option on **all applicable** measures within the COPD Measures Group for each patient within the eligible professional's patient sample.

- Measures #47 and #111 are only applicable for patients 65 years of age and older.

- Measure #110 only needs to be reported a minimum of once during the reporting period when the patient's visit included in the patient sample population is between January and March for the 2014-2015 influenza season **OR** between October and December for the 2015-2016 influenza season. When the patient's office visit is between April and September, Measure #110 is not applicable and will not affect the eligible provider's reporting or performance rate. Measure #110 need only be reported on patients 18 years and older.

- Instructions for qualifying numerator option reporting for each of the measures within the Chronic Obstructive Pulmonary Disease (COPD) Measures Group are displayed on the next several pages. The following composite Quality Data Code (QDC) has been created for registries that utilize claims data. This QDC may be reported in lieu of individual QDCs when **all quality clinical actions** for **all applicable** measures within the group have been performed.

  Composite QDC G8757: All quality actions for the applicable measures in the COPD Measures Group have been performed for this patient

- To report satisfactorily for the COPD Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.

- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.

- **NOTE**: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures group option.

***Measure #47 (NQF 0326): Care Plan -- National Quality Strategy Domain: Communication and Care Coordination**

DESCRIPTION:
Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

NUMERATOR:
Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Numerator Instructions: If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, report **1124F**.

Definition:
Documentation that Patient did not Wish or was not able to Name a Surrogate Decision Maker or Provide an Advance Care Plan – May also include, as appropriate, the following:

- That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.

Numerator Options:
Performance Met: Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record **(1123F)**
OR
Performance Met: Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan **(1124F)**

OR

***Performance Not Met*:** Advance care planning **not** documented, reason not otherwise specified **(1123F *with* 8P)**

▲ Measure #51 (NQF 0091): Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry results documented

NUMERATOR:
Patients with documented spirometry results in the medical record (FEV_1 and FEV_1/FVC)

Numerator Instructions: Look for most recent documentation of spirometry results in the medical record; do not limit the search to the reporting period.

Numerator Options:
Performance Met: Spirometry results documented and reviewed **(3023F)**

OR

Medical Performance Exclusion: Documentation of medical reason(s) for not documenting and reviewing spirometry results
(3023F *with* 1P)
OR
Patient Performance Exclusion: Documentation of patient reason(s) for not documenting and reviewing spirometry results
(3023F *with* 2P)
OR
System Performance Exclusion: Documentation of system reason(s) for not documenting and reviewing spirometry results
(3023F *with* 3P)

OR

Performance Not Met: Spirometry results **not** documented and reviewed, reason not otherwise specified **(3023F *with* 8P)**

▲ Measure #52 (NQF 0102): Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV_1/FVC less than 60% and have symptoms who were prescribed an inhaled bronchodilator

NUMERATOR:
Patients who were prescribed an inhaled bronchodilator

Definition:
Prescribed – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

Numerator Options:
Performance Met:
Inhaled bronchodilator prescribed **(4025F)**
AND
Spirometry test results demonstrate FEV_1/FVC < 60% and patient has COPD symptoms (e.g., dyspnea, cough/sputum, wheezing) **(G8924)**

OR

Medical Performance Exclusion: Documentation of medical reason(s) for not prescribing an inhaled bronchodilator **(4025F *with* 1P)**
OR
Patient Performance Exclusion: Documentation of patient reason(s) for not prescribing an inhaled bronchodilator **(4025F *with* 2P)**
OR
System Performance Exclusion: Documentation of system reason(s) for not prescribing an inhaled bronchodilator **(4025F *with* 3P)**

AND
Spirometry test results demonstrate FEV_1/FVC < 60% and patient has COPD symptoms (e.g., dyspnea, cough/sputum, wheezing) **(G8924)**

OR

Other Performance Exclusion: Spirometry test results demonstrate FEV_1/FVC ≥ 60% or patient does not have COPD symptoms **(G8925)**
OR
Other Performance Exclusion: Spirometry test **not** performed or documented, reason not given **(G8926)**

OR

Performance Not Met:
Inhaled bronchodilator **not** prescribed, reason not otherwise specified **(4025F *with* 8P)**
AND
Spirometry test results demonstrate FEV_1/FVC < 60% and patient has COPD symptoms (e.g., dyspnea, cough/sputum, wheezing) **(G8924)**

▲Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization -- National Quality Strategy Domain: Community/Population Health

DESCRIPTION:
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

NUMERATOR:
Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

Numerator Instructions:

- If reporting this measure between January 1, 2015 and March 31, 2015, quality-data code **G8482** should be reported when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2014 or January, February, and March of 2015 for the flu season ending March 31, 2015.
- If reporting this measure between October 1, 2015 and December 31, 2015, quality-data code **G8482** should be reported when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2015 for the flu season ending March 31, 2016.
- Influenza immunizations administered during the month of August or September of a given flu season (either 2014-2015 flu season OR 2015-2016 flu season) can be reported when a visit occurs during the flu season (October 1 - March 31). In these cases, **G8482** should be reported.

