Public Comment Summary Report Posting

Project Title:

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.

1. Transfer of Medication Profile to Provider
2. Transfer of Medication Profile to Patient

Dates:

- The Call for Public Comment ran from March 19, 2018 to May 3, 2018
- The Public Comment Summary Report was finalized on July 31, 2018

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with RTI International and Abt Associates to develop cross-setting post-acute care transfer of health information and care preferences quality measures in alignment with the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act). The contract names are Development and Maintenance of Symptom Management Measures (contract number HHSM-500-2013-13015I; Task Order HHSM-500-T0001) 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 encourages the public to submit comments on the specifications for the quality measures.

Project Objectives:

To obtain input on the development of the following cross-setting quality measures for use in post-acute care settings, including Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies:

1) Transfer of Medication Profile to Provider
2) Transfer of Medication Profile to Patient

Information About the Comments Received:

- Web site used: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/PC-Currently-Accepting-Comments.html#0120
- Public comments were solicited using the following methods:
  - Posting on the CMS Public Comment website
  - Email notification to relevant stakeholders and stakeholder organizations
  - Email notification to the measures' Technical Expert Panel members

Public comments were specifically solicited regarding the following topics:

1. Whether the measure titles clearly capture the measure concept across the PAC settings
2. Potential impact and any unintended consequences of the measures (either positive or negative)
3. Potential measure exclusions
4. The definition of a medication profile and the types of medications to be included in the medication profile
5. Whether the medication profile description captures the most important sources of medication profile information
6. The feasibility of collecting the medication profile data elements
7. Information to include in a medication profile and which pieces of information in the medication profile should be designated "*if applicable*"
8. Differences, if any, in what information should be included in a medication profile provided to a healthcare provider as compared to a medication profile provided to the patient/family/caregiver
9. Whether discontinued medications should be included in the medication profile
10. Whether it is feasible and important for the patient's primary physician contact information to be included on the medication profile
11. Whether it is feasible and important to include an assessment of a patient's ability to understand/accept his or her condition and the importance of taking medications as prescribed
12. Whether it is feasible and important for the prescriber of each medication to be identified in the medication profile
13. For transfers from a home health agency to a subsequent provider, are there any issues with adding the response option of "NA – The agency was not made aware of this transfer timely"?
14. Whether consumers will find value in knowing the routes by which the information profile was transmitted (e.g., verbal communication) and whether the route of transmission information would inform consumer choice of providers/facilities
15. Sufficiency of existing health IT standards to support interoperable exchange of the information proposed in the draft medication profile

- CMS received 30 relevant comment letters, including one comment letter excluded from the verbatim comment table located at the end of this report because of personal health information. CMS received three letters that were considered out of scope to measure development.

Stakeholder Comments- General and Measure-Specific

This report provides a summary of public comments received and CMS' responses to the public comments. CMS would like to thank all commenters for sharing their comments, concerns, and suggestions. In general, we received considerable support for the concept of the transfer of medication profile to subsequent providers and patients, their families or caregivers, with 16 of the comments indicating their support for the concept and/or the measures. We appreciate the feedback and concerns

stated by commenters and have provided responses and clarifications addressing these issues. At the end of this report, we provide a table containing the verbatim text of all public comments received.

There was some support for the draft measures, especially the evolution from the "transfer of health information and patient care preferences" measures, which included multiple categories of information, to the more narrowly focused "transfer of medication profile." Six commenters supported the actual measures in their current form, while most provided suggestions for ways to change the measures. Overall, the majority of comments focused on the specific questions in the request for public comment solicitation. These comments included diverse suggestions related to the items in the medication profile and the data collection items used to calculate the measures. However, some commenters also expressed concern over the measures, including issues related to the number and types of information suggested for inclusion in the medication profile, that these measures are redundant with other existing regulations and requirements, that PAC technology adoption is an expectation for these measures, that the measures do not align well with existing health information technology standards, that the measures do not measure the accuracy or timeliness of the medication profile transferred and that these measures would place undue burden on providers. In the next sections, specific comments and CMS' responses to these comments are summarized by theme.

1. Definition of Medication Profile

Summary: Ten comments addressed the definition of a medication profile:

> 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.

Five of the commenters agreed with the definition of a medication profile provided in the draft measure specifications. Nine comments were also received specifically addressing the medications to be included in the medication profile (e.g., over-the-counter). Of those nine, eight supported the medications currently included in the definition of medication profile and one commenter did not. The one commenter stated concern about inclusion of oxygen in the definition of the medication profile and noted that the Joint Commission excludes oxygen as a drug. One commenter requested clarification about whether the medication profile would have information about opioid medications because the timeliness of the transfer of such information would be even more important to prevent the potential of inappropriate use of opioids.

