Drug Regimen Review Measure Information Form

Project Title:

IMPACT Act of 2014 Cross-Setting Quality Measure: Drug Regimen Review

Project Overview:

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 was signed into law on October 6, 2014.¹ This Act requires Post-Acute Care (PAC) providers to report standardized patient assessment data and quality measure data to the Secretary of the Department of Health and Human Services.

The Centers for Medicare & Medicaid Services (CMS) is aligning quality measurement with PAC assessment instruments. 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.

The Centers for Medicare & Medicaid Services (CMS) has contracted with Abt Associates and RTI International to develop a cross-setting post-acute care measure for the quality measure domain—medication reconciliation. The contract names are 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 contractor 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 Home Health §484.55c).

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

Information included is current on September 18th, 2015.

Measure Name

Drug Regimen Review Conducted with Follow-Up for Identified Issues

Descriptive Information

Measure Name (Measure Title De.2.);
Drug Regimen Review Conducted with Follow-Up for Identified Issues

Measure Type De.1.:
Process

Brief Description of Measure De.3.:
Percentage of stays Inpatient Rehabilitation Facility (IRF), Long Term Care Facility (LTCH), and Skilled Nursing Facility (SNF) or care episodes Home Health (HH) in which a drug regimen review was conducted at the Admission (IRF, LTCH or SNF)/ Start of Care (SOC)/ Resumption of Care (ROC) (HH) and timely follow-up with a physician occurred each time potentially significant medication issues were identified throughout the stay (IRF, LTCH, or SNF) or care episode (HH).

If Paired or Grouped De.4.:
N/A

Subject/Topic Areas De.5.:
Prevention: Prevention

Crosscutting Areas De 6.:
Care Coordination: Care Coordination
Safety: Medication Safety
Measure Specifications

Measure-specific Web Page S.1;

<table>
<thead>
<tr>
<th>Measure Title: Drug Regimen Review Conducted with Follow-Up for Identified Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure Description</strong></td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
</tr>
</tbody>
</table>
| 1. | Item 1 = [0, 1, 9]  
   The agency/facility conducted a drug regimen review at the [Admission/SOC/ROC] (Item 1 = [0,1])  
   OR  
   Patient/resident is not taking any medications (Item 1 = [9])  
   AND  
| 2. | If Item 1 = [1], then Item 2 = [1]  
   If clinically significant medication issues were identified at the [Admission/SOC/ROC] (Item 1 = [1]), then the agency/facility contacted a physician (or physician-designee) within one calendar day and completed prescribed/recommended actions in response to the identified issues (Item 2 = [1]).  
   AND  
| 3. | Item 3 = [1, 9]  
   The agency/facility contacted a physician (or physician-designee) and completed prescribed/recommended actions within one calendar day each time clinically significant medication issues were identified since the [Admission/SOC/ROC] (Item 3 = [1])  
   OR  
   No clinically significant medications issues were identified since the [Admission/SOC/ROC] (Item 3 = [9]) |
| **Numerator Exclusion** | Home Health – None  
SNF – None  
IRF – None  
LTCH – None |
| **Denominator** | Care episodes or stays ending during the reporting period (end of care/discharge). |
| **Denominator Exclusions** | Home Health – None  
SNF – None  
IRF – None  
LTCH – None |
## Items Used

### Beginning of care episode or stay

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

- [ ] 0 – No – No issues found during review [Skip to XXXX]
- [ ] 1 – Yes – issues found during review
- [ ] 9 – N/A – patient/resident is not taking any medications [Skip to XXXX]

### Beginning of care episode or stay

**Item 2 Medication Follow-up:** Did the agency/facility contact a physician (or physician-designee) within one calendar day and complete prescribed/recommended actions in response to the identified clinically significant medication issues?

- [ ] 0 – No
- [ ] 1 – Yes

### End of care episode or stay

**Item 3 Medication Intervention:**

- **LTCH/SNF/IRF:** Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions within one calendar day each time clinically significant medication issues were identified since the Admission?
- **HHA:** Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions within one calendar day each time clinically significant medication issues were identified since the SOC/ROC?

