Technical Expert Panel Summary Report: Development of two quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) Domain of Transfer of Health Information and Care Preferences When an Individual Transitions to Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs)

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TECHNICAL EXPERT PANEL SUMMARY REPORT: DEVELOPMENT OF TWO QUALITY MEASURES TO SATISFY THE IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION ACT OF 2014 (IMPACT ACT) DOMAIN OF TRANSFER OF HEALTH INFORMATION AND CARE PREFERENCES WHEN AN INDIVIDUAL TRANSITIONS TO SKILLED NURSING FACILITIES (SNFS), INPATIENT REHABILITATION FACILITIES (IRFS), LONG-TERM CARE HOSPITALS (LTCHS), AND HOME HEALTH AGENCIES (HHAS)

DELIVERABLE 14

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CONTENTS

Appendixes

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LIST OF ACRONYMS AND SHORT FORMS

CIO	Chief Information Officer
CMS	Centers for Medicare & Medicaid Services
EMR	Electronic Medical Record
HHA	Home Health Agency
IMPACT Act	Improving Medicare Post-Acute Care Transformation Act of 2014
IRF	Inpatient Rehabilitation Facility
IRF-PAI	Inpatient Rehabilitation Facility-Patient Assessment Instrument
IVAR	Intravenous Medication Record
LTCH	Long-Term Care Hospital
MAR	Medication Administration Record
MDS	Minimum Data Set
NQF	National Quality Forum
OASIS	Outcome and Assessment Information Set
OTC	Over the Counter
PAC	Post-Acute Care
PCP	Primary Care Physician
PRN	Pro re nata (Latin): When necessary
QM	Quality Measure
QRP	Quality Reporting Program
SNF	Skilled Nursing Facility
RTI	Research Triangle Institute
TEP	Technical Expert Panel
TPN	Total Parental Nutrition

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SECTION 1.
INTRODUCTION AND OVERVIEW

1.1   Introduction

On behalf of the Centers for Medicare & Medicaid Services (CMS), RTI International and Abt Associates reconvened a Technical Expert Panel (TEP) for the fourth time on April 20, 2018 to seek additional expert input on the development of quality measures (QMs) that would satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain, the Transfer of Health Information and Care Preferences When an Individual Transitions. The initial TEP meeting was held on September 27, 2016, the second TEP meeting was held January 27, 2017, and the TEP was reconvened for a third meeting on August 3, 2017. Reports from previous TEP meetings can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html. Discussion was moderated and facilitated by Abt Associates, with support from various members of the RTI and Abt measure development team. Representatives from CMS were also in attendance.

To satisfy this domain, and after additional testing and modification work from prior development efforts, CMS and their contractors developed two quality measures, Medication Profile Transferred to the Provider and Medication Profile Transferred to Patient/Family/ Caregiver. These cross-setting measures are developed for the Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH), and Home Health Agency (HHA) settings. These measures were revised from previous versions, which measured the transfer of a number of categories of information. These revisions were made based on suggestions from the TEP, public comment and other stakeholder input. The measures under development focus on the transfer of health information, such as medication information from the Post-Acute Care (PAC) provider to the subsequent provider and/or to the patient/family/ caregiver at discharge or transfer. This report summarizes the key discussion points from the fourth TEP meeting, including recommendations and feedback on assessment items and the quality measure specifications that are under development.

1.2   TEP Webinar

Ten of the fourteen TEP members attended this three and a half hour TEP webinar. The webinar and discussion focused on: (a) revisions to the measure concept and measure specifications since the TEP last met; (b) best practices in the transfer of medication information that differentiate quality of care; (c) information to be included in the medication profile to meet the measure criteria; (d) importance and feasibility of information in the medication profile; (e) the measures' relationship to quality of care; (f) collecting routes of transfer of the medication profile; and (g) possible unintended consequences of the measures. The meeting was audio recorded and transcribed by a professional transcriptionist for the purpose of summarizing TEP proceedings in this report.

Prior to the meeting, the TEP members were requested to complete a pre-TEP survey on the importance and feasibility of the medication profile information, referred to as data elements. Eleven of the 14 TEP members provided responses to this survey and results were calculated by

RTI and shared during the meeting. A copy of the Pre-TEP survey can be found in Appendix E and the results of the survey can be found in Appendix F of this document.

1.3   Organization of Report

The following sections of this report summarize TEP members' input during the April 20th, 2018 TEP webinar. ***Section 2*** summarizes TEP discussion and feedback and starts with an introduction in Section ***2.1***. Section ***2.2*** summarizes best practices for the transfer of medication information; ***2.3*** provides an overview of the draft measure specifications; ***2.4*** summarizes the medication profile; Section ***2.4.1*** summarizes medications to be included in the profile; ***2.4.2*** summaries the medication profile data elements;***2.4.3*** summarizes feasibility of data elements; ***2.5*** summarizes routes of transmission; ***2.6*** summarizes unintended consequences of the quality measures; and ***2.7*** summarizes the quality measures and relationship to quality of care; ***Section 3*** provides an overall summary. Section ***3.1*** summarizes the current state of measure development and next steps.

SECTION 2.
SUMMARY OF TEP DISCUSSION: TEP MEETING #4

2.1 Introduction

This section summarizes the TEP discussion. The sub-sections represent the main topics discussed with the TEP.