Ten comments received were related to the inclusion of discontinued medications in the profile. Seven commenters recommended including discontinued medications in the medication profile transferred. Of those, four recommended including parameters such as medications discontinued within the previous seven days or only providing this information to subsequent providers to reduce confusion among patients, families, and caregivers.

Response: We appreciate the comments addressing the definition of a medication profile and the medications to be included and will take these comments into consideration as we further develop these measures. We also appreciate commenters' suggestions for inclusion of discontinued medications and information about opioids in the medication profile. As currently drafted, the medication profile

includes all prescribed and over-the-counter medications the patient is taking, and this would include opioids. Discontinued medications were not included in the definition because many of our technical expert panel (TEP) members advised these would be burdensome to include and possibly confusing to patients, families, and caregivers. We will consider the inclusion of discontinued medications and possible parameters as we continue to refine these measures.

2. Contents of the Medication Profile

Summary: Sixteen commenters made suggestions about reducing, adding, or better defining the suggested types of information in the medication profile. Several commenters suggested types of information that could be removed from the contents of the medication profile, such as lab tests, patient preferences, and patient adherence strategies. Other commenters suggested information that could be added to the contents of the medication profile such as the patient's ability to self-administer medications and socio-economic information (e.g., presence of a social support system, finances). Further, one commenter suggested that the definition of a medication profile should be narrative and flexible allowing providers to include information or not based on what was relevant and available.

There were also six comments about differences in what should be included in a medication profile sent to the next provider versus a medication profile shared with a patient, family member, or caregivers. One commenter suggested that patients and their representatives should only be provided with the essential information needed to safely self-administer medications after discharge. Other commenters stated that the patient should receive the same information as the next provider. Seven comments related to inclusion of contact information for the patient's primary care provider and other physician information and six comments discussed inclusion of prescriber information (e.g., name and contact information). Some commenters suggested that inclusion of physician and/or prescriber contact information would be helpful. Some noted that not all patients have a primary care physician. Another commenter recommended including the contact information for the post-acute care physician. Whereas five commenters did not feel that it was important or necessary to include the prescriber information in the medication profile. One commenter added that including prescriber information was potentially confusing and not relevant to medication reconciliation. Six comments also addressed our question about inclusion of the patient's ability to understand their medications in the medication profile. Some of these commenters agreed with including this information and some disagreed.

Response: We thank commenters for their input and recommendations regarding the suggested content of a medication profile. We have also sought input on the types of information included in a medication profile from our TEP and other stakeholders. We will consider additional changes to the contents of a medication profile as these measures are refined.

3. Inclusion of "If Applicable" Information

Summary: Six comments were related to the inclusion of information in the medication profile that is "if applicable." Half of the comments regarding the inclusion of "if applicable" requested further guidance. More specifically, two commenters requested that the items marked as "if applicable" be further clarified in order to minimize subjectivity in determining an item's inclusion in the medication profile and reduce validity issues. One commenter stated that in most cases it appears that including an 'if applicable' item in a medication profile at transfer/discharge would only apply if the information was necessary to start, change, or discontinue a medication by a provider following-up on the care after the

transfer or discharge, while In other cases, the potential 'if applicable' items are related to patient preferences, education, and adherence behaviors that are not clearly defined.

Conversely, two comments stated that items marked as "if applicable" should be required. One commenter suggested that information about when the last dose of the medication was administered by the discharging/transferring provider, if patient education was provided about potential risks and side effects, and when to notify the prescriber should be included in the medication profile for all transfers or discharges. The second commenter stated that the items marked as "if applicable" should always be captured, specifically pointing to the importance of capturing weight and patient adherence strategies. One commenter suggested the item special instructions being included in the medication profile as "if applicable."

Response: We appreciate the feedback from commenters regarding requested input on the items marked as "if applicable." If the measures are finalized with the "if applicable" coding, thorough guidance for what is meant by "if applicable" will be included in the coding guidance manual, per the usual CMS assessment and measure guidance process. We will consider additional changes to the items marked as "if applicable" as these measures are refined and ensure that if included, the "if applicable" coding option is clearly defined for purposes of the measure outcome.

4. Need for Definitions or Guidance

Summary: Seven commenters suggested the need for better definitions of some of the terms and concepts used in the measures. Three commenters requested clarification of terms used in the draft measure specifications, such as for the term "provider".