- [ ] 0 – No
- [ ] 1 – Yes
- [ ] 9 – N/A – There were no clinically significant medication issues identified since [Admission/SOC/ROC] or patient/resident is not taking any medications.

## Assessment Timing

### Beginning of care episode or stay:

**Item 1**

- HH – SOC or ROC
- SNF – Admission
- IRF – Admission
- LTCH – Admission

**Item 2**

- HH – SOC or ROC
- SNF – Admission
- IRF – Admission
- LTCH – Admission

### End of care episode or stay:

**Item 3**

- HH – Transfer or Discharge
- SNF – Discharges
- IRF – Discharge
- LTCH – Discharges

---

**If this is an eMeasure S.2a.;**

No HQMF specs

**Data Dictionary, Code Table, or Value Sets S.2b.;**

No data dictionary/code table – all information provided in the submission form
For Endorsement Maintenance S.3.;
N/A

Numerator Statement S.4.;
Number of patients/resident’s whose medical record contains documentation of a drug regimen review conducted at admission or start-of-care or resumption-of-care with all significant medication issues identified during the course of care and followed-up with a physician or physician designee.

Time Period for Data S.5.
TBD

Numerator Details S.6.;
Number of stays (IRF, LTCH, or SNF) or care episodes (HH) in which all of the following are each true:

1. Item1 = [0, 1, 9]
The agency/facility conducted a drug regimen review at the [Admission/SOC/ROC] (Item 1 = [0, 1])

OR

Patient/resident is not taking any medications (Item 1 = [9])

AND

2. If Item 1 = [1], then Item 2 = [1]
If clinically significant medication issues were identified at the [Admission/SOC/ROC] (Item 1 = [1]), then the agency/facility contacted a physician (or physician-designee) within one calendar day and completed prescribed/recommended actions in response to the identified issues

(Item 2 = [1]).

AND

3. Item 3 = [1, 9]
The agency/facility contacted a physician (or physician-designee) and completed prescribed/recommended actions within one calendar day each time clinically significant medication issues were identified since the [Admission/SOC/ROC] (Item 3 = [1])

OR
No clinically significant medications issues were identified since the [Admission/SOC/ROC] (Item 3 = [9])

**Denominator Statement S.7.;**
Stays (IRF, LTCH, and SNF) or care episodes (HH) ending during the reporting period (end of care/discharge).

**Target Population Category S.8.;**

**Denominator Details S.9.**
All patients/residents who had a start of care, resumption of care or admission assessment completed during the reporting period

**Denominator Exclusions (NQF Includes “Exceptions” in the “Exclusion” Field) S.10.;**
Home Health – None
SNF – None
IRF – None
LTCH – None

**Denominator Exclusion Details (NQF Includes “Exceptions” in the “Exclusion” Field) S.11.;**
None

**Stratification Details/Variables S.12.;**
N/A – measure not stratified

**Risk Adjustment Type S.13.;**
No risk adjustment or risk stratification

**Statistical Risk Model and Variables S.14.;**
N/A – process measure

**Detailed Risk Model Specifications S.15.;**

**Type of Score S.16.;**
Count
Ratio

**Interpretation of Score S.17.;**
Better quality = higher score

**Calculation Algorithm/Measure Logic S.18 (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.);**

**Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19.**
IMPACT Act
The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires
the submission of standardized and interoperable data by post-acute care providers
including Long-Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Home Health
Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs). Furthermore, the IMPACT Act
authorizes Health and Human Services (HHS) to modify post-acute care assessment
instruments to provide for the submission of standardized data.

