



**Summary of Feedback from the
Technical Expert Panel (TEP)
Regarding the Drug Regimen
Review Cross-Setting Measure to
Meet
The IMPACT Act of 2014**

**Outcome and Assessment
Information Set (OASIS) Quality
Measure Development and
Maintenance Project**

**HHSM -500-2013-130011
Task Order HHSM-500T0002**

**Development and Maintenance
Of Symptom Management Measures**

**HHSM-500-2013-130151
Task Order HHSM-500T0002**

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Prepared for:
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Background

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) was signed into law on October 6, 2014¹. This Act requires Post-Acute Care (PAC) providers, specifically, Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs) to report standardized patient assessment data and quality measure data to the Secretary of the Department of Health and Human Services (HHS).

The Centers for Medicare & Medicaid Services (CMS) is working to ensure that data elements within PAC assessment instruments are standardized and interoperable. Current federal assessment instruments are setting-specific and contain assessment items with varying concepts, definitions, and measurement scales. The move towards standardized assessment data elements facilitates cross-setting data collection, quality measurement, outcome comparison, and interoperable data exchange.

CMS has contracted with Abt Associates and RTI International to develop a cross-setting PAC measure for the quality measure domain medication reconciliation under two contracts: Development and Maintenance of Symptom Management Measures (contract number HHSM-500-2013-13015I) and Outcome and Assessment Information Set (OASIS) Quality Measure Development and Maintenance Project (contract number HHSM -500-2013-13001I, Task Order HHSM-500T0002). As part of its measure development process, CMS asks contractors to convene groups of stakeholders and experts who contribute direction and thoughtful input to the measure contractors during measure development and maintenance.

In this measure, medication reconciliation and drug regimen review are defined as:

Medication Reconciliation - The process of comparing the medications a patient is taking (and should be taking) with newly ordered medications in order to identify and resolve discrepancies. (Reference: The Joint Commission, National Patient Safety Goals)

Drug Regimen Review - A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. (Reference: Home Health Conditions of Participation §484.55c)

The Measure Development Team

The cross-setting Drug Regimen Review (DRR) measure development team includes individuals from Abt Associates and RTI International. It is multidisciplinary team with knowledge and expertise in the areas of quality measure development, PAC, epidemiology, statistics, public health, and health care policy. The Abt Associates Drug Regimen Review measure development is led by a team of measure development experts Robin Williams, RN; Sara Galantowicz, MPH; Nicole Keane, MSN, RN, and Linda Krulish PT, MHS, COS-C.

¹ <https://www.govtrack.us/congress/bills/113/hr4994>

The RTI International measure development team includes: Carole Schwartz, MS, OTR/L, Karen Reilly, ScD, Samruddhi Thaker, MBBS, MHA, PhD*, Laura Smith, PhD, Anne Deutsch, RN, PhD, CRRN, Julie Seibert, MPH, MA, PhD, Teresa Mota, BSN, RN*, Nan Tracy Zheng, PhD, Terry Eng RN, PhD, Ramandeep, Kaur, Ph.D., and Emily Haines, BA.

* No longer with RTI International

Technical Expert Panel Members

The DRR Technical Expert Panel (TEP) met on July 29, 2015 from 1:00 pm to 3:30 pm EST using a Webinar format. The TEP was composed of a diverse group of stakeholders with PAC expertise across settings of care. TEP members were selected from those who responded to an open call for nominations posted June 5, 2015. The individuals who participated in the DRR TEP are listed below:

Home Health Agencies (HHA)

Mary Carr, RN, MPH

Vice President for Regulatory Affairs
National Association for Home Care and Hospice

Melissa O'Connor, PhD, MBA, RN, COS-C

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Diane Vaughn, RN, C-DONA-LTC, LNHA

Vice President, Clinical Services
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Long Term Care Hospital (LTCH)

Chris Marshall, RPh, MBA

SVP and Chief Pharmacy Officer
Select Medical

Carolyn Winchester, BSN RN

Quality Data Coordinator and Regulatory Readiness Manager
Spartanburg Hospital for Restorative Care

Post-Acute Care Settings (PAC)

Susan Yendro, RN, MSN

Associate Project Director Department of Quality Measurement
The Joint Commission

Technical Expert Panel Feedback

This section presents a summary of the TEP meeting, including the objectives and proposed measure concept. TEP member feedback was guided by a series of open-ended questions about the proposed measure construct. The questions are delineated below and TEP member input is listed under each measure topic. An appendix with post-meeting feedback regarding the proposed cross-setting drug regimen review measure is included.

Meeting Objectives

- 1) Introduce the measure concept and approach for capturing data for a drug regimen review measure in the medication reconciliation domain for PAC settings.
- 2) Explore setting-specific feedback (needs, concerns, and barriers) on the measure concept.
- 3) Gather feedback on feasibility, usability and potential impact of incorporating the drug regimen review concept into existing setting-specific PAC assessment instruments.

Measure Concept

Process Measure: Drug Regimen Review Conducted with Follow-Up for Identified Issues.

Measure Description

Percentage of **care episodes or stays** in which a drug regimen review was conducted at the **Admission/Start of Care (SOC)/Resumption of Care (ROC)**, and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout the **care episode or stay**.

(Note: Setting-specific wording is in **bold**. The collection instruments will include the language appropriate for the setting. To facilitate discussion, all wording to be used in all instruments as represented in the measure concept.)

Data Collection Items

(Item #1) Drug Regimen Review:

Did a complete drug regimen review identify potential clinically significant medication issues?

0 - No – No issues found during review

1 - Yes – Issues found during review

9 - NA – Patient/resident is not taking any medications

(Item #2) Medication Follow-up:

Did the **agency/facility** contact a physician (or the physician-designee) within one calendar day and complete prescribed/recommended actions in response to the identified clinically significant medication issues?

0 - No

1 - Yes

(Item #3) Medication Intervention:

Did the **agency/facility** contact and complete physician (or physician-designee) prescribed/recommended actions each time clinically significant medication issues were identified since the **Admission/SOC/ROC**?

0 - No

1 - Yes

9 - NA – There were no clinically significant medication issues identified since **Admission/SOC/ROC** or **patient/resident** is not taking any medications

Denominator

Care episodes or stays ending during the reporting period, other than those covered by generic or measure-specific exclusions.

Numerator

The Number of care episodes or stays in which all 3 of the following are true:

- 1 The **agency/facility** conducted a drug regimen review at the **[Admission/SOC/ROC]** (Item #1 = [0, 1]),
OR the **patient/resident** is not taking any medications (Item #1 = [9])
- 2 No clinically significant medication issues were identified at **[Admission/SOC/ROC]**,
OR the **patient/resident** is not taking any medications (Item #1 = [0, 9]),
OR If clinically significant medication issues were identified at the **[Admission/SOC/ROC]**, the **agency/facility** contacted a physician (or the physician-designee) within one calendar day and completed prescribed/ recommended actions in response to the identified issues (Item #1 = [1] and Item #2= [1])
- 3 No clinically significant medications issues were identified since the **[Admission/SOC/ROC]**,
OR the **patient/resident** is not taking any medications. (Item #3 = [9]),
OR the **agency/facility** contacted a physician (or the physician-designee) and completed prescribed/recommended actions each time clinically significant medication issues were identified since the **[Admission/SOC/ROC]** (Item #3 = [1])

Data Collection Tool & Time Points

Data Collection Tool & Time Points – Home Health (HH)

OASIS Items	Time Points for Data Collection
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Technical Expert Panel Feedback

OASIS Items	Time Points for Data Collection
(Item #1) = Drug Regimen Review	<ul style="list-style-type: none"> • SOC • ROC
(Item #2) = Medication Follow-up	<ul style="list-style-type: none"> • SOC • ROC
(Item #3) = Medication Intervention	<ul style="list-style-type: none"> • Transfer • Discharge

Data Collection Tool & Time Points – Skilled Nursing Facility (SNF)

MDS Items	Time Points for Data Collection
(Item #1) = Drug Regimen Review	5-day Prospective Payment System (PPS) (Part A) scheduled assessment
(Item #2) = Medication Follow-up	5-day PPS (Part A) scheduled assessment
(Item #3) = Medication Intervention	<ul style="list-style-type: none"> • Discharge Assessment—Return anticipated • Discharge Assessment—Return not anticipated <p>* Discharge Assessment— PPS “Part A” Discharge (end of stay); (Nursing Home, PPS, End-of-Stay (NPE); Swing-bed, PPS, End-of-stay (SPE)</p>

* Note that PPS “Part A” discharge (end of stay) (NPE/SPE) is proposed to be implemented 10/1/2016.