Response: We understand the importance of providing thorough and clear guidance, primarily when we introduce new quality measures. With every measure and assessment release, we will ensure that thorough guidance for completing the data elements associated with the measures will be included in the coding guidance manuals for each provider setting. As is standard with all quality measures used in the quality reporting program (QRP), we will ensure that the guidance is applicable, usable and feasible for all stakeholders.

5. Redundant with Other Regulations and Requirements

Summary: Seven commenters stated that they believed the draft quality measures were redundant with existing regulations and requirements in terms of the information providers must transfer at discharge. Commenters noted that some of the contents of the medication profile are already required to be included as part of transfer or discharge documentation, such as discharge summaries. One commenter stated that the existing skilled nursing facility (SNF) requirements had been further updated in the recent November 2017 revision to the SNF Requirements of Participation and that the description of the contents of the medication profile are more specific and burdensome. Similarly, another commenter stated that inpatient rehabilitation facilities (IRF) already communicate the content of the medication profile through medication reconciliation, discharge planning processes, or other clinical practices.

Response: We acknowledge the measure profile information for these measures under development aligns with existing regulations and requirements that are finalized, such as the discharge summaries. The measures under development, and specifically the medication profile information for these measures, is aligned with various other facility and agency requirements to reinforce best practices and to decrease burden of collection for the provider.

6. Provider Burden

Summary: Seven commenters stated that the measures would be burdensome. Commenters conveyed concern that the current definition of medication profile is overly burdensome, and the proposed checklist is too long, which may create significant administrative burden for providers and lead to delays in needed care and unintended negative outcomes. Multiple commenters noted that adding new items to the patient assessment instruments would increase the time associated with completing the instruments. One commenter noted that the measure would drastically increase the time required to prepare patients for discharge. Commenters noted potential negative impacts on patient health, particularly in cases of urgent "unplanned" transfers/discharges.

A few commenters noted EMR-related burden for providers, such as providers utilizing an EMR requiring time for vendors to develop and test necessary updates. One commenter further noted that, given current HIT interoperability limitations, the measures are unrealistic and burdensome and cannot be reasonably achieved universally until interoperability barrier issues are resolved.

Two commenters noted that the measures are inconsistent with the Patients over Paperwork and Meaningful Measure initiatives, which aim to reduce provider burden and increase clinical time with patients. Additionally, commenters suggested that the overall value added from information collected would not offset the increase in provider burden caused by the measures. A few commenters noted the information collected would be largely duplicative of preexisting discharge/ transfer documentation for PACs. One commenter suggested many of the proposed data elements are too subjective to be useful to subsequent caregivers, thus adding unnecessary burden. To minimize burden, commenters supported a smaller core set of non-duplicative standardized patient assessment data elements. One commenter suggested that CMS focus on an "essential medication information" list. Another commenter urged CMS to approach the measures in a practical and minimally burdensome manner that adds value beyond current medication reconciliation and/or discharge planning practices. Finally, one commenter encouraged CMS to identify new items to comply with legal requirements but also determine what items can be eliminated or streamlined to minimize burden.

Response: We appreciate the feedback pertaining to burden of collection for these measures and would like to note that we are very mindful of burden as supported by the CMS Meaningful Measure and Patients over Paperwork initiatives. The timely and complete transfer of information focuses on the medication profile, as suggested by our TEP, public comment, and SMEs. We would like to emphasize that each measure is comprised of two items, and further, the activities associated with these measures align with existing requirements related to transferring information at the time of a discharge in order to safeguard patients. Research has shown that high numbers of adverse events occur at times of transition, particularly related to medications. However, we are mindful of our approaches to measure development, particularly the unintended consequences and burden that may occur from the collection and reporting of our measures. Therefore, we will take each comment on burden into considering as we further define these measures.

7. Unintended Consequences

Summary: Four commenters suggested that there could be unintended consequences related to the measures under development. Two commenters stated that the transfer of the medication profile in urgent or unplanned transfers could result in unintended consequences. Specifically, one commenter noted that the medication profile to be transferred as currently proposed is unrealistic and could result

in delays in needed care and unintended negative outcomes. Both of these commenters raised concerns regarding verification that the information was transferred and that given current HIT interoperability limitations, adding a process of additional verification of every item prior to coding the proposed new assessment items beyond existing requirements appear to be excessively burdensome and could have significantly negative impacts on patient health, particularly in cases of urgent or 'unplanned' transfers, such as to an emergency room or inpatient hospital.