2.2 Best Practices for the Transfer of Medication Information

TEP members were asked about the best practices for medication information transfer that are often adopted by high quality providers and may differentiate higher from lower quality care providers. The TEP mentioned several practices for high quality transfer of medication information including, 1) ensuring that the most critical information is referenced first so providers, patients, or caregivers do not have to wade through information; 2) providing clear, jargon-free information, written in lay terms for patients and their caregivers about their medications (e.g., "stopped" rather than "discontinued"), including the generic and brand names, descriptions or pictures of the medications (e.g., blue pill), any indications, start and stop dates, and when the last dose was given before discharge; 4) providing information on the medications in more than one manner (e.g., printed, verbally, written on the medication bottles themselves); 5) getting the medications before discharge so that patient education can be done with the "actual pills"; 6) an interoperable EHR shared between home care services, skilled nursing facility, and the hospital with an "After Visit Summary" for the patient; and 7) assessing the medications that are taken at home early in the PAC stay.

2.3 Draft Measure Specifications

TEP members were shown the draft assessment items (see Appendix B) and draft specifications (see Appendix C) for the two quality measures: Medication Profile Transferred to Provider and Medication Profile Transferred to Patient/Family/Caregiver and asked their reactions to these. One TEP member stated that the measures do not address the timeliness or accuracy of the information transferred. Three other TEP members added that accuracy of the medication information transferred can depend on the medical record system being used and how often it is updated.

One TEP member asked for and received clarification that both questions one and two would be answered for patients/residents discharged to home health. This TEP member also questioned the different payers included in the denominator for the different settings (Part A for SNF; Part A and Medicare Advantage for IRF; Part A, Medicare Advantage and Medicaid for Home Health; and all payers for LTCH) and suggested that inclusion of different payers could result in erroneous comparisons across payers on the measures.

There was also some discussion of whether the patient's primary care physician (PCP) should be considered a subsequent provider. However, several TEP members stated that there was no good process for getting the information to the PCP and ensuring that the PCP would review it. They stated that the information could be out of date by the time the PCP reviews the information, and they questioned the utility of the PCP receiving such information.

3

2.4   Medication Profile

TEP members were provided with a draft definition of a medication profile (see Appendix D), including the information, referred to as data elements, related to the patient and each medication that are recommended to be transferred as part of a medication profile. The data elements themselves would not be collected as new assessment items. This includes several data elements that are to be transferred "if applicable." TEP members were asked to comment on the data elements included in the draft definition of a medication profile and were asked to suggest any elements that should be added to the definition, any existing elements that should be removed and whether the elements labeled "if applicable" were appropriate.

2.4.1   Medications to be Included in Profile

The draft definition of a medication profile includes all prescribed and over-the-counter (OTC) medications, including oxygen and total parenteral nutrition (TPN). The TEP unanimously agreed with the medications and substances to be included in the medication profile definition. That is, they agreed with including OTC medications, oxygen and TPN. Recommendations for additional medications to be included were made by individual TEP members. One was any PRN medications (i.e., those taken when necessary, such as acetaminophen or allergy medication) that the patient takes at home but not during their PAC stay, and another was self-administered medications. Ten TEP members felt that alcohol and/or recreational drugs should be included in the medication profile if the patient reports use, as these drugs can alter the effects of medications. Specifically, one TEP member commented that this is standard information in most medication documentation, and another pointed out that alcohol and recreational drugs can potentiate the effects of medications. One also noted that medical marijuana may be included in the medical profile in states where it is legally available. A follow-on recommendation was that if this information were to be collected, the type of drug and the alcohol amount, frequency, and the patient's history of binge drinking should be included. One TEP member also suggested that this information be easily removable or modifiable in the medical record so that changes in patient use of these substances can be made.

2.4.2   Importance of the Medication Profile Data Elements

All of the TEP members agreed that the medication profile data elements listed in the draft specifications are important. However, some reported that it is currently not feasible to transfer all of the data elements. One TEP member stated that their practice is to include all of the types of medications as described in the draft specifications in the patient's medical record, but that there are challenges inputting the brand, strength, and other data elements for some of the over the counter (OTC) products. Getting this information can be time consuming and the information can change frequently because each time the person goes to store they may try a different OTC product. Another TEP member noted that the profile may only be accurate for a brief moment in time.

Several TEP members stated that certain data elements are more important to patients/caregivers and some more important to providers. For patients, it was suggested that the medication name, dose, route, frequency, directions, and reason for holding the medication are the most essential elements to convey. For patients/caregivers, they also suggested that it is

important to have the brand and generic names of the medication in the profile to avoid double dosing.

When asked in the pre-TEP questionnaire if all or certain medications discontinued during the stay/episode be included in the medication profile transferred at discharge/transfer, six TEP members responded 'yes' and five responded 'no.' Some members who recommended that discontinued medications be included also suggested the information transferred include the start and stop dates and indications (3 members) and the reason for the discontinuation (2 members). TEP members who recommended that discontinued medications not be included in the medication profile felt that this would add too much information and complicate medication reconciliation. One member stated it is key to be able to "call out" the most important information within the medication profile, including the medication the patient is currently taking, and that inclusion of discontinued medication impedes this. Furthermore, two TEP members emphasized the importance of educating patients and caregivers to understand the medications that they are taking and which medications that have been discontinued.