Data Collection Tool & Time Points – Inpatient Rehab Facility (IRF)

IRF-PAI Items	Time Points for Data Collection
(Item #1) = Drug Regimen Review	Admission
(Item #2) = Medication Follow-up	Admission
(Item #3) = Medication Intervention	Discharge

Data Collection Tool & Time Points – Long Term Care Hospital (LTCH)

LTCH- CARE Data Set Items	Time Points for Data Collection
(Item #1) = Drug Regimen Review	Admission
(Item #2) = Medication Follow-up	Admission
(Item #3) = Medication Intervention	Planned Discharge

LTCH- CARE Data Set Items	Time Points for Data Collection
	Unplanned Discharge Expired Assessment

Discussion and Questions on Measure Concepts

Questions 1 & 2

*What does “timely follow-up” with a physician mean in your setting and how can “timely follow-up” be harmonized across PAC settings? (Note: Setting-specific wording are in **bold**.)*

Measure Description: Percentage of **care episodes or stays** in which a drug regimen review was conducted at the **Admission/SOC/ROC** and timely follow-up with a physician occurred each time potentially clinically significant medication issues were identified throughout the **care episode or stay**.

Is the “one calendar day” time-frame reasonable across the settings?

Measure Question: Did the **agency/facility** contact a physician (or the physician-designee) within one calendar day and complete prescribed/recommended actions?

Discussion:

- IRF representatives agreed that medication reconciliation done in one calendar day represented timely follow-up. In the IRF setting medication reconciliation is performed within 12 hours of admission since they have access to in-house physicians and it is practical and feasible to follow-up with the physician within the proposed timeframe.
- SNF representatives proposed that while 24 hours is ideal, a 72 hour window to follow-up with the physician was more realistic since they do not have on-site physicians/nurse practitioners and getting a response in 24 hours is challenging especially on the weekends. SNFs in rural settings rely on community pharmacists to complete the drug regimen review/medication reconciliation activities. Pharmacist availability after hours, on weekends and holidays is a challenge.
- HHA representatives proposed that while 24 hours is ideal, a 72 hour window to follow-up with the physician was more realistic since they do not have on-site physicians/nurse practitioners and getting a response in 24 hours is challenging especially on the weekends.
- Even though 72 hours allows facilities from all post-acute care (PAC) settings to complete follow-up, patient’s safety and quality of care could be affected adversely if providers take 72 hours to clarify medication regimen. One participant suggested setting the quality bar high rather than matching the current practice.
- Some participants used “24 hours” in their responses and others used “one calendar day”.
- A majority of participants preferred using “hours” instead of “calendar days” as the designated unit of time to avoid ambiguity when specifying a quality measure; whereas one

participant said that using “hours” as the unit of time instead of “calendar days” could be harder to track.

The measure development team additionally asked if the documentation available at the end of the care episode or stay would have the exact time noted when the medication issue was identified and resolved in order to allow the use of “hours” as the measured unit of time.

Discussion:

- Time and date when the medication issue is identified and resolved is automatically documented for facilities that have Electronic Medical Record (EMR) systems.
- A SNF representative said that the time when an issue was identified can be found in the progress report (nursing notes); the organization would have to audit the progress report (nursing notes) to find that information.

Summary:

A majority of the participants agreed that 24 hours is sufficient to collect and report medication issues to the physician, but that it may not be feasible for the physician/designee to respond within 24 hours in all PAC settings.

Question 3

What are “clinically significant medication issues” in your setting? Who determines what a “clinically significant medication issue” may be?

(Item #1) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?

0 - No – No issues found during review

1 - Yes – Issues found during review

9 - NA – Patient/resident is not taking any medications

Discussion:

- IRF representatives identified clinically significant medication issues due to discrepancies in previous medication list for anticoagulants and antibiotics.
- An IRF representative said that a patient’s renal function could cause a clinically significant medication issue since dosage must be modified if renal function is compromised.
- SNF representatives identified insulin, diabetic medications, laxatives, pain medications, medications that have an impact on vital signs, and medications administered parenterally as high risk.

- An SNF representative suggested that a list of adverse events related to medications in SNFs is identified in the OIG February 2014 Adverse Events in Skilled Nursing Facilities report². The participant suggested that this list can inform the definition of clinically significant medication issues.
- The term “Clinically Significant Medication Issues” must be clearly defined to avoid any confusion among the PAC settings.
- Participants pointed out that the difference between medications considered clinically safe/appropriate and timeliness to review and those that are clinically appropriate but do not need immediate review is important to workflow.
- A participant suggested that the current MDS assessment tool drug categories could be cross-referenced during the DRR activity by those PAC settings that use the MDS tool. This would provide more robust data collection and measurement.
- One participant noted that clinically significant medication issues can also be based on a patient’s comorbidities and acuity; what is clinically significant for one patient, may not be clinically significant for another.
- Omission of medications and duplication of medications caused by generic brand name confusion can cause clinically significant issues.
 - Medication omission can be caused by lack of clarity about the medication list from hospitals on discharge.
 - Medication omission can be caused by patient’s inability to purchase increasingly expensive medications.
- Drug allergies can cause clinically significant issues.
- An HHA representative noted that there is potential for adverse drug interactions between medications prescribed at discharge with those that the patient was on at home prior to coming into a PAC facility. Patients must be advised to clarify with their primary care physician (PCP) whether they should continue using older medications.

Summary:

The term “Clinically Significant Medication Issues” must be clearly defined to avoid any confusion among the PAC settings.

The measure development team additionally asked, in each of the care settings, who is responsible for creating the patient’s medication list to assist in determining if a clinically significant medication issue exists.

Discussion:

² <http://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf>

- Physicians determine the medication regimen in IRF settings; occasionally physicians and nurses team up to determine medication regimens, since nurses monitor patients' blood pressure and blood sugar levels.
 - IRFs have access to a pharmacist, who is primarily responsible for identifying any potential adverse medication interactions.
- One SNF representative stated that in SNFs, typically a transcribing nurse initiates the documentation of the medication profile, after which the pharmacist reviews to check the current list of medications with any previous existing orders and either approves the list or asks for clarification.
- LTCHs rely on a physician, nurse, and pharmacist combination to determine and review patients' medication lists. In the absence of a pharmacist, two nurses review the medication list.
- The skilled nurse/physical therapist who opens the case or the case manager compiles the medication profile in HH settings.
 - HHAs that have access to a pharmacist collaborate to review medication profiles to identify potential adverse interactions.

Summary:

Identification of clinically significant medication issues varies by setting.

Could this definition [clinically significant medication issues] be harmonized across PAC settings?

According to the OASIS Guidance Manual: Clinically significant medication issues are those that, in the care provider's clinical judgment, pose an actual or potential threat to patient health and safety, such as drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, medication omissions, dosage errors, or non-adherence to prescribed medication regimen.

Discussion:

- One participant suggested removing the word "potential" as it is ambiguous and could lead to confusion.
- Another participant suggested replacing "potential threat to patient health and safety" with "causes/risks immediate patient harm."
- One participant suggested adding examples for the significant issues. Others commented that it may be very difficult to check through a list of examples. Another participant suggested that the definition of what is a significant medication issue "can't be cookie cutter" across PAC settings.
- One participant recommended that, since this is the first quality measure for medication reconciliation, it should start with process mechanics documenting the following: drug regimen review, follow-up with pharmacy recommendation, physician notification, and

action after receiving physician response. Once the measure is established, it can be revised to include increased scrutiny.