One commenter suggested additional detail on the timeframe intended by "current medications". Another commenter noted that the introduction of a third quality measure focused on the risk of medication-related errors during a care transition needs to be introduced carefully and thoughtfully, and consistent and dovetailed with extant measures such as the medication reconciliation measure accredited by the Joint Commission in order to mitigate confusion among providers.

Response: We thank the commenters for their input on the potential for unintended consequences of the measures and will take these comments into consideration as we further develop these measures. We also appreciate the comment about the medication reconciliation measure and will take the idea of a structural measure into consideration. For the measures under development, "current medications" includes those medications being taken by the patient at the time of discharge or transfer. In the case of urgent or unplanned transfers, sharing information about medications can help to promote care coordination. What is transferred at urgent or unplanned transfers should be guided by CoPs and Meaningful Use standards when applicable. As discussed below, in the case where an HHA is not made aware of the transfer timely, there is an NA option.

8. Does not Measure Accuracy or Timeliness

Summary: Four comments were received relating to the inability of the measures to address the accuracy or timeliness of the medication profile that was transferred. Three commenters stated that the measures do not measure the accuracy of the medication profile. One noted that the medication profile should be complete, while another noted that it should be current at the time of transfer or discharge. One comment received suggested that the list of sources of information for the medication profile include time limits when using external sources.

Response: We appreciate the comments received regarding the measurement of accurate and timely medication information and agree that the medication profile transferred should consist of accurate and timely information. In order to address the timeliness of the transfer of a medication profile, the measure requires the information be shared with the subsequent provider and/or patient, family, or caregiver at the time of discharge or transfer. This will be clarified in the medication profile item coding guidance. We will take into consideration in future efforts measures that assess for the accuracy of medication information.

9. Does not Measure Transfer of Medication Profile from other Providers

***Summary*:** Four comments discussed the need to address the transfer of the medication profile from hospitals or other "upstream" providers. Two of the commenters stated that the measures do not address the transfer of information to post-acute care providers from hospitals or other "upstream" sources as described by the IMPACT Act. One commenter suggested that a measure be developed that would allow providers to report on the accuracy and timeliness of the information received from these providers.

Response: We understand commenters concerns with the timeliness and accuracy of information they receive from other providers. The transfer of timely and accurate information at all care transitions is an important goal. It should be noted that development of a previous measure entitled "Transfer of Health Information at Post-Acute Care Admission" was discontinued due to stakeholder concerns about accountability of PAC providers for the information they receive from other providers. The current measures under development, which measure the transfer of medication information at PAC discharge and not at PAC admission, are being developed in response to the previous input. However, as we continue measure development, we will be mindful or the need to address transfer of health information in a timely manner across PAC as well as other settings.

10. Route of Information Transmission Data Collection Item

Summary: Comments discussed inclusion of an item to assess the route by which information was transferred to the provider or patient. Six commenters provided feedback on this topic, including four who supported the inclusion of such an item. One commenter agreed with the inclusion of verbal and printed materials as an acceptable route of transmission as these allow nurses to accurately document and provide follow-up care to their patients in the absence of an EHR and HIE, or when providers have different EHR systems. However, two commenters stated that "verbal" should not be an acceptable route for transferring the medication profile if it is the only route of communication, noting that while necessary, it should always be paired with another route of transmission. These commenters expressed concern about errors and other negative consequences related to potential verbal miscommunications. One commenter stated that the route of information would be useful to consumers. Two commenters wrote that collecting standardized information on the route of transmission would be useful and used to justify additional funds for investment in EHR and HIE adoption, referencing the barriers to EHR adoption for PAC providers as cited in the Background section of the Measure Justification. One commenter agreed with the definitions provided for the routes of transmission and recommended that there should be more attention to describing the patient portal. One commenter suggested that documentation sources for the medication profile (e.g., discharge summary records, a Medication Administration Record) be more closely aligned with the routes of transmission described, because the available or appropriate transmission routes may vary across documentation sources.

Response: An item to collect the routes by which information is transferred could help support efforts that would enable PAC adoption of EHRs and health information exchange. As summarized in the public comment document, an item of this kind also could support shared decision making. We appreciate the comments on the route of verbal communication. It is recognized that verbal communication may support and improve information transfer when combined with other routes. However, we will explore the collection of this item, as commenters believed that verbal communication as a sole route of communication can be problematic.