TEP members noted that, while information about discontinued medications is important, it is likely not feasible to include them all in the medication profile, especially among providers still using paper records. One suggested that only medications discontinued due to adverse events be included. However, another TEP member noted that information would be found in the allergies or reactions section. Several TEP members agreed that a way to balance the need for information about discontinued medications, while not overwhelming profile recipients or overshadowing key information, may be to limit this information to medications discontinued within the last 30 days. Another suggested that the 30-day window be confined to the period during the PAC stay. In other words, if the PAC stay is shorter than 30 days then only those medications discontinued during the PAC stay should be included.

When probed about which data elements should be included in the medication profile as 'if applicable,' suggestions from some TEP members included relevant lab test results to guide medication management, known sensitivities and reactions, significant food and drug interactions, and the patient's ability to understand/accept their condition. Two TEP members felt that height and weight should be required and not 'if applicable' as indicated in the medication profile description. TEP members disagreed as to whether the patient's ability to understand or accept their condition should be required or only included 'if applicable'. One TEP member noted that while this information may be applicable, it may not be available. Another felt that it should remain a required element in order to ensure providers collect the information. A third TEP member felt that the patient's ability to understand their medications should be determined by the subsequent provider because a patient may appear to accept or understand the importance of taking medications as prescribed during the inpatient stay and yet fail to do so once discharged or transferred. Additionally, a TEP member suggested that the timing of the last dose of the medication was administered by discharging/transferring provider should be required rather than 'if applicable'. Finally, one TEP member requested clarification about the distinction between 'if applicable' and 'if available'. In their conceptualization, 'if applicable' involved a decision by the transferring provider as to whether the data element is relevant, whereas 'if available' would prompt the transferring provider to pass the data element on to the subsequent provider as long as it was present.

2.4.3 Feasibility of the Medication Profile Data Elements

As noted above, TEP members reported that the feasibility of collecting and transferring the data elements in the medication profile will often be related to the medical record system the provider is using. While feasibility was noted to be likely most difficult among providers still using paper-based records, TEP members noted that electronic systems will store the suggested data elements in various locations. For example, one TEP member noted that there is usually not a place in the record where patient preferences would be located, and that this information would most often be recorded in a note and not in a standardized form. Several TEP members agreed that the more feasible elements would be those that currently have standards associated with them.

Less feasible data elements identified by TEP members included the reason for holding medications and when to resume, the medication prescriber, patient preferences, patient adherence strategies, and the patient's ability to understand and accept their condition and the importance of taking the medications as prescribed. Two TEP members recommended the measures be implemented requiring only the most feasible data elements in order to get credit for the measure, and that other data elements be added over time as they become more feasible. They and a few other TEP members expressed confidence that there will be health IT standards in the future for these data elements that will allow for their capture in a structured format by EHR systems. The pre-TEP survey asked that TEP members rate the draft data elements in terms of feasibility. Results of that polling are found in Appendix F.

2.5 Routes of Transmission

TEP members were asked to comment on the importance of the items meant to capture the route of transmission of the medication profile to the subsequent provider and to the patient, family or caregiver. Four TEP members said that capturing the route of transmission does not provide much value and suggested removing these items. Two TEP members stated that the burden of completing the items is high and the value is low. These two members also said that most PAC providers will use and code the same routes all the time. Therefore, this information does not need to be collected for every discharge and could be more easily collected periodically, such as by survey. There was also a suggestion that the route of transmission not be publicly reported until it has been demonstrated that the transfer of medication profile measure has demonstrated value.

2.6 Unintended Consequences of the Quality Measures

TEP members were asked if there are any possible unintended consequences to either of the quality measures. One member stated that there would be additional costs and burden to update software and workflow to implement these quality measures. A second TEP member agreed with this, pointing out that several data elements are currently not collected or could be in various areas within PAC providers' medical records, and other systems (e.g., their Medication Administration Record system, medication orders, the patient's plan of care, the pharmacy system). Two TEP members also felt that collecting these quality measures will necessitate IT and workflow changes, with one adding that the workflow could be updated to collect the best data possible until IT solutions are in place. One member was concerned that the measures may hold back progress if the ultimate aim is to develop a mechanism that can provide a one "true

source" of information rather than passing the information back and forth among providers. Another member described the "short shelf life" of the information and suggested that we need to understand the implications of rapidly changing medication information. Another possible unintended consequence raised by a TEP member was that certain programs would use this quality measure to penalize providers. One TEP member expressed concern that the measures still leave the opportunity for inaccurate, incomplete information to be transferred. The measures could be coded as yes, the medication profile was transferred, but it won't be possible to validate that it is as robust as we would like it to be. This TEP member suggested that we look toward the future state where mechanisms are developed to ensure that what we're asking to be transferred actually does get transferred. The mechanisms would ensure that the information was transferred to the next facility or into the hands of patients and family members.