- Participants suggested starting with an item that measured if the review was done or not.
- The MIDS OASIS quality measure team shared that this measure is currently part of the HH Quality Reporting Program and is “topped out”. The 2010 Evidence Task Force defined the term “topped out” as meaning “there are high levels of performance with little variation and, therefore, little room for further improvement”³.
- For those facilities with an EMR system, medication reconciliation is done at admission and throughout the patient’s stay in the facility.
- For settings that do not have access to an in-house physician, such as HHAs and SNFs, potential adverse interaction warnings that must be addressed by a physician are continuously reported to the physician.

Summary: Participants agreed that clinically significant medication issues that need immediate attention must be clearly defined; they should be identified within 24 hours to ensure patient safety and also to be compliant with facility/agency standards.

Question 4

- *During episode of care/stay should follow-up be to “initiate” or “complete” Item #2 (see above)?*
- *At discharge, would it be appropriate to use the word “complete” rather than “initiate” Item #3 (see above)?*

Discussion/ Summary: One participant suggested replacing both “complete” and “initiate” with “act upon.”

Question 5

Should there be exclusions for this measure in any PAC setting? Are there additional exclusions that should be included?

Denominator: Care episodes or stays ending during the reporting period, other than those covered by generic or measure-specific exclusions.

Measure Specific Exclusion: HH - Care episodes ending in death.

Summary:

³ https://www.qualityforum.org/docs/Reserve_Endorsement_Status.aspx

All participants agreed that there should not be any exclusions. Feedback from the post TEP worksheets contradicted that received during the TEP; death was included as a relevant exclusion. Detailed comments on exclusions are in Appendix 1.

The measure development team additionally asked, about medication reconciliation verses drug regimen review.

Discussion:

- Participants agreed that medication reconciliation and drug regimen review should take place at admission and must be ongoing during the care episode/stay to ensure patient safety and quality of care. This is often challenging when an accurate medication list is not provided by the hospital from where the patient is discharged.
- An HHA representative said that their medical director reviews the medication list and approves it when the physician cannot be reached.
- An SNF representative suggested that the drug regimen review should ideally occur after medication reconciliation, to allow time to gather laboratory results and additional information from other settings.

The measure development team additionally asked if the quality measure should focus on medication reconciliation or drug regimen review.

Discussion:

- A majority of the participants agreed that medication reconciliation was a component of a drug regimen review, and felt medication reconciliation was a complex and problematic issue that needed to be addressed first.
- Medication reconciliation takes place at admission, transfer, and discharge; drug regimen review is broader and ongoing.
- Medication reconciliation should be completed at each transition of care from acute care to PAC. One participant noted that hospitals are not required to send an “approved” reconciled list of medications upon patient discharge. The participant feels that the discharge summary is not considered an approved list. This leads to confusion once the patient enters a PAC setting.
- A question was raised: Should acute care be required to reconcile medications as a patient transfers to the PAC. Another participant responded that this would function as an interim set of medical orders.
- Differences in EMR systems used causes confusion when reconciling medication lists from other settings.
- At least one TEP member suggested that the bar should be set for DRR upon admission, for all settings.

- One participant suggested that the risk of medication discrepancies occurring during care transitions could be reduced via the development of a universal form for all settings to use upon discharge to standardize the medication reconciliation process across settings.
- All PAC settings are required to complete drug regimen review upon admission as part of their Conditions of Participation. Sometimes it is challenging for SNFs to complete medication reconciliation upon admission as they do not have a reconciled list of medications from the hospital where the patient was discharged.

Summary:

The terminology and concepts related to “medication reconciliation” and “drug regimen review” is not uniformly defined among the participants. Most characterized the medication reconciliation as a part of the drug regimen review. One participant characterized the drug regimen review as part of medication reconciliation. Participants agreed that to provide high quality of care and safety to the patient, medications should be reconciled from all sites of care at the point of admission and transitions of care, including discharge. The TEP recommended creating a standard/universal form for medication reconciliation for all settings to use, including acute care.

Question 6

Is this the quality measure we should use?

- *Are there other quality measures that we can use or adapt to represent the medication reconciliation domain?*
- *Should we add additional items to all PAC assessments in order to measure medication reconciliation activity?*

Discussion:

- Some participants reasoned that a tiered risk system should be created for medications to address the highest risk medications and their interactions first, followed by other medications.
 - An IRF representative said that the MDS has key categories of medications listed (e.g., antipsychotic and anticoagulant medications), which can help prioritize key medications for review.
 - An HH representative noted that in order to stay compliant with their Conditions of Participation, they have to reconcile all medications including those available over the counter and vitamins; hence, home health agencies cannot follow the tier system for medication review.

Summary:

The TEP concluded that there are too many medications to identify a comprehensive list.

Question 7

In your setting, do you currently conduct drug/medication reviews as part of your quality improvement activities?

If so, please describe this activity, including data collection, personnel involved, frequency/time points and lessons learned.

Discussion:

- An IRF representative described the process they use to include medication review as part of their quality improvement activities:
 - They setup the EMR so it does not allow clinicians to close a patient encounter until the medication review has been completed.
 - Their grant program includes a weekly review of medications for those patients over the age of 65 with three questions: 1) is the medication appropriate for the patient; 2) are the dosage and indication appropriate; and 3) can the patient do without the medication?
 - Their hospital has a central quality assurance team that is connected to data in every unit in the hospital; this team presents monthly reports to the department chairs, who then share the reports with faculty and residents. These monthly reports include unit specific (quality) targets.
- A SNF representative said that the pharmacy consultant reports on drug regimen reviews during their quality assurance meetings.
- Another SNF representative whose facility has an enterprise-wide clinical software program said that the program collects information and recommendations, which are shared in a report by the quality assurance committee. Faculty leadership and clinical leadership are involved in report reviews that occur on a quarterly basis.
- A LTCH representative said that even though their facility collects data regarding medication reconciliation, they do not formally report that data to quality assurance committees.
- Since the drug regimen review is part of the Conditions of Participation for home health agencies, they are reviewed to check for 100% compliance.
 - In cases where an adverse event occurs due to medication, an inter-disciplinary committee is convened to discuss quality improvement.
- Another home health agency delivers quarterly reports and audits medication records on a quarterly basis; this information is shared in staff meetings.

Question 8

In the setting(s) you represent, do you foresee any challenges to collecting the data as specified for this quality measure?

Discussion:

- One participant indicated it is challenging to receive a patient's medications from home and an accurately reconciled list of medications from the hospital upon patient discharge.
 - Additionally, it may not always be advisable to reconcile with the patient's medications from home, as those medications could have contributed to the hospital visit.
 - To avoid complications from the patient's previous medications, some participants said that they ask their patients to reconcile those medications with the primary care provider (PCP) who prescribed them.
- Hospitals carry a variety of brand names of the same medication formula, which can potentially cause medication dosage duplication (e.g., generic and commercial brand of same medication being simultaneously taken).
- Home health agencies have less control than other PAC settings over their patient's adherence to medication consumption.
- Representatives from SNF settings did not foresee any challenges in collecting data as required by this measure. They did however indicate the information may have varying degrees of accuracy.
- At least one participant mentioned that while data collection may not be burdensome, reviewing every patient record would be a significant burden.

Summary: Participants identified potential challenges with reconciling medications from home as well as issues with medication dosage duplication due to varied medication brand names. HHA representatives noted that HHAs cannot control or ensure patient adherence to medication consumption. SNF representatives did not foresee any challenges meeting this requirement.

The measure development team additionally asked:

- *Where drug regimen review is defined in each of the settings. If home health representatives thought it acceptable to include death as exclusion for this measure.*
- *If it is burdensome to complete Item #3 (see below) for patients with a long stay in the settings.*

Item #3: Medication Intervention

Did the **agency/facility** contact and complete physician (or physician designee) prescribed/recommended actions each time clinically significant medication issues were identified since the **Admission/SOC/ROC**?