11. PAC Providers Ability to Transfer the Medication Profile Electronically Through Their EHRs/EMRs

Summary: Twelve comments were received regarding the ability of PAC providers to transfer the medication profile electronically through their EHRs/EMRs. Four of the comments pertained to the state of PAC adoption of EHRs/EMRs and participation in health information exchange (HIE), and how the lack of adoption universally impacts their ability to transfer the information electronically. Three commenters stated that their EHR/EMR system does not currently include all of the medication profile information that would be required to be transferred to meet the measure criteria. Medication profile data elements that are currently not defined by standards and not collected by their systems were

identified with a recommendation that there be defined standards around all of the elements in the medication profile. Several of these commenters stressed that it is important to have more defined standards around all of the elements included in the medication profile. Those without defined standards included patient preferences, patient adherence strategies, patient ability to understand/ accept their conditions and importance of taking medications, and purpose/indications/ contraindications. One of these commenters added that there are significant costs and resources allocated to customize EHR/EMR systems in order to meet data collection requirements of the IMPACT Act and each addition or change requires significant education and training across their clinical departments. Related, another commenter stated that the medication profile information may be "pulled" from various places within the EHR/EMR, but vendors would need specifications and details plus time to develop and test their ability to create a document with this information.

Four commenters stated that interoperability does not currently exist or is mixed or limited in PAC settings, and that transferring the medication profile through EHRs/EMRs is difficult due to different software used by providers and lack of uniform EHR/EMR and HIE capabilities from market to market. One commenter said many of their member providers participate in a large national HIE, as well as local market-specific HIEs. However, there has not been a critical mass of acute care hospitals or PAC providers participating in these HIEs to date, so the ability to utilize HIE for true information exchange between provider entities is limited. One commenter identified environmental limitations in high-speed internet access as a barrier to EHR adoption and interoperability and felt that environmental and institutional barriers would create a measure bias against SNFs, particularly those located in rural and other geographically disadvantaged areas. One commenter recommended that until interoperable HIE technology is more widely adopted and used, this measure should not require that the specific data elements be incorporated into a single document as long as all of the required elements are transferred in some manner. This commenter referenced the SNF Requirements of Participation which allow flexibility in how information is conveyed to downstream providers and/or the patient/representative upon discharge/transfer from a SNF. A commenter recommended that the medication profile measure specifications be limited to only essential items due to the current state of PAC EHR/EMRs.

Response: Adoption of EHRs and HIE may result in a more seamless and less costly health information exchange, while reducing provider burden through the use and reuse of healthcare data. CMS believes that PAC provider health information exchange supports the goals of high quality, personalized, and efficient healthcare, care coordination and person-centered care, and supports real-time, data driven, clinical decision making. Further, CMS believes that the interoperability provisions of the 21st Century Cures Act provides a strong framework to enable electronic sharing of information. CMS is optimistic that these measures will encourage the electronic transfer of current and important medication information at transitions. CMS will also support efforts to ensure that, over time, the medication profile information transferred conforms with HIT standards that supports the exchange of the information. As noted above, the quality measures will also collect information to help CMS, consumers, policymakers, and other stakeholders better monitor the extent to which patient/resident medication profile information is transferred electronically and through Health Information Organizations (HIOs) by PAC providers to other healthcare providers and to patients/family members during transitions.

12. Sufficiency of Existing Health IT Standards to Support Interoperable Exchange of the Types of Information Proposed in the Draft Medication Profile

Summary: Ten comments were received regarding the sufficiency of health IT standards to support interoperable exchange of the types of information proposed in the draft medication profile. One

commenter did not believe there are sufficient standards to support the exchange of the medication profile information, citing a recent study by the Office of the National Coordinator for Health Information Technology (ONC) on EHR adoption and interoperability among U.S. skilled nursing facilities. Another commenter stated that there is no standardized template or mechanism recommended in the draft specifications for capturing data. One commenter noted that the information in the medication profile could be transferred electronically such as a PDF document; however, EHR/EMR systems currently do not have universal language for the exchange of discrete data, such as dose info. The commenter added that any subjective information in the profile, such as general remarks about patient adherence, could be constructed in free text fields, and due to lack of common definitions, it would be difficult for EHR/EMR systems to exchange this information.

Seven of the comments related to aligning the medication profile data elements with or leveraging existing standards and vocabularies in order to be able to support electronic, interoperable exchange of the medication profile. One commenter stated that the use of existing clinical and interoperability standards should be considered in the development of these and future measures to reduce documentation burden and automate data collection for quality measures and public reporting. The commenter also noted that the current PAC assessment instruments are not standardized or interoperable which places burden on the receiver.