2.7   Quality Measures and Improvement in Quality of Care

TEP members were asked if the quality measures will improve the transfer of medication information to the provider and/or patient/family/caregiver. TEP members were asked to respond by means of webinar software. Seven members responded to the poll questions via the webinar polling capability. When asked if the first measure will improve the transfer of medication information to the subsequent provider, six members agreed, one somewhat agreed, and none disagreed. When asked if the second measure will improve the transfer of medication information to the patient/family/caregiver, five agreed, two somewhat agreed, and none disagreed.

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SECTION 3.
SUMMARY

The TEP was supportive of the new measures' concepts of the transfer of a medication profile to the subsequent provider and to the patient/family/caregiver. They reported that the measures under development provide an opportunity to improve the transfer of medication information. Most of the TEP members polled felt that the measures could improve the transfer of medication information to providers and to patients, families and caregivers. All data elements in the draft medication profile specifications were considered important to transfer, but some attributes of the medication profile were reported as less feasible to collect, particularly attributes captured as narrative text rather than structured data. Several TEP members emphasized the importance of transferring information to patients and their caregivers in a very clear manner using lay language. A recommendation was made to examine ways in which the medication profile elements, as specified in the guidance, can be reduced to include the most important elements only, or that additional elements be phased in over time based on their feasibility.

A few possible unintended consequences of the measures were identified. The most common unintended consequence noted by the TEP was workflow and system changes that would be required to implement the new assessment items and the associated costs and burden. No TEP members offered support for collecting the route of transmission. Some TEP members indicated that they did not support collecting the route of transmission items, expressing concern about the burden of collecting this information on every discharge assessment and the fact that the route would not change enough to warrant doing so. They found limited value in collecting and publicly reporting this information and did not believe that consumers would find this information useful for care choices.

3.1   Current State Next Steps

Feedback from this TEP will be used to continue to develop and further refine the specifications for these measures. A public comment period was also held from March 19 to May 3, 2018. Plans are underway for pilot testing of these measures during the spring and summer of 2018.

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APPENDIX A:
TRANSFER OF HEALTH INFORMATION AND CARE PREFERENCES TECHNICAL
EXPERT PANEL MEMBERS

Name, Credentials	Professional Role Organizational Affiliation City, State
Maria Brenny-Fitzpatrick DNP, RN, FNP-C, GNP-BC	**Director of Transitional Care** University of Wisconsin Hospitals and Clinics *Madison, Wisconsin*
Bruce Hanson, BA, MS (patient/caregiver perspective)	**Rural Parish Pastor** Evangelical Lutheran Church **Patient Advocate** National Patient Advocacy Foundation *Garnavillo, IA*
Robert Latz, PT, DPT, CHCIO	**Chief Information Officer (CIO)** Trinity Rehabilitation Services *St. Clairsville, OH*
Cheryl Meyer, MS, RN, PHCNS-BC	**Director of Clinical Excellence** Advocate at Home *Oak Brook, IL*
Cheryl Miller, DrOT	**National Director of Therapy Operations** Encompass Health *Sunrise, FL*
Grace Wummer, RN (caregiver perspective)	**Clinical Director of Senior Services** Main Line Health *Bryn Mawr, PA*
Susan Tracy Moore, MPH, RN, CCM	**Senior Director of Case Management** Spaulding Rehabilitation Network *Cambridge, MA*
Angela Orsky, DNP, LNHA, RN	**Senior Administrator, Post-Acute Care** Greenville Health System *Greenville, SC*
Marjory Palladino, RN, BS, MSN, CRRN, CSPHSP	**Director of Nursing** Southington Care Center, Hartford Healthcare Senior Services *Chicago, IL*
Jane Pederson, MD, MS	**Chief Medical Quality Officer** Stratis Health *Bloomington, MN*
Robert Rosati, PhD	**Chair, Connected Health Institute** VNA Health Group *Red Bank, NJ*
Wayne Saltsman, MD, PhD, CMD, FACP	**Chief, Geriatrics/Transitional Care** Lahey Health *Burlington, MA*
Mary Van de Kamp, MS, CCC-SLP	**Senior Vice President of Quality** Kindred Healthcare *Louisville, KY*
Victoria Zombek, RN, BSN, ACM	**Director of Post Acute Liaisons** University of Pittsburgh Medical Center *Pittsburgh, PA*

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APPENDIX B:
DRAFT QUALITY MEASURE ASSESSMENT ITEMS

QM #1: Medication Profile Transferred to Subsequent Provider

Q1A At the time of discharge/transfer to another provider, did your facility/agency provide the patient's/resident's current medication profile to the subsequent provider?	
Enter Code ☐	1. Yes – Current medication profile provided to the subsequent provider → Go to Q1B. 2. No – Current medication profile not provided to the subsequent provider? 3. NA (Home Health transfer only) – The agency was not made aware of this transfer timely

Q1B   Indicate the route(s) of transmission of the current medication profile to the provider. (Check all that apply)

☐ 1. Electronic Health Record

☐ 2. Health Information Organization

☐ 3. Verbal (e.g., in-person, telephone, video conferencing)

☐ 4. Paper-based (e.g., fax, copies/printouts)

QM #2: Medication Profile Transferred to Patient

Q2A At the time of discharge/transfer, did your facility/agency provide the patient's/resident's current medication profile to the patient, family and/or caregiver?	
Enter Code ☐	1. Yes – Current medication profile provided to the patient, family and/or caregiver → Go to Q2B. 2. No – Current medication profile not provided to the patient, family and/or caregiver.