Definition:
Previous Receipt - Receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

Numerator Options:
Performance Met: Influenza immunization administered or previously received **(G8482)**

OR

Other Performance Exclusion: Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons) **(G8483)**

OR

Performance Not Met: Influenza immunization was **not** administered, reason not given **(G8484)**

♠ Measure #111 (NQF 0043): Pneumonia Vaccination Status for Older Adults -- National Quality Strategy Domain: Community/Population Health

DESCRIPTION:
Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine

NUMERATOR:
Patients who have **ever** received a pneumococcal vaccination

Numerator Options:
Performance Met: Pneumococcal vaccine administered or previously received **(4040F)**

OR

Performance Not Met: Pneumococcal vaccine was **not** administered or previously received, reason not otherwise specified **(4040F *with* 8P)**

♠ Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record - - National Quality Strategy Domain: Patient Safety

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, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosage, frequency and route of administration

NUMERATOR:
Eligible professional attests to documenting, updating or reviewing a patient's current medications using all immediate resources available on the date of 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

Definitions:
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).
Not Eligible - A patient is **not** eligible if the following reason is documented:

- 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.

NUMERATOR NOTE: *The eligible professional must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. G8427 should be reported if the eligible professional documented that the patient is not currently taking any medications.*

Numerator Options:
Performance Met: Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications **(G8427)**

OR

Other Performance Exclusion: Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional **(G8430)**

OR

Performance Not Met: Current list of medications **not** documented as obtained, updated, or reviewed by the eligible professional, reason not given **(G8428)**

▲ Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention -- National Quality Strategy Domain: Community/Population Health

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user

NUMERATOR:
Patients who were screened for tobacco use at least once within 24 months **AND** who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:
Tobacco Use – Includes use of any type of tobacco.
Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

***NUMERATOR NOTE*:** *In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report **4004F** with **8P**.*

Numerator Options:
Performance Met: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user **(4004F)**
OR
Performance Met: Current tobacco non-user **(1036F)**

OR

Medical Performance Exclusion: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons) **(4004F *with* 1P)**

OR

Performance Not Met: Tobacco screening OR tobacco cessation intervention **not** performed, reason not otherwise specified **(4004F *with* 8P)**

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) MEASURES GROUP RATIONALE AND CLINICAL RECOMMENDATION STATEMENTS

Measure #47- Care Plan

RATIONALE:

It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply not having addressed the issue at all is so much more substantial (Teno, 1997) than the risk that an established plan has become outdated that we should not define a specific timeframe at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific timeframe should be included.

CLINICAL RECOMMENDATION STATEMENTS:

Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.

Oral statements

- Conversations with relatives, friends, and clinicians are most common form; should be thoroughly documented in medical record for later reference.
- Properly verified oral statements carry same ethical and legal weight as those recorded in writing.

Instructional advance directives (DNR orders, living wills)

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.
- May be revoked or altered at any time by the patient.
- Clinicians who comply with such directives are provided legal immunity for such actions.

Durable power of attorney for health care or health care proxy

- A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS)

The National Hospice and Palliative Care Organization provides the Caring Connection web site, which provides resources and information on end-of-life care, including a national repository of state-by-state advance directives.

Measure #51 - Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation

RATIONALE:

Evaluation of lung function for a patient with COPD is vital to determine what treatments are needed and whether those treatments are effective. COPD is often underdiagnosed and misdiagnosed in the primary care setting. (Tinkelman, 2006) Marked underutilization of spirometry testing has been well documented and is thought to be a contributing factor. (Foster et al, 2007; Yawn et al, 2008; Lee et al, 2006; Damarla et al, 2006) A recent study found that only 32% of patients with a new diagnosis of COPD had undergone spirometry within the previous 2 years to 6 months following diagnosis. (Han et al., 2007) This measure is for patients already diagnosed with COPD, in order to confirm diagnosis.