Seven commenters recommended standards to consider. One commenter recommended that standardized templates currently used in HIT for the collection of health information be considered and suggested the standard that the ONC included in its 2014 EHR Certification for Meaningful Use Stage 2 - the Health Level Seven (HL7) Consolidated Clinical Document Architecture (C- CDA). The C-CDA was recommended by the commenter because it defines the structure of certain medical records, such as discharge summaries and progress notes, and is seen as a better way to exchange this information between providers and patients. One commenter recommended that the medication profile information be reconciled and aligned with the ONC's draft U.S. Core Data for Interoperability (USCDI). The commenter also recommended that other proposed rules for the FY 2019 prospective payment systems and quality reporting programs also adopt USCDI and the CMS 'Promoting Interoperability Programs'. The commenter added that the intent of these initiatives is to make the transfer of health information more streamlined and interoperable. The commenter also stated that the draft USCDI Version 1 Data Classes propose 21 data elements and that the draft specifications list only 11 of these.

One commenter recommended that the draft specifications ensure that standardized vocabularies are incorporated to collect clinical and drug information, including observations. This commenter recommended the use of standardized vocabularies and notes (e.g., HL7, C-CDA) to drive the collection of the medication profile information. Two commenters identified vocabularies that are widely used by federal agencies and health care providers including: Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT), RxNorm, and Logical Observation Identifier Names and Codes (LOINC). The commenters noted that these standardized vocabularies facilitate the exchange of a patient's health information and enable interoperability and clear communication between systems, regardless of software and hardware compatibility. A commenter recommended that the measure developers work with standard setting organizations.

Response: We appreciate the comments about the sufficiency of existing health IT standards to support interoperable exchange of the types of information proposed in the draft medication profile and for providing us with some of the applicable standards that can be leveraged or aligned with, including the C-CDA, LOINC, SNOMED and the USCDI. CMS recently announced the release of the Data Element

Library (DEL), a new public resource aimed at advancing interoperable health information exchange by enabling users to view patient assessment questions and response options about demographics, medical problems, and other types of health evaluations and their associated health IT standards. All data elements adopted for use in the Quality Reporting programs (QRPs) will be included in the DEL. In the initial version of the DEL (https://del.cms.gov/), assessment questions and response options are mapped to LOINC and SNOMED, where feasible. We also recognize the importance of obtaining input from standards setting organizations and alignment across federal interoperability efforts as part of the measure development. CMS' intent is that, over time, the medication profile information transferred by PAC and other providers increasingly conforms with federally recognized HIT standards that support the exchange of the medication information and aligns with the USCDI and the DEL.

13. Patients Should be Provided the Medication Profile at all Transitions

Summary: Three commenters stated that patients should be provided with their medication profile at all transitions and not just upon return to home or another community setting. One commenter stated that it will help ensure patient inclusion at every transition, while another commenter noted that it will increase patient access to medical records, which are linked to patient decision-making, understanding of care, and awareness of safety issues. A few commenters emphasized the importance of provider-to-patient accountability throughout the care trajectory and one commenter further recommended CMS consider collecting both measures regardless of the site to which the patient is transferred/discharged.

Response: We thank commenters for their comments and the emphasis on the importance of critical and complete information at the time of discharge and/or transfer.

14. Medication Profile to Patient Should Use Consumer Friendly Terminology

Summary: Six commenters recommended that the medication profile should be written in standard or consumer-friendly terminology. Several commenters noted the importance of ensuring information provided to patients and caregivers is clear and understandable to promote transparent access to medical record information and meet the goals of the IMPACT Act related to the transfer of health information. One commenter conveyed this will require mapping standardized patient data elements (SPADEs) across PAC settings to terms and codes that can be understood by patients of varying backgrounds, education and literacy levels. One commenter recommended including preferred language and method of sending information in the patient information data elements. Another commenter recommended including illustrations as a mechanism for transmitting information to patients with limited verbal or reading skills. A few commenters noted that electronic health records can be utilized to simplify patient discharge information and translate provider language into consumer-friendly terms.

Response: We thank commenters for their feedback. CMS is working to uphold the intent of the IMPACT Act and will take commenter suggestions into consideration during continued development of the draft measures. In addition, the CMS DEL is working toward the goal of standardizing language and terms across assessment items and existing HIT standards.

15. Inclusion of an NA response for Home Health Agencies

Summary: Nine comments were received regarding the inclusion of the "not applicable" or "NA" response that is used to code the home health measures. Several commenters