Q2B   Indicate the route(s) of transmission of the current medication profile to the patient/family/caregiver. (Check all that apply)

☐ 1. Electronic Health Record (e.g., electronic access to patient portal)

☐ 2. Health Information Organization

☐ 3. Verbal (e.g., in-person, telephone, video conferencing)

☐ 4. Paper-based (e.g., fax, copies/printouts)

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APPENDIX C:
DRAFT MEASURE SPECIFICATIONS

1. Medication Profile Transferred to Provider Measure Specifications

1.1 Measure Title

Medication Profile Transferred to Provider

1.2 Measure Type

Process

1.3 Target Population

All patients/residents discharged or transferred to another provider from LTCH, SNF, IRF, or HHA

1.4 Data Sources

This measure is calculated from the LCDS, the MDS, the IRF-PAI, and the OASIS.

1.5 Data Collection Time Point

Discharge/Transfer

1.6 Summary Description

This process-based measure calculates the proportion of patient/resident stays with a discharge or transfer assessment indicating that a current medication profile was provided to another provider at the time that the patient/resident was discharged or transferred to a short-term general hospital, skilled nursing facility, intermediate care, home under care of an organized home health service organization or hospice, hospice in an institutional facility, swing bed, IRF, LTCH, Medicaid nursing facility, inpatient psychiatric facility, or critical access hospital.

1.7 Purpose/Rationale for Quality Measure

The specific purpose of this measure is to improve the timely transfer of a current medication profile to other providers. There is also an item that collects structural information about the routes of information transfer being used by PAC providers.

1.8 Items Used in Quality Measure Calculation and Reporting

In order to calculate the Medication Profile Transferred to Provider process measure, one item would be required to be collected to assess if the facility/agency provided a current medication profile at the time of discharge or transfer to another provider. This item entitled (at the current time), Question 1A, would be collected at discharge/transfer in the HH, SNF, IRF, and LTCH settings.

In addition to Question 1A, one additional item, Question 1B, would be collected if the facility/agency provided a current medication profile at the time of discharge or transfer to another provider. Question 1B collects information on the route(s) of transmission of the medication profile. Question 1B would potentially be collected as a standardized patient assessment data element and would be used for the public reporting of information for consumers, but would not be used to calculate the quality measure.

Medication Profile Transferred to Subsequent Provider: Example of Assessment Items

Q1A	At the time of discharge/transfer to another provider, did your facility/agency provide the patient's/resident's current medication profile to the subsequent provider?
Enter Code ☐	1. Yes – Current medication profile provided to the subsequent provider → Go to Q1B. 2. No – Current medication profile not provided to the subsequent provider? 3. NA (Home Health transfer only) – The agency was not made aware of this transfer timely

Q1B	Indicate the route(s) of transmission of the current medication profile to the provider. (Check all that apply)

☐ 1. Electronic Health Record

☐ 2. Health Information Organization

☐ 3. Verbal (e.g., in-person, telephone, video conferencing)

☐ 4. Paper-based (e.g., fax, copies/printouts)

1.9 Denominator Statement

All patient/resident stays/episodes ending in discharge/transfer to another provider

1.10 Denominator Details

LTCH Denominator: The denominator for this measure is the total number of LTCH patient stays, regardless of payer, ending in discharge/transfer to a short-term general hospital, a SNF, intermediate care, home under care of an organized home health service organization or hospice, hospice in an institutional facility, a swing bed, an IRF, another LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a critical access hospital.

SNF Denominator: The denominator for this measure is the total number of SNF Medicare Part A covered resident stays ending in discharge/transfer to a short-term general hospital, another SNF, intermediate care, home under care of an organized home health service organization or hospice, hospice in an institutional facility, a swing bed, an IRF, a LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a critical access hospital.

IRF Denominator: The denominator for this measure is the total number of IRF patient stays Medicare Part A and Medicare Advantage (Part C) ending in discharge/transfer to a

short-term general hospital, a SNF, intermediate care, home under care of an organized home health service organization or hospice, hospice in an institutional facility, a swing bed, another IRF, a LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a critical access hospital.

HHA Denominator: The denominator for this measure is the number of Medicare Part A and Medicare Advantage (Part C) and Medicaid home health quality episodes ending in discharge/transfer to a short-term general hospital, a SNF, intermediate care, home under care of another organized home health service organization or hospice, hospice in an institutional facility, a swing bed, an IRF, a LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a critical access hospital.

1.11   Denominator Exclusions

None

1.12   Numerator Statement

The numerator is the number of patient/resident stays/episodes with a discharge/transfer assessment indicating a current medication profile was provided to the subsequent provider at the time of discharge/transfer.

1.13   Numerator Details

Number of patient/resident stays/episodes where:

A current medication profile was provided to the provider at the time of discharge/transfer to another provider (Q1A = [1])

1.14   Quality Measure Calculation

The following steps would be used to calculate the measure.

Step 1. Calculate the denominator count

Calculate the total number of patient/resident stays/episodes ending in discharge/transfer to another provider.

Step 2. Calculate the numerator count

Calculate the total number of discharges/transfers where the current medication profile was provided to the provider at the time of discharge/transfer to another provider.