Home Health Agency
The measure could be calculated based on the data obtained from the Outcome and
Assessment Information Set (OASIS), which is a core standard assessment data set that
home health agencies integrate into their patient-specific, comprehensive assessment to
identify each patient’s need for home care. The OASIS is the assessment instrument used
to collection and report data for the Home Health Quality Reporting Program (HH QRP).
The OASIS is the foundation for valid and reliable information for patient assessment, care
planning, and service delivery in the home health setting, as well as for the home health
quality assessment and performance improvement program. Home health agencies are
required to collect OASIS data on all non-maternity Medicare/Medicaid patients, 18 or
over, receiving skilled services. Data are collected at specific time points (admission,
resumption of care after inpatient stay, recertification every 60 days that the patient
remains in care, transfer, and at discharge). Home health agencies are required to encode
and transmit patient OASIS data to the national QIES ASAP System. Each HHA has on-line
access to outcome and process measure reports based on their own OASIS data
submissions, as well as comparative state and national aggregate reports, case mix reports,
and potentially avoidable event reports. CMS makes measures based on submitted OASIS
data (to include the Drug Regimen Review Conducted with Follow-Up for Identified Issues
measure) available to consumers and to the general public through the Medicare Home
Health Compare website.
**LTCH, SNF, IRF Settings**

This measure could be calculated based on the quality reporting data collected from the Long Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set; Minimum Data Set Version 3.0 Instrument (MDS 3.0); and Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI). At present the LTCH CARE Data Set, MDS and the IRF-PAI instruments do not include drug regimen review or medication reconciliation quality measure items but could be modified to include items for the Drug Regimen Review Conducted with Follow-Up for Identified Issues quality measure.

**LTCH**

The LTCH CARE Data Set Version 3.0 (to be implemented April 1, 2016; [note: LTCH CARE Data version 2.01 is currently in use through March 31, 2015]) is a standard assessment for all patients receiving inpatient services in a facility certified as a hospital and designated as an LTCH under the Medicare program. These hospitals are certified as acute-care hospitals that treat patients requiring extended hospital-level care, typically following initial treatment at a general acute-care hospital. If a hospital is classified as an LTCH for purposes of Medicare payments it is subject to the requirements of the LTCH Quality Reporting (LTCHQR) Program. It is not applicable to patients receiving services in LTCH units that are not designated as LTCHs under the Medicare program.

The LTCH CARE Data Set Version 3.0 is the assessment instrument used to collect and submit data to CMS as part of the LTCH Quality Reporting Program (QRP). The LTCH CARE Data Sets include Admission, Unplanned Discharge, Planned Discharge, and Expired Assessments. These data sets are completed for individual LTCH patients who are admitted to, discharged from, or die in the LTCH, and are considered part of the patient’s medical record. Data collection using the LTCH CARE Data Set is applicable regardless of patient’s age, diagnosis, length of stay, or payment/payer source. Each year, LTCHs are required to report data to meet the LTCH QRP requirements. The LTCH CARE Data Set is transmitted to CMS through the Assessment Submission and Processing (ASAP) system to the Quality Improvement Evaluation System (QIES).

**SNF**

The MDS 3.0 is part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes (including skilled nursing facilities [SNF] and nursing facilities [NF]) and non-critical access hospital swing beds (SB). This process provides a comprehensive assessment of each resident’s functional capabilities and health characteristics and helps nursing home staff identify health problems. MDS assessment forms are completed for all residents in certified nursing homes, regardless of source of payment for the individual resident.

MDS assessments are required for residents on admission to the nursing home and then periodically, within specific guidelines and time frames. In most cases, participants in the assessment process are licensed health care professionals employed by the nursing home. MDS information is transmitted electronically by nursing homes to the MDS database in
IRF
The submission of Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) is required by the Centers for Medicare & Medicaid Services (CMS) as part of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) and the IRF QRP.

The completion of the IRF-PAI is required for every Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) patient discharged from an IRF.

IRF-PAI data are submitted to CMS per IRF PPS requirements and the IRF QRP allows corrections based on quarterly deadlines. The IRF-PAI must be transmitted to CMS through the Assessment Submission and Processing (ASAP) system to the Quality Improvement Evaluation System (QIES). Each IRF provider has access to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system that provides validation reports for successful data submission based on the IRF-PAI record specifications.

Data Source or Collection Instrument (Reference) S.25.;
Level of Analysis S.26.;
Facility
Care Setting S.27.;
Home Health
Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility
Post Acute/Long Term Care Facility: Inpatient Rehabilitation Facility
Post Acute/Long Term Care Facility: Long Term Acute Care

Composite Performance Measure S.28.;
N/A