0 - No

1 - Yes

9 - NA – There were no clinically significant medication issues identified since Admission/SOC/ROC or patient/resident is not taking any medications

Discussion:

- *Appendix PP* in the *State Operations Manual* for SNFs has a four page definition for drug regimen review.
- A LTCH representative who collects CARE data twice a week said that collecting item #3 is burdensome since they can have patients in their setting for several months.
- It is increasingly burdensome to review for clinically significant medication issues in facilities that do not have an EMR since in-depth chart reviews must be used instead.
- There is variability when performing a look back, especially when the provider changes. Some providers may deem certain medication issues clinically significant while others may not.
- A participant recommended adding another option in Item #3 to indicate that review was completed and the clinically significant medication issue was communicated to the physician/designee but that the physician/designee chose not to recommend any specific action for the provider to implement.

Summary: Participants agreed that it is burdensome to collect data for Item #3 since it frequently requires in-depth chart reviews and communication with providers who may no longer be caring for the patient. One participant recommended adding an additional response option under Item #3 to indicate review was completed and communicated to the physician/designee but that he or she chose not to recommend a specific action for the provider to implement.

The measure development team additionally asked if it is burdensome to complete Item #2.

Item #2:

Medication Follow-up: Did the agency/facility contact a physician (or the physician-designee) within one calendar day and complete prescribed/recommended actions in response to the identified clinically significant medication issues?

0 - No

1 - Yes

Discussion/ Summary: All commenters agreed that “continue prescribed/recommended actions” be acceptable and not just “complete prescribed/recommendation actions.”

Question 9

How would you predict the four settings (HH, SNF, LTCH, and IRF) may perform on this measure relative to one another, and why?

Discussion/ Summary: Participants agreed that if physician/designee follow-up is required within 24 hours of the identification of the issue, SNFs and HHAs will not perform as well as IRFs and LTCHs.

Question 10

Please provide any other feedback or insight related to the described plan to utilize this Drug Regimen Review measure as a means of satisfying the IMPACT Act requirement for cross-setting medication reconciliation quality measure.

Discussion:

- “Clinically significant medication issue” needs to be clearly defined to avoid any confusion.
- The time period for action (hours vs. days) needs to be clearly defined. The measure development team clarified the existing definition of “one calendar day” used in OASIS, which is from the time the issue is identified until 11:59 pm the next day; so one calendar day ensures at least 24 hours to resolve or complete the action. [Note: one calendar day per OASIS differs from IRF definition for a calendar day for other assessment items.]
- One participant suggested a different time period requirement to complete action; one category would be for patient admissions between Monday to Friday and the second category would include patient admissions from late Friday to Sunday. Another participant stated that differentiating into these two categories might imply two different standards of care, which is not optimal.

Acronyms and Abbreviations

AMA	Against Medical Advice
CARE	Continuity Assessment Record & Evaluation
CARF	Commission on Accreditation of Rehabilitation Facilities
CMS	Centers for Medicare & Medicaid Services
COP	Conditions of Participation
DON	Director of Nursing
DRR	Drug Regimen Review
EMR	Electronic Medical Record
FTE	Full Time Employees
HH	Home Health
HHA	Home Health Agencies
HHS	Department of Health and Human Services
IG	Implementation Guide
IMPACT	Improving Medicare Post-Acute Care Transformation Act of 2014
IRF	Inpatient Rehabilitation Facility
IRF-PAI	Inpatient Rehabilitation Facility Patient Assessment Instrument
LTC	Long Term Care
LTCH	Long Term Care Hospital
MD	Medical Doctor
MDS	Minimum Data Set
MIDS	Measure Instrument Development and Support
NP	Nurse Practitioner
NPE	Nursing Home, PPS, End-of-Stay
OASIS	Outcome and Assessment Information Set
OIG	Office of Inspector General
OTC	Over the Counter

PA	Physician Assistant
PAC	Post-Acute Care
PCP	Primary Care Physician
QA	Quality Assurance
QA&A	Quality Assurance and Automation
QM	Quality Measure
RCA	Root Cause Analysis
RN	Registered Nurse
ROC	Resumption of Care
RR	Rate Review
SNF	Skilled Nursing Facility
SOC	Start of Care
SPE	Swing-bed, PPS, End-of-stay
TEP	Technical Expert Panel
TJC	The Joint Commission

Appendix: Post Technical Expert Panel Worksheets

After the TEP meeting, participants received two follow-up worksheets. The first asked the same questions as those discussed during the meeting, allowing a chance for further feedback. The second worksheet presented questions related to the presentation slides.

Participant responses are organized into their representative settings:

- Consumer
- Home Health (HH)
- Skilled Nursing Facility (SNF)
- Inpatient Rehabilitation Facility (IRF)
- Long Term Care Hospital (LTCH)

Where more than one participant in a setting responded, each additional participant response is bulleted.

Follow-Up on DDR TEP Meeting Discussion Questions

Question 1

What does “timely follow-up” with a physician mean in your setting and what how can “timely follow-up” be harmonized across PAC settings?

Consumer:

- One calendar day, speaking with the physician.

HH:

- Either use 24 or 48 hours or define what one calendar day means.
- Currently, timely follow-up means we contact the physician within one calendar and the physician instructs and/or advises us on what should be done. The reality is we rarely hear back from the physician within that calendar day. A more realistic time frame for “timely follow-up” for the HH setting is 72 hours or 3 calendar days. Having a realistic and standard time frame across all PAC setting would help harmonize the process.
- In HH timely follow-up for Med Rec is one calendar day, which is defined as the end of the next calendar day from when the event is discovered. This timeframe is appropriate for “clinical significant” medication issues. Beyond one day would not be in line with the goal of facilitating best practices for medication reconciliation.

SNF:

- Generally urgent/emergent issues within 30 minutes, important same day and routine would be next working day.

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- 72 hours. Some situations are complex and multiple providers (primary MD and specialist MD) need to be reached. There are also rural settings and weather issues that could decrease ability to reach providers and receive timely reply. Some rural communities don't have a business type pharmacy consultant – with less available hours over a long weekend/holiday. Less than 72 hours would be problematic. They can't always be serviced by the LTC pharmacies related to location. Yes this could be harmonized across PAC settings.

IRF:

- At the IRF level a 24 hour follow-up with the Physician is very appropriate and should be mandated. While in the LTCH it should also be 24hrs and at SNF and the HH level it is practical to have three days or 72 hours follow-up with physician when potential clinically significant medication issues were identified on medication reconciliation or drug regimen review through the care episode or stay.
- Timely follow up would be 24 to 48 hours depending on the availability of the physician. In stat or emergency situations follow-up would occur immediately. Enabling harmonization across all settings would depend on the availability of the health care provider.
- 48-72 hours if something that may cause immediate pt. harm, I would expect a much shorter window

LTCH:

- In the LTCH setting, 24 hours would be a timely follow-up. May be more difficult in HH and SNF setting.
- As the TEP discussed, accessibility of the primary or ordering physician may be an issue, especially for HH. However, we always had access to our medical directors to intervene. Clarifying the definition of clinically significant may help with the timing concerns. If I put on my consumer hat, I would not want to wait 72 hours to resolve a “clinically significant” issue. That doesn't make sense from a patient safety/ quality standpoint, despite the availability issues. If an organization is Joint Commission accredited, standards state that prior to implementing an order/prescription the staff receive answers to any questions.

Question 2

Is the “one calendar day” time-frame reasonable across the settings?

Consumer:

- Yes.

HH:

- 48 hrs more realistic.
- No, it is very difficult to meet the “one calendar day” in the HH setting since we don't have immediate access to the physician, having multiple physicians involve such as Hospitalist,

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PCP and MD Specialist and not getting an accurate medication list from the referring provider.