Step 3: Calculate the facility/agency observed score

Divide the facility's/agency's numerator count by its denominator count to obtain the observed score; in other words, divide the results of Step 2 by the results of Step 1. Multiply by 100.

1.15   Risk Adjustment

This measure is not risk adjusted.

1.16   Score

1.16.1 Type of Score

Percent

1.16.2 Interpretation of Score

Higher = better

1.16.3 Level of Analysis

Facility/Agency

2. Medication Profile Transferred to Patient Measure Specifications

2.1 Measure Title

Medication Profile Transferred to Patient

2.2 Measure Type

Process

2.3 Target Population

All patients/residents discharged or transferred from LTCH, SNF, IRF, or HHA settings to a private home/ apartment (apt.), board/care, assisted living, group home, transitional living, or home under care of organized home health service organization or hospice.

2.4 Data Sources

This measure is calculated from the LTCH CARE Data Set (LCDS), the MDS, the IRF-PAI, and the OASIS.

2.5 Data Collection Time Point

Discharge/Transfer

2.6 Summary Description

This process-based measure calculates the proportion of patient/resident stays with a discharge/transfer assessment indicating that a current medication profile was provided to the patient/family/caregiver at the time that the patient/resident was discharged/transferred to a private home/ apartment (apt.), board/care, assisted living, group home, transitional living or home under care of organized home health service organization or hospice.

2.7 Purpose/Rationale for Quality Measure

The purpose of this measure is to improve the timely transfer of a current medication profile to patients/families/caregivers. There is also an item that collects structural information about the routes of information transfer being used by PAC providers.

2.8 Items Used in Quality Measure Calculation and Reporting

In order to calculate the Medication Profile Transferred to Patient process measure, one item would be required to be collected to assess if the facility/agency provided a current medication profile at the time of discharge/transfer to the patient, family and/or caregiver. This item entitled (at the current time), Question 2A, would be collected at discharge/transfer in the HH, SNF, IRF, and LTCH settings.

In addition to Question 2A, one additional item, Question 2B, would be collected if the facility/agency reports that a medication profile was provided to the patient, family and/or caregiver at the time discharge/transfer. Question 2B collects information on the route(s) of transmission of the medication profile Question 2B would potentially be collected as a standardized patient assessment data element and would be used for the public reporting of information for consumers, but would not be used to calculate the quality measure.

Medication Profile Transferred to Patient: Example of Assessment Items

Q2A At the time of discharge/transfer, did your facility/agency provide the patient's/resident's current medication profile to the patient, family and/or caregiver?	
Enter Code ☐	1. Yes – Current medication profile provided to the patient, family and/or caregiver → Go to Q2B.
	2. No – Current medication profile not provided to the patient, family and/or caregiver.

Q2B Indicate the route(s) of transmission of the current medication profile to the patient/family/caregiver. (Check all that apply)
☐ 1. Electronic Health Record (e.g., electronic access to patient portal)
☐ 2. Health Information Organization
☐ 3. Verbal (e.g., in-person, telephone, video conferencing)
☐ 4. Paper-based (e.g., fax, copies/printouts)

2.9 Denominator Statement

All patient/resident stays/episodes ending in discharge or transfer to a private home/ apartment (apt.), board/care, assisted living, group home, transitional living or home under care of organized home health service organization or hospice.

2.10   Denominator Details

LTCH Denominator: The denominator for this measure is the total number of LTCH patient stays, regardless of payer, ending in discharge or transfer to a private home/ apartment (apt.), board/care, assisted living, group home, transitional living or home under care of organized home health service organization or hospice.

SNF Denominator: The denominator for this measure is the total number of SNF Medicare Part A covered resident stays ending in discharge or transfer to a private home/ apartment (apt.), board/care, assisted living, group home, transitional living or home under care of organized home health service organization or hospice.

IRF Denominator: The denominator for this measure is the total number of IRF patient stays Medicare Part A and Medicare Advantage (Part C) ending in discharge or transfer to a private home/ apartment (apt.), board/care, assisted living, group home, transitional living or home under care of organized home health service organization or hospice.

HHA Denominator: The denominator for this measure is the number of Medicare Part A and Medicare Advantage (Part C) and Medicaid home health quality episodes ending in discharge or transfer to a private home/ apartment (apt.), board/care, assisted living, group home, transitional living or home under care of organized home health service organization or hospice.

2.11   Denominator Exclusions

None

2.12   Numerator Statement

The numerator is the number of patient/resident stays/episodes with a discharge/transfer assessment indicating a current medication profile was provided to the patient, family and/or caregiver at the time of discharge/transfer.

2.13   Numerator Details

Number of patient/resident stays/episodes where:

A current medication profile was provided to the patient, family or caregiver at the time of discharge/transfer (Q2A = [1])

2.14   Quality Measure Calculation

The following steps would be used to calculate the measure.

   Step 1. Calculate the denominator count

   Calculate the total number of patient/resident stays/episodes ending in discharge/transfer to a private home/ apartment (apt.), board/care, assisted living, group home, transitional living or home under care of organized home health service organization or hospice.

Step 2. Calculate the numerator count

Calculate the total number of discharges/transfers where the current medication profile was provided to the patient, family and/or caregiver at time of discharge/transfer.