CLINICAL RECOMMENDATION STATEMENTS:
A clinical diagnosis of COPD should be considered in any patient who has dyspnea, chronic cough or sputum production, and/or a history of exposure to risk factors for the disease. Spirometry is required to make the diagnosis in this clinical context; the presence of a post-bronchodilator $FEV_1/FVC < 0.70$ confirms the presence of persistent airflow limitation and thus of COPD. Spirometry is the most reproducible and objective measurement of airflow available. (GOLD, 2011)

For the diagnosis and assessment of COPD, spirometry is the gold standard as it is the most reproducible, standardized, and objective way of measuring airflow limitation. $FEV_1/FVC < 70\%$ and a post bronchodilator $FEV_1 < 80\%$ predicted confirms the presence of airflow limitation that is not fully reversible. (NHLBI/WHO)

Measure #52 - Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy
RATIONALE:
Inhaled bronchodilator therapy is effective in treating and managing the symptoms of COPD, particularly, for those patients with moderate to very severe COPD, and improving a patient's quality of life. The Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines recommend inhaled bronchodilators as a cornerstone of COPD symptom management; however, PCPs often turn to other agents as first-line COPD therapy (Barr et al, 2005; Foster et al, 2007). In a recent study of general medicine practices, 154 clinicians completed a survey to identify barriers to implementing seven recommendations from the GOLD guidelines. Adherence was only 54% to prescribing long-acting bronchodilators when $FEV_1 < 80\%$ predicted (Perez, et al, 2011).

CLINICAL RECOMMENDATION STATEMENTS:
For stable COPD patients with respiratory symptoms and $FEV_1 < 60\%$ predicted, ACP, ACCP, ATS, and ERS recommend treatment with inhaled bronchodilators (Grade: strong recommendation, moderate-quality evidence). (Qaseem et al, 2011)

Bronchodilator medications are given on either an as-needed basis or a regular basis to reduce or prevent symptoms (Evidence A). Bronchodilator medications are central to symptom management in COPD. Inhaled therapy is preferred. Long-acting inhaled bronchodilators are convenient and more effective at producing maintained symptom relief than short-acting bronchodilators. (GOLD, 2011)

Measure #110 - Preventive Care and Screening: Influenza Immunization
RATIONALE:
Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza vaccine is recommended for all persons aged ≥ 6 months who do not have contraindications to vaccination.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

Routine annual influenza vaccination is recommended for all persons aged ≥ 6 months. To permit time for production of protective antibody levels, vaccination should optimally occur before onset of influenza activity in the community, and providers should offer vaccination as soon as vaccine is available. Vaccination also should continue to be offered throughout the influenza season. (CDC/ACIP, 2011)

Measure #111 - Pneumonia Vaccination Status for Older Adults
RATIONALE:
Pneumonia is a common cause of illness and death in the elderly and persons with certain underlying conditions such as heart failure, diabetes, cystic fibrosis, asthma, sickle cell anemia, or chronic obstructive pulmonary disease (NHLBI, 2011). In 1998, an estimated 3,400 adults aged > 65 years died as a result of invasive pneumococcal disease (IPD) (CDC, 2003).

Among the 91.5 million US adults aged > 50 years, 29,500 cases of IPD, 502,600 cases of nonbacteremic pneumococcal pneumonia and 25,400 pneumococcal-related deaths are estimated to occur yearly; annual direct and indirect costs are estimated to total $3.7 billion and $1.8 billion, respectively. Pneumococcal disease remains a substantial burden among older US adults, despite increased coverage with 23-valent pneumococcal polysaccharide vaccine, (PPV23) and indirect benefits afforded by PCV7 vaccination of young children (Weycker, et al., 2011).

Vaccination has been found to be effective against bacteremic cases (OR: 0.34; 95% CI: 0.27–0.66) as well as nonbacteremic cases (OR: 0.58; 95% CI: 0.39–0.86). Vaccine effectiveness was highest against bacteremic infections caused by vaccine types (OR: 0.24; 95% CI: 0.09–0.66) (Vila-Corcoles, et al., 2009).

CLINICAL RECOMMENDATION STATEMENTS:
The Advisory Committee on Immunization Practices' (ACIP) Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine recommends pneumococcal vaccine for all immunocompetent individuals who are 65 and older or otherwise at increased risk for pneumococcal disease. Routine revaccination is not recommended, but a second dose is appropriate for those who received PPV23 before age 65 years for any indication if at least 5 years have passed since their previous dose (USPSTF, 1989; ACIP, 2010).

The major updates for the 2010 update are: 1) the indications for which PPSV23 vaccination is recommended now include smoking and asthma, and 2) routine use of PPSV23 is no longer recommended for Alaska Natives or American Indians aged <65 years unless they have medical or other indications for PPV23.

MEASURE #130 - Documentation of Current Medications in the Medical Record
RATIONALE:
In the American Medical Association's (AMA) *Physician's Role in Medication Reconciliation* (2007), 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. Consequently, clinical judgments may be based on incomplete, inaccurate, poorly documented or unavailable information about the patient and his or her medication.

Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting where two-thirds of physician visits result in writing at least one prescription (Stock et al., 2009). Chronically ill patients are increasingly being treated as outpatients, many of whom take multiple medications requiring close monitoring (Nassaralla et al., 2007).

Adverse drug events (ADEs) prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassaralla et al., 2007). According to The Commonwealth Fund report (2010) about 11 to 15 of every 1,000 Americans visit a health care provider because of ADEs in a given year, representing about three to four of every 1,000 patient

visits during 1995 to 2001. The total number of visits to treat ADEs increased from 2.9 million in 1995 to 4.3 million visits in 2001.

ADEs in the ambulatory setting substantially increased the healthcare costs of elderly persons and estimated costs were $1,983 per case. Further findings of The Commonwealth Fund studies additionally identified 11% to 28% of the 4.3 million visit related ADEs (VADEs) in 2001 might have been prevented with improved systems of care and better patient education, yielding an estimate of 473,000 to 1.2 million potentially preventable VADEs annually and potential cost-savings of $946 million to $2.4 billion.

In the Institute for Safe Medication Practices, *The White Paper on Medication Safety in the U.S. and the Roles of Community Pharmacists* (2007), the American Pharmaceutical Association identified that Americans spend more than $75 billion per year on prescription and nonprescription drugs. Unnecessary costs include: improper use of prescription medicines due to lack of knowledge costs the economy an estimated $20-100 billion per year; American businesses lose an estimated 20 million workdays per year due to incorrect use of medicines prescribed for heart and circulatory diseases alone; failure to have prescriptions dispensed and/or renewed has resulted in an estimated cost of $8.5 billion for increased hospital admissions and physician visits, nearly one percent of the country's total health care expenditures.

In 2005, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient days. Emerging research suggests the scope of medication-related errors in ambulatory settings is as extensive as or more extensive than during hospitalization. Ambulatory visits result in a prescription for medication 50 to 70% of the time. One study estimated the rate of ADEs in the ambulatory setting to be 27 per 100 patients. It is estimated that between 2004 and 2005 in the United States, 701,547 patients were treated for ADEs in emergency departments, and 117,318 patients were hospitalized for injuries caused by an ADE. Individuals aged 65 years and older are more likely than any other population group to require treatment in the emergency department for ADEs (AMA, 2007).

A Systematic Review on “Prevalence of Adverse Drug Events in Ambulatory Care” finds that “The median ADE prevalence rate for retrospective studies was 3.3% (interquartile range [IQR] 2.3–7.1%) vs 9.65% (IQR 3.3–17.35%) for prospective studies. Median preventable ADE rates in ambulatory care-based studies were 16.5%, and 52.9% for hospital-based studies. Median prevalence rates by age group ranged from 2.45% for children to 5.27% for adults, 16.1% for elderly patients, and 3.45% for studies including all ages (Tache et al., 2011).”

The Agency for Healthcare Research and Quality’s (AHRQ) The National Healthcare Disparities Report (2011) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings as 50 per 1,000 person-years. In 2005, AHRQ reported data on adults age 65 and over who received potentially inappropriate prescription medicines in the calendar year, by race, ethnicity, income, education, insurance status, and gender. The disparities were identified as follows**:** older Asians were more likely than older whites to have inappropriate drug use (20.3% compared with 17.3%); older Hispanics were less likely than older non-Hispanic Whites to have inappropriate drug use (13.5% compared with 17.6%); older women were more likely than older men to have inappropriate drug use (20.2% compared with 14.3%); there were no statistically significant differences by income or education.

Weeks et al. (2010) noted that fragmented medication records across the health care continuum, inaccurate reporting of medication regimens by patients, and provider failure to acquire all of the necessary elements of medication information from the patient or record, present significant obstacles to obtaining an accurate medication list in the ambulatory care setting. Because these obstacles require solutions demonstrating improvements in access to information and

communication, the Institute of Medicine and others have encouraged the incorporation of IT solutions in the medication reconciliation process. In a survey administered to office-based physicians with high rates of EMR use, Weeks, et al found there is an opportunity for universal medication lists utilizing health IT.

CLINICAL RECOMMENDATION STATEMENTS:

The Joint Commission's 2014 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" includes the following: "Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor."

The National Quality Forum's 2010 update of the *Safe Practices for Better Healthcare*, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care. Improving the safety of healthcare delivery saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Every healthcare stakeholder group should insist that provider organizations demonstrate their commitment to reducing healthcare error and improving safety by putting into place evidence-based safe practices.

The AMA's published report, *The Physician's Role in Medication Reconciliation*, identified the best practice medication reconciliation team as one that is multidisciplinary and--in all settings of care--will include physicians, pharmacists, nurses, ancillary health care professionals and clerical staff. The team's variable requisite knowledge, skills, experiences, and perspectives are needed to make medication reconciliation work as safely and smoothly as possible. Team members may have access to vital information or data needed to optimize medication safety. Because physicians are ultimately responsible for the medication reconciliation process and subsequently accountable for medication management, physician leadership and involvement in all phases of developing and initiating a medication reconciliation process or model is important to its success.

Measure #226 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

RATIONALE:

This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines:

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (U.S. Preventive Services Task Force, 2009)