SNF:

- Maybe not for home care.
- No, up to 3 days would be reasonable. Also, the prescribers need time to think situations through vs making knee jerk decisions r/t time pressure.

IRF:

- No.
- One calendar day should be re-defined to be 24 hours. I do not think it is a reasonable time from across all settings.
- No.

LTCH:

- Calendar day would be difficult in all settings due to potential for late admissions or SOC.
- I believe for purposes of the measure it is. There was some confusion around what calendar day meant, and it was mentioned how it is defined for OASIS, which is clarifying language that would need to be included in the detailed specifications for this measure as well.

Question 3

What are “clinically significant medication issues” in your setting?

Who determines what a “clinically significant medication issue” is?

Could this definition be harmonized across PAC settings?

Consumer:

- Duplication, omission, side effects. Case manager who opens the case/clinical supervisor. Facilities appear to have pharmacist/doctors available 24/7. Home health does not have these options. They may call and get the on call Doc who will not/cannot give answers.

HH:

- Duplicates, poly-pharmacy, drug interactions, incorrect meds, incorrect dosage, not taking a med at all, taking something not prescribed, allergies
- We are using the OASIS definition for ‘Potential clinically significant medication issues’ which states: Potential clinically significant medication issues which include adverse reactions to medications, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, noncompliance or impairment or decline in an individual’s mental or physical condition or functional or psychosocial status.

It would be difficult to harmonize across the PAC setting since the HH setting does not have

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control over what medications are in the home (OTC medications /herbal) , duplications, missing medications, over/under dosing, and lack of funds for medications.

- Duplications, omissions and discrepancies in prescribe dosages from the prior home medication regimen when the patient is dc/d from an inpatient stay. Also, non-adherence to a medication regimen.

The admitting clinician.

Without a full understanding of the care environment within the other PAC settings, it's hard to say if a harmonized definition can be developed. A clear and agreed upon definition of "clinically significant" is critical in implementing this measure across settings. Some common definitions or parameters might be established to use in an interpretive guideline for the measure.

SNF:

- Clinically significant are those that can cause harm to patient through omission or commission. Currently the nurse and/or pharmacist determine this. I believe we could come up with a common definition.
- Medications ordered that are contraindicated with other meds that are also ordered (e.g. top 10 meds never to give with Coumadin).

The pharmacist consultant should be the one who identifies the issue primarily. (Of course, nurses can identify some of these from experience and with training and intervene at any time, but the pharmacist is the best subject matter expert in this case).

There is a lot to be learned from the OIG Feb 2014 Adverse Events Report for SNF. Thirty seven per cent of adverse events were related to medications. There are a few main categories of medications requiring better scrutiny in prescribing and monitoring. That list could be utilized in determining what is significant.

Yes, it should be universal – location of care doesn't remove medication interactions or other adverse events.

Co-morbid consideration, too

IRF:

- In an IRF, it could be discontinuation or non- renewal of a needed medication, omission duplication therapy or overdose or under dose. Inappropriate drug for its use or drug interactions with other medications or side effects are "clinically significant medication issues."

The Physician, Pharmacist and the nurses determine that there is a clinically significant medication issue.

Yes certainly! This definition should be harmonized across PAC settings, as it refers to

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potential harm or threat to the patient's health and a safety issue that could lead to increased mortality, morbidity and increased length of stay at the facilities regardless of the setting and results in unnecessary use of resources.

- Clinically significant medications in my setting include but are not limited to anticoagulants, antibiotics, pain meds and other medications that have narrow therapeutic indexes. It is very difficult to define clinically significant-it depends on patient population (i.e. diabetic medications would only be significant to a diabetic patient) A team of Pharmacists, doctors and nurses have input on what a clinically significant medication is (Pharmacy and Therapeutics Committee)
- Something that would cause immediate patient harm.
Yes.

LTCH:

- Adverse Drug Events, Drug Reactions, Duplication of meds for same indication, dosage errors, ineffective therapy. Decided by physician, pharmacist, and Risk Management. Definition would have to be established so standardization could occur over the settings.
- I think the definition provided could be used, with some specific examples added. I think it makes a difference if the item is answered on an item set by someone qualified to make the assessment as opposed to another individual reviewing and abstracting the record. I think most of the data set/ instruments are intended to be completed by a clinician doing the initial assessment? Or is this just in HH?

Question 4

During episode of care/stay should follow-up be “initiated” or “completed”?

At discharge, would it be appropriate to use the word “complete” rather than “initiated”?

Consumer:

- At SOC I would use “initiated” and at discharge “completed.”

HH:

- Initiated; complete upon discharge.
- It needs to be completed. In the HH setting we get the opportunity to see the patient in their own environment so we get to see the shoeboxes filled with medications often ordered by multiple physicians, no medications in the home due to lack of funding or inability to get or no prescription was given to them.
- One participant recommended the phrase “initiated a change” which is in the IG for SNF. I agree with this is phrase.

SNF:

- I would say initiated since completed may take time to resolve for some issues and may be beyond control of facility i.e., provider, hospital, family, etc.

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- Each episode of med rec requires initiation. The admission to SNF from hospital and Discharge from SNF to home (as an example) are completely separate med recs.

The SNF Staff cannot truly “complete” the task – it is the prescriber that ultimately completes the task. The nurse or pharmacist contacts the prescriber, but we have no control on the prescriber answering us timely. We attempt multiple times, but can’t make them respond. So I would hate to see a SNF obtain a citation in med Rec or have a lower QM outcome because of an uncooperative prescriber. (It doesn’t mean the SNF doesn’t keep trying – but can’t control the timeline for the prescriber response).

I really liked the comment made to add an additional choice to the data elements re: MD chose not to accept the recommendation.

The phrase stated at the end of the meeting, “Act upon” is much better than both initiate and complete.

IRF:

- During episode it should be initiated via contact to the physician and (not or) completed with recommended/prescribed actions to the identified clinically significant medication issues. At discharge, it is most appropriate to use the word completed rather than initiated after it is fulfilled.
- Follow-up should be initiated. More appropriate to use the word “completed” at discharge.
- Initiated.
Yes.

LTCH:

- Initiated
- The TEP discussion regarding the use of “acted upon” may work for both. However this would need to be defined and examples given. Thought should be given as to what the item is intended to measure, is it that the agency made an initial attempt to resolve the issues or that they completed any necessary follow through to assure the issue was resolved. Initiated is more in the providers control, but closing the loop is part of the quality issue as well. That being said, I would have to vote for completed.

Question 5

Should there be exclusions for this measure in any PAC setting?

Are there additional exclusions that should be included?

Consumer:

- Death and no additional.

HH:

- Med rec upon soc and any time there is a change, DRR ongoing. I think drr is the broader term/activity; med Rec is a part of the DRR
- In the HH setting we would like to continue excluding the care episodes ending in death.
- HH currently excludes a “death” due to the construct of the OASIS assessment.

SNF:

- No and No.
- Yes, if it is kept at a one day or 24 hour timeframe. There is not generally a MD/NP/PA on-site at all times in a SNF or HH. (Possibly “uncooperative prescriber” proven by documented attempts in the medical record).

If the MD/NP/PA doesn't return the call or agree/take action with the pharmacist consultant, it is not the fault of the SNF or HH.

The SNF / HH could notify their medical director, but it would take time for the case to be reviewed (up to 72 hours).

IRF:

- There should be no exclusions for this measure at any setting.
- I do not believe that there should be any exclusion.
- No.

LTCH:

- Death
Patients who leave AMA.
- No, there should not be any exclusions. While I understand there are operational issues regarding deaths in HH, there doesn't appear to be any clinical reason to exclude anyone.

Question 6

Is this the measure we should use?

Are there other measures that we can use or adapt to represent the medication reconciliation domain?

Should we add additional data set items to all PAC assessments in order to measure medication reconciliation activity?

Consumer:

- I am not sure how reasonable this is but it would be nice to have two measures. Med reconciliation and drug review and identify specific criteria that must be met.

HH:

- The DRR should be measured; the med rec within the DRR.
- The measure is appropriate if standardized definitions can be agreed upon for medication reconciliation vs. drug regime review- Is this one process or separate processes? Additional data set items to consider would be to separate the following:

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1. Did the PAC facility notify MD within 1 calendar day.
2. Did the MD follow-up within 1 calendar day of being notified by PAC facility.

In this way the performance of the PAC facility can be tracked separate from the MD performance.

- I believe the measure as propose is adequate.

SNF:

- Need to clarify are we talking about med rec which is currently NOT required in nursing homes or drug regimen review or both-might need two measures and might need to define what you mean by med rec and do all steps need to be completed for “credit”.
- Close, but no. I understand the logic of the measure as it is, but pharmacy / medication management is quite complex, individualized, and huge. There are thousands of medications. This measure could become very burdensome in the measurement and monitoring. (Med Rec is essential, but it is so complex and there are so many meds – is there another way to do it?) There is the admission order med rec; there is asking the patient to bring in all their pill bottles during the SNF stay; there is the discharge med rec; there is the follow up phone call med rec.

Would it be better to start with just the process the first year? Was a Med Rec done upon admission and at the next transition (discharge)?

Or later add specific medication categories to monitor through QM’s.

IRF:

- We should use this measure as a start and monitor compliance before going to another measure.

Reported con-compliance resulting in harm and its frequency should be added to the data set to all PAC assessments and that may drive us to develop other possible measures.

- First measure should be medication reconciliation. An accurate list is imperative. Patient’s lists of medications should include medications taken at home, at acute care hospital and any deviations should be highlighted.
- I think Med Rec and DRR are both beneficial functions

LTCH:

- I feel that Medication Reconciliation should be used for items 1, 2, and 3.

Feel additional items should not be added at this time due to intensity of the 3 suggested items.

- I am not aware of any other measures.

Question 7

In your setting, do you currently conduct drug/medication reviews as part of your quality improvement activities?

If so, please describe this activity, including data collection, personnel involved, frequency/time points and lessons learned.

Consumer:

- Charts are audited for medication profiles, review and documentation for issues; 100% note review and quarterly chart review that includes all adverse events.

HH:

- Varies among HH agencies but is burdensome which is why some do it and some don't.
- Yes, by doing random supervisory visits to review the patient medication list in the home against our list in the patient's chart. The managers would make shared visits with the clinical staff on a monthly basis to conduct a medication audit review. Managers would discuss their findings and provide any education to the staff at the end of the visit. The Medication Audit Forms were then turn into the required to fill out Medication Supervisory form which was then turn into the Director of Homecare to process the data. The data was disseminated in the quarterly staff meetings. We also have an interdisciplinary team that meets quarterly to look at the potentially avoidable events. Our software system pulls the data from the OASIS. The information is discussed to determine best practice.
- Drug regimen review with the focus on identifying potential problems is part of the HH COP §484.55- Comprehensive Assessment.

SNF:

- DRR is typically tracked and trended by consultant pharmacist and reported through QA&A. Usually number of concerns, response to concerns and if agree or disagree are tracked and trended. Patterns and trends are also addressed and there may be focused review of the process if problems identified. Most facilities carefully looking at antipsychotics because of quality indicators and regulations. Other meds may also be targeted based on quality concerns or survey issues. Nine plus meds may be looked at as well as use of prn meds.
- Med Rec is done upon admission (actually starts in the pre-screening process).

Indirectly med rec is tracked through RCA of Re-hospitalizations and ED visits and/or re-hosp. are sometimes r/t medication events (such as electrolyte imbalance – loop diuretic).

In SNF, a thorough DRR is completed within the first seven days. Some SNFs, voluntarily fax the new orders to the pharmacy upon admission and pay extra fees for a quicker DRR.

The outcome of the DRR is given in writing or electronically in an EHR for the Director of Nursing (DON) to manage. The expectation is that timely (Now, within 30 days, or FYI are typical categories of timeliness).

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The admission and every 30 days requires DRR to be reported on quarterly by the pharmacy consultant at the QAA meeting.

What is reported on is the DRR is the number of items identified compared to number of items identified that were addressed.

There are various other reports (utilization of certain drugs e.g. anti-psychotics) or other problematic issues found through QAA processes.

IRF:

- Yes! At our IRF, we conduct periodic drug/medication reviews as part of quality improvement activities and it becomes a performance evaluation assessment for the practitioner.

We review inpatient and outpatient medical records of each other in the physician group on a standardized review form and collect data monthly to give feedback and learn from the deficiencies. The QA liaison joins the physicians in the group and generates reports.

We constantly critique inappropriate usage and/ or safety issues with intent to avoid future occurrences and to make sure that standard of cares are met.

- Yes, medication reviews are done on a daily basis at the time of verification of medication orders. There is a dedicated staff of pharmacists that are involved as well as the patient's attending physician and admission referral specialists. Before a patient is admitted, the admission referral specialists try's to obtain a list of patients meds from referring facility including home medications and sends this information to the pharmacy. Data is collected by reviewing and categorizing pharmacist's interventions. Lessons learned are that medication reconciliation is only as good as the information that is provided. There are times that these lists are not available and then there is nothing to go by. Recently our facility did a project with the specific aim of determining the frequency of medication reconciliation discrepancies when patients are transferred from acute care to IRF or SNF. Over 100 closed charts were reviewed. The conclusion was no surprise....medication reconciliation errors continue to pose a threat to patient safety with the potential to cause adverse drug events. The data collected in this project illustrates that this is a common problem across facilities and that even informal efforts with one facility did not make an impact. Clearly more effort and resources must be invested to minimize medication reconciliation errors.
- Yes. Perform med rec on admission, perform DRR w/in 72 hours and weekly. Do not currently collect data.

LTCH:

- Medication Reviews currently reported out in Medication Management Committee which reports to Performance Management Council, Medical Executive Board, and then Board of Directors. Examples are Anticoagulation Therapy, Adverse Drug Events, Medication

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Variances (omissions, incorrect dosages, etc.), and Antibiotic Stewardship. Data collected by pharmacists, RN Data Coordinator, Quality Director, and Risk Manager on a monthly basis.

- N/A.

Question 8

In the setting(s) you represent, do you foresee any challenges to collecting the data as specified for this quality measure?

Consumer:

- No

HH:

- Item 3 is going to be difficult; I believe it is highly likely that HHA would not truly look back and those completing the dc OASIS may not remember.
- Challenges to collecting the data include - Standardizing definitions.
- Developing new processes for such things as decreasing inter-rater variability when entering data, minimizing / streamlining the process for chart reviews at the time of discharge.
- The look back required at discharge for this measure is burdensome. However, HH agencies have been required to conduct look back reviews in order to accurately respond to several of the process items on the OASIS.

SNF:

- No, but will need to be clear on definitions.
- Yes, it will be a very manual process. (initial med rec and later getting patient meds from home) Knowing SNF's they will develop additional worksheets, checklists, and audits that will take additional time.

This measure addresses the wrong root cause. Prescribers should be held accountable for preventable adverse events related to their orders. The SNF cannot prescribe or fix the order without the prescriber. The caregivers do not have the rich knowledge the pharmacist has. Yet the neither pharmacist nor SNF can make the prescriber change their order or respond timely.

IRF:

- Yes! As in any setting, the challenges are busy schedules and constant demands of work. However, given that it affects safety and quality of patients I do not see any alternatives to collecting the data for this quality measure.
- Yes, the challenge I see is lack of compliance. All parties need to be mandated to comply. Perhaps if there was a data base containing the standardization of this required information that was made available all parties would "be on the same page".

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- Yes will be difficult to capture and mine data as we do not have capacity in our current system.

LTCH:

- I do foresee challenges particularly with item 3. Processes will need to be assessed and modified in order to collect the necessary data throughout the patient's service time. Capturing documentation for each physician intervention will be difficult for the various settings.
- See below.

Question 9

How do you predict the four PAC settings will perform on the measure, relative to one another, and why?

Consumer:

- Home health is experienced in this. I do see any problems across the transition. The major issue is with the hospitals. Inappropriate discharges without planning and gross duplication of meds are seen with 8-9 P.M. discharges into the weekend with high risk patients for re hospitalization

HH:

- Loaded question – sadly, I think this will be most difficult for home health as clinicians are practicing in the patient homes without a physician or NP on site.
- With the current timeframes HH will perform worse than the IRF due to response time by physicians.
- HH should be positioned well since this is already measured in the HH setting. I do not have a sense for the other PAC settings.

SNF:

- LTCHs are hospitals and IRFs often close or part of hospitals and often have most resources are TJC and CARF accredited. Next would be SNF/NH and then home care. I think with a phase in of the measure over 12-18 months you should see good compliance.
- IRF, LTCH have prescribers on duty 24/7 so they will do well.

SNF and HH will have more challenges r/t getting the prescribers to respond and cooperate. This is because there are multiple prescribers: The clinic MD, the hospitalist or SNF is in the hospital, the primary SNF MD, HH MD... for them all to review and determine the right drug regimen is complex.

IRF:

- It is a tough question however, if bundled payments come to effect, this measure is going to be applicable and will be effective across all settings and we will be forced to perform better and we will do better and improve safety and quality of care of our patients.
- The settings are too different with too many variables to be measured or related to each other.
- I would think IRF/LTCH would perform the best due to most having on-site pharmacy/access to pharmacist. I would think SNF would be 2nd. HH would have most trouble.

LTCH:

- I feel the LTCH and IRF facilities will perform more efficiently due to the controlled inpatient setting. Physicians tend to respond in a timely manner in an acute inpatient setting.
- It was mentioned that HH was already performing very high. I think LTCH will struggle with item 3 due perhaps to the acuity of the patients, higher volume of changes, and longer stays. SNFs may have some of the same issues. Some of the IRF, SNF, and LTCH settings may fair better if they have on-site pharmacy.

Question 10

Please provide any other feedback or insight related to the described plan to utilize this Drug Regimen Review measure as a means of satisfying the IMPACT Act requirement for cross-setting medication reconciliation quality measure.

Consumer:

- Any change identifies new issues and challenges from the users, however with education I see no problems

HH:

- I think this will be a work in progress; but we have to start somewhere.
- Would recommend that Med Reconciliation and a complete drug regime review be integrated into one process. To complete one without the other is an incomplete process leaving the patient vulnerable to errors, injury, and adverse effects. Both processes should be completed anytime a patient has a change in the drug regime in an effort to achieve Quality Outcomes. The resultant data would be more beneficial if the PAC facility's performance could be separated out from MD follow up performance. In this way specific areas could be targeted for improvement or identified to use as a model for others.
- Again, there must be clarity and agreement on the definition of "clinically significant", perhaps even another term.

SNF:

- True medication reconciliation is time consuming and often requires nurse/physician and pharmacist to collaborate as well as patient (who may be ill and confused) and family.

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Hospitals are NOT required to send reconciled lists of medications with the patient that have been authenticated by a provider. The discharge summary may be incorrect and NOT authenticated. Would be nice to have this addressed in hospital COPs-1-2 days later is not adequate given the acuity of patients being discharged to various settings.

- If this described plan is utilized for DRR it would be nice if the data collection was built within the e.g. SNF MDS (and other level of care assessments). Clear definitions of significant issues. There is already plenty of ambiguity in SNF requirements. It must be clear and not subjective.

Perhaps start with the process itself at admission / discharge, and then advance this type of QM over the next few years.

IRF:

- Given the implications that safety and quality bring to our practices, all settings must utilize this Drug Regimen Review measure as a means of satisfying the IMPACT Act requirement for cross-setting medication reconciliation quality measure.
- An accurate and meaningful drug regimen review can only occur if the medication reconciliation is accurate.

LTCH:

- Medication Reconciliation is a part of Drug Regimen Review. If Medication Reconciliation at time of admission/SOC and discharge meets the needs of the IMPACT Act, decision needs to be made to look at the reconciliation at admission and discharge and not Drug Regimen Review throughout the entire service time.
- See below

Other Comments

Consumer:

- No additional comments.

HH:

- No additional comments.

SNF:

- I think all would agree that medication management including medication reconciliation is essential in reducing adverse events as described in the Feb 2014 OIG Adverse Events Report in SNF's. This problem begins with the prescriber's e.g. the discharging hospital to the admitting SNF or HH. This situation is massively complex and not within the complete authority of the SNF/HH. Perhaps starting with "Was a med rec completed?" "Were recommendations called to the MD/NP/PA within 72 hours?" "Did the MD/NP/PA respond to the recommendations?"

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IRF:

- Important to define/differentiate Med Rec/DRR
- 2. Important to have realistic time frame expectations
- 3. Important to define “clinically significant” as this can have different things across the 4 post-acute settings

LTCH:

- Will this affect all SNF patients or only Medicare/Medicaid patients?

Assessment of DDR TEP Presentation Statements

TEP participants commented on and ranked agreement with statements related to the presentation (1=strongly disagree, 5=strongly agree).

1. *The data collection items accurately reflect activities needed to measure medication reconciliation information.*

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree
Consumer				1	
HH		1	1	1	
SNF			1	1	
IRF		1		2	
LTCH			2		

Comments:

- Consumer:
 - No comment.
- HH:
 - Not sure this is perfect, as stated above, it’s a work in progress and we have to start somewhere.
 - Depends on if the data collection items address Med Reconciliation OR Drug regime review? Or if the standard could incorporate both processes.
- SNF:
 - Admission and Discharge are clear, but the piece where it is on-going throughout the stay (which means with every MD order change) will make it ambiguous and be burdensome to audit/measure. In a SNF, orders may change daily.
- IRF:

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- No comments.
- LTCH:
 - Need definition of “clinically significant medication issues.”
 - While it seems a good place to start, I wonder about the comments that HH is already performing very high on this measure. Is there some aspect that is not reflected in that measure; are there studies that would lead us to believe that med rec is not accurately occurring? It was suggested that med rec issues were a cause for readmissions. So would specifications be different for the new measure and help an organization look more critically at the DRR process?

2. The data collection items are worded in a way to be understandable to the assessing clinician.

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree
Consumer				1	
HH		1		2	
SNF		1		1	
IRF		1		2	
LTCH		1	1		

Comments:

- Consumer:
 - No comment.
- HH:
 - Should say the specified time period and not ‘calendar day’ which could mean “that day” to some clinicians or “24 hours” to others
 - Needs to be standardized across multiple PAC settings.
- SNF:
 - Not totally. I’m most concerned about what is a “clinically significant medication issue” definition. This MUST be clear, but with so many meds and so many types of adverse drug events, this is very challenging to define. For the SNF, ultimately the regulatory surveyors will look at these measures and dig deeper. So SNF’s will have so many additional checklists and audits developed making this extremely burdensome for the amount of staff we can have on r/t reimbursement issues. I did like the recommendation to add another choice to the Data Elements of “MD chose not to change” but with some word-smithing.

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- IRF:
 - No comments.
- LTCH:
 - Clarification needed for Medication Reconciliation and Drug Regimen Review and which is done at time of admission/SOC and discharge.
 - There were differing opinions on definitions on the TEP call of what constituted a “drug regimen review” and what was “med rec”. I think adding a more detailed description of what – for purposes of this measure – is included as the “drug regimen review.”

“Clinically significant” should also be further clarified to reduce the varied interpretations of what this means.

3. This measure will be useful to healthcare providers in quality improvement efforts.

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree
Consumer				1	
HH			1	2	
SNF			1		1
IRF			1	1	1
LTCH		1		1	

Comments:

- Consumer:
 - No comment.
- HH:
 - Potentially if the “problem area” can be identified. Would the measure identify / separate intrinsic vs. extrinsic factors?
- SNF:
 - Depends on definitions.
 - With the modifications to the collection items suggested during the TEP call. [See Discussion and Questions on Measure Concept section of this summary, specific questions 1 – 4]
 -
- IRF:

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- No comments.
- LTCH:
 - It seems that items 1 and 2 relate to the initial start of care and item 3 relates to the on-going care. It may be useful to split these into 2 measures or sub-measures so the provider can see if the issue is with initial start or on-going care.

4. The numerator conditions are appropriate to reflect desired provider actions.

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree
Consumer				1	
HH				3	
SNF			1		
IRF				2	1
LTCH		1	1		

Comments:

- Consumer:
 - No comment.
- HH:
 - No comments.
- SNF:
 - Depends on the point about “clinically significant events.” (I do know most SNF’s do recognize the events that need immediate change)
- IRF:
 - No comments.
- LTCH:
 - Item 2 would need to be reworded to reflect that physician was contacted and decision made not to make changes. As currently stated, should only be counted if MD acted on recommendation.
 - Item #1, as mentioned on the call, will need an allowable answer or code to reflect when a drug review was not done, otherwise everyone is in the numerator.

Appendix 1: Post Technical Expert Panel Worksheet

5. The data collection time points described are clinically appropriate.

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree
Consumer					1
HH				2	1
SNF	1			1	
IRF		2			1
LTCH		1		1	

Comments:

- Consumer:
 - No comment.
- HH:
 - No comments.
- SNF:
 - No comments.
- IRF:
 - No comments.
- LTCH:
 - I feel that “calendar day” should be changed to “24 hours” or “72 hours.” Calendar day may not be appropriate for all settings.

Appendix 1: Post Technical Expert Panel Worksheet

6. The data collection time points described are clearly defined.

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree
Consumer					1
HH		1		1	1
SNF	1		1		
IRF		1		2	
LTCH				2	

Comments:

- Consumer:
 - No comment.
- HH:
 - Calendar day is often interpreted to mean 24 hours. In HH, calendar day is defined as the end of the next calendar day from when the event is discovered for med reconciliation.
- SNF:
 - I would agree if it did not say “throughout the stay”. (Medication safety is watched with every MD order transcription, but doing a formal DRR with every order change would be nearly impossible to measure without a position designated to monitor and audit for this – very costly.) I don’t believe we are prohibited from adding additional QM’s in this area over time, so maybe start with admission/discharge and later add another QM.
- IRF:
 - No comments.
- LTCH:
 - No comments.

7. In the setting(s) I represent, drug review and reconciliation processes are conducted and documented in a way that will allow the data items for this measure to be collected without unreasonable provider burden.

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree
Consumer				1	
HH		1		2	

Appendix 1: Post Technical Expert Panel Worksheet

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree
SNF	1			1	
IRF		2		1	
LTCH		1+ 1 (item 3)		1 (item 1, 2)	

Comments:

- Consumer:
 - No comment.
- HH:
 - Then final one is a burden and I worry if it is/will be answered accurately.
 - Yes but not consistently or without great difficulty at this time. For example – retrospective chart review.
- SNF:
 - This will be a huge / unreasonable burden related to amount of med rec done, and that it is a very manual process. This burden is related to the definition of “clinically significant event”. If the definite was very clear it would still mean a manual chart review for every patient.

If it is just collecting a process measure (minus the clinically significant definition) that would be easy.
- IRF:
 - It will be a burden to collect this data.
- LTCH:
 - In LTCH setting, current drug profiles completed by pharmacy are not part of the permanent medical record. New process and documentation will be necessary. Processes for capturing data pertaining to Drug Regimen Reviews on a daily basis will have to be established. Large amount of data will be collected due to extended services of Post- Acute Care patients. Foresee need of additional Full Time Employees.
 - Across organizations that I have had contact with, many have mechanisms / fields in place to document this has been completed upon the admission of the patient. If the item is added to the existing instruments/data sets it should not be unreasonable, with the exception of item #3 (see below).

Appendix 1: Post Technical Expert Panel Worksheet

8. For the setting(s) I represent, I foresee challenges to collecting the data items required for this measure.

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree
Consumer		1			
HH				2	1
SNF		1			1
IRF				2	1
LTCH		2			

Comments:

- Consumer:
 - No comment.
- HH:
 - MD participation in follow up. Staff education, changes / clarification of policies. Identifying a process to more efficiently perform a retrospective chart review.
- SNF:
 - No comments.
- IRF:
 - No comments.
- LTCH:
 - Item #3 seems like it would be particularly burdensome. Especially in LTCH where there could be a great volume of documentation to sift through. The start of care/ admission items should not cause a great deal of challenge once definitions are clarified.

9. This measure is an appropriate way to compare drug regimen review performance within and between the HH, SNF, IRF and LTCH settings.

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree
Consumer				1	
HH			1	2	
SNF		1	1		
IRF		2			1

Appendix 1: Post Technical Expert Panel Worksheet

	1 Strongly disagree	2 Disagree	3 Undecided	4 Agree	5 Strongly agree
LTCH			1	1	

Comments:

- Consumer:
 - No comment.
- HH:
 - Must start somewhere.
 - Could be if definitions of drug regime review / medication reconciliation could be standardized.
- SNF:
 - Yes within but NOT between which I think is the goal.
 - Could be if the clinically significant definition and the word “throughout the stay” was removed.
- IRF:
 - I predict we will set targets and will meet them and do well with this measure as the institution (IRF and the main hospital). I work for values quality and safety with serious commitment.
 - I would think it will work within each setting but would be difficult to compare across the four settings due to unique challenges

- LTCH:
 - If it is decided to look at Medication Reconciliation for the 3 items, I feel it will be a way to compare the 4 settings.
 - It seems to be a good place to start. I also wonder why not implement across ALL settings. Perhaps in the future a measure may be constructed that could get at the quality of the review. Using the EHR to pull in pharmacy and clinical assessment to identify potential issues that may not have been picked up as clinically significant by the provider completing the data set.

Slide 31

10. How do you predict the setting(s) that you represent will perform in this measure? And why?

Comments (no scoring):

- Consumer:
 - Home health will perform well. They are used to change and med review and reconciliation is a major component of home health.
- HH:
 - Again, [in] HH, we practice in patient's homes. There are no colleagues, physicians, pharmacists or NPs in the patients' homes, but do have them at the agency sometimes.
 - MD follow-up and one calendar day will contribute to lower performance scores in HH.
- SNF:
 - It is being done but may not be done correctly. You are not truly getting at the transitions issue. Everyone says they do this then why do we still have so many issues?
 - Depends on the definition of clinically significant and also on the timeframe. If 72 hours – we will be the same. If less than 72 hours, we will do worse. This is related to the ability to reach the prescriber timely on evenings, weekends, and holidays. IRF and LTCH have prescribers on site.
- IRF:
 - Poorly-too many variables as well as different patient populations.
 - I think we do well at completing since we already do it. My concern would be the timeframe and the burden of data collection.
- LTCH:

Appendix 1: Post Technical Expert Panel Worksheet

- LTCH will perform efficiently after process of capturing documentation is developed. SNF and HH will have more difficulty meeting this requirement if item 3 remains as Drug Regimen Review.

Other Comments

- Consumer:
 - No comment.
- HH:
 - Thank you for the opportunity to participate in the Drug Regimen Review Technical Expert Panel.
- SNF:
 - I thought the call preparation was excellent and the facilitation allowed everyone a chance to speak. Looking forward to the next steps!
- IRF:
 - It was a good exercise and very practical points were raised at different settings. The implementation of the measure is useful to improve patient safety.

The significant medication discussion we had regarding what medications fall in to significance was not in the above list of questions however, we should regard any and all medications as significant although the degree might vary.
 - I enjoyed being a part of this panel. I am very passionate about the fact that poor medication reconciliation can severely impact the safety of our patients. Thank you for the opportunity to allow for my input.
- LTCH:
 - Thank you for the opportunity to participate in this TEP, it was a very interesting discussion and I look forward to seeing how it moves forward.