Step 3: Calculate the facility/agency observed score

Divide the facility's/agency's numerator count by its denominator count to obtain the observed score; in other words, divide the results of Step 2 by the results of Step 1. Multiply by 100.

2.15   Risk Adjustment

This measure is not risk adjusted.

2.16   Score

2.16.1 Type of Score

Percent

2.16.2 Interpretation of Score

Higher = better

2.16.3 Level of Analysis

Facility/Agency

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APPENDIX D:
DRAFT DEFINITION OF A MEDICATION PROFILE

Medication Profile

For these quality measures, a Medication Profile is seen as a comprehensive summary of information for the current prescribed and over the counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route to the patient/resident. Medications also include total parenteral nutrition (TPN) and oxygen. A medication profile also includes information about the patient/resident that is relevant to the medications.

Documentation sources for medication profile information include electronic and/or paper records, including discharge summary records, a Medication Administration Record (MAR), Intravenous Medication Record (IVAR), home medication list, and physician orders.

The medication profile to be transferred at discharge/transfer should include all current medications, prescribed and over-the-counter, including nutritional supplements, vitamins, homeopathic and herbal products, TPN and oxygen at the time of discharge or transfer. This includes those that are: 1) active, including those that will be discontinued after discharge; and 2) held during the stay/episode and planned to be continued/resumed after discharge.

The medication profile should include at least all of the following data elements. Some are required only if applicable. These data elements are indicated with *"*If applicable."*

<u>Patient Information</u>

1. Patient name
2. Patient date of birth
3. Primary physician name and contact information
4. Height and date taken **If applicable*
5. Weight and date taken **If applicable*
6. Patient active diagnoses and any other diagnoses that have medication implications
7. Known medication and other allergies
8. Known drug sensitivities and reactions
9. Patient preferences (e.g., preferred packaging such as no childproof lids, form of medication such as time-released medication, how medication information provided to patient) **If applicable*
10. Patient adherence strategies (e.g., alarms, drug diaries) **If applicable*
11. Patient ability to understand/accept condition(s) and importance of taking medications as prescribed

<u>Medication Information (Complete for each medication)</u>

12. Name (generic and proprietary names if applicable) and strength
13. Dose
14. Route of medication administration

15. Frequency
16. Directions
17. Special instruction (e.g., crush medications) *If applicable*
18. (For held medications) Reason for holding medication and when medication should resume
19. Purpose/Indications/Contraindications
20. Prescriber (for prescribed medications only)
21. When the last dose of the medication was administered by discharging/transferring provider *If applicable*
22. When the final dose of the medication should be given *If applicable*
23. Patient education provided about potential risks/side effects/contradictions and when to notify prescriber (*for profile provided to patient/family/caregiver)*
24. Patient adherence with the medication therapy
25. Relevant lab test results to guide medication management (e.g., serum creatinine) *If applicable*

*Elements designated with "*If applicable" should be included in the medication profile when applicable to the patient or medication.

APPENDIX E:
PRE-TEP MEETING QUESTIONS ABOUT THE MEDICATION PROFILE

Please respond to the questions using the space provided and email your responses to Samantha Clark (sclark@rti.org) by **April 13.** Responses will be shared in the aggregate during the TEP meeting.

Medications to be included in medication profile

Below is the draft definition of a medication profile and medications and substances to be included:

For the Transfer of Medication Profile quality measures, a Medication Profile is defined as a comprehensive summary of information for the current prescribed and over the counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route to the patient/resident. Medications also include total parenteral nutrition (TPN) and oxygen. A medication profile also includes information about the patient/resident that is relevant to the medications.

The medication profile to be transferred at discharge/transfer should include all current medications, prescribed and over-the-counter, including nutritional supplements, vitamins, homeopathic and herbal products, TPN and oxygen at the time of discharge or transfer. This includes those that are: 1) active, including those that will be discontinued after discharge; and 2) held during the stay/episode and planned to be continued/resumed after discharge.

The draft quality measures include items asking if a medication profile, as defined in the guidance, was transferred. The measures and items will <u>not</u> collect the medication profile data elements.

Questions 1–3 ask about the types of medications and substances to be included in the medication profile:

1. Do you agree with the medications and substances to be included in the medication profile as described above?

   If no, please explain. Are there medications or substances that should not be included? Other types of medications or substances that should be included?

2. Should use of alcohol or recreational drugs be included if the patient reports regular use?
3. Should all or certain medications discontinued during the stay/episode be included in the medication profile transferred at discharge/transfer?

   If all or certain medication discontinuation should be included, provide suggestions of any parameters for inclusion in the medication profile (e.g., medications that were initiated and discontinued during the PAC stay, or medications discontinued within the past week, etc.)

Data elements to be included in the medication profile to meet the measure criteria (get credit for the measure)

The medication profile must include at least all of the data elements to meet the draft measure criteria. Some data elements are required only if applicable and are indicated with *"*If applicable."*

4. For each data element below, please rate how (A) important and (B) feasible it is to include in the medication profile, using a scale of 1 - High to 3 - Low. Rate the importance by recipient: a. the provider; and b. the patient/family/caregiver. If you are unable to rate a data element, please leave it blank.

Data Element	A. Importance of Including in Medication Profile 1=High, 2=Moderate, 3=Low		B. Feasibility to Include in Medication Profile (extent to which the data are readily available or could be captured without undue burden and can be implemented for measurement) 1=High, 2=Moderate, 3=Low
To be Completed for Each Patient:			
	a. Recipient is Provider	**b. Recipient is Patient**	
1. Patient name			
2. Patient date of birth			
3. Primary physician name and contact information			
4. Height and date taken *If applicable*			
5. Weight and date taken *If applicable*			
6. Patient active diagnoses and any other diagnoses that have medication implications			
7. Known medication and other allergies			
8. Known drug sensitivities and reactions			
9. Patient preferences (e.g., preferred packaging such as no childproof lids, form of medication such as time-released medication, how medication information provided to patient) *If applicable*			
10. Patient adherence strategies (e.g., alarms, drug diaries) *If applicable*			

Data Element	A. Importance of Including in Medication Profile 1=High, 2=Moderate, 3=Low		B. Feasibility to Include in Medication Profile (extent to which the data are readily available or could be captured without undue burden and can be implemented for measurement) 1=High, 2=Moderate, 3=Low
11. Patient ability to understand/accept condition(s) and importance of taking medications as prescribed			

To be Completed for Each Medication in the Profile:

	A. Importance		B. Feasibility
	a. Recipient is Provider	b. Recipient is Patient	
12. Name (generic and proprietary names if applicable) and strength			
13. Dose			
14. Route of medication administration			
15. Frequency			
16. Directions			
17. Special instruction (e.g., crush medications) *If applicable*			
18. (For held medications) Reason for holding medication and when medication should resume			
19. Purpose/Indications/Contraindications			
20. Prescriber (for prescribed medications only)			
21. When the last dose of the medication was administered by discharging/transferring provider *If applicable*			
22. When the final dose of the medication should be given *If applicable*			
23. Patient education provided about potential risks/side effects/contradictions and when to notify prescriber *(for profile provided to patient/family/caregiver)*			
24. Patient adherence with the medication therapy			

Data Element	A. Importance of Including in Medication Profile		B. Feasibility to Include in Medication Profile (extent to which the data are readily available or could be captured without undue burden and can be implemented for measurement)
	1=High, 2=Moderate, 3=Low		1=High, 2=Moderate, 3=Low
25. Relevant lab test results to guide medication management (e.g., serum creatinine) *If applicable*			

5. Are there any other important data elements that should be included in the medication profile in order to meet the measure criteria? For the provider? For the patient/family/caregiver?

6. Do you agree with the data elements that are '*If applicable*'? Should any other data elements be listed as '*If applicable*'? Are there any data elements listed as '*If applicable*' that should apply to all patients or medications?

APPENDIX F:
RESULTS OF PRE-TEP POLL OF DRAFT MEDICATION PROFILE ELEMENTS IMPORTANT AND FEASIBILITY

To be Completed for Each Patient:			
	Importance **(3 = high)**		**Feasibility** **(3 = high)**
	a. Recipient is Provider	**b. Recipient is Patient**	
1. Patient name	1.0	1.3	1.0
2. Patient date of birth	1.0	1.1	1.0
3. Primary physician name and contact information	1.0	1.1	1.3
4. Height and date taken *If applicable*	1.5	1.9	1.5
5. Weight and date taken *If applicable*	1.2	1.5	1.5
6. Patient active diagnoses and any other diagnoses that have medication implications	1.1	1.1	1.2
7. Known medication and other allergies	1.0	1.1	1.0
8. Known drug sensitivities and reactions	1.0	1.0	1.3
9. Patient preferences (e.g., preferred packaging such as no childproof lids, form of medication such as time-released medication, how medication information provided to patient) *If applicable*	1.9	2.0	2.7
10. Patient adherence strategies (e.g., alarms, drug diaries) *If applicable*	1.5	1.9	2.5
11. Patient ability to understand/accept condition(s) and importance of taking medications as prescribed	1.4	1.6	2.3
12. Name (generic and proprietary names if applicable) and strength	1.0	1.0	1.0
13. Dose	1.0	1.0	1.0

	Importance (3 = high)		Feasibility (3 = high)
To be Completed for Each Patient:			
	a. Recipient is Provider	**b. Recipient is Patient**	
14. Route of medication administration	1.0	1.0	1.0
15. Frequency	1.0	1.0	1.0
16. Directions	1.2	1.0	1.3
17. Special instruction (e.g., crush medications) *If applicable	1.0	1.1	1.3
18. For held medications) Reason for holding medication and when medication should resume	1.0	1.0	1.7
19. Purpose/Indications/Contraindications	1.1	1.1	1.5
20. Prescriber (for prescribed medications only)	1.2	1.1	2.0
21. When the last dose of the medication was administered by discharging/ transferring provider *If applicable	1.2	1.3	1.7
22. When the final dose of the medication should be given *If applicable	1.1	1.1	1.5
23. Patient education provided about potential risks/side effects/contradictions and when to notify prescriber (for profile provided to patient/family/caregiver)	2.0	1.3	2.0
24. Patient adherence with the medication therapy	1.3	1.7	2.4
25. Relevant lab test results to guide medication management (e.g., serum creatinine) *If applicable	1.3	1.8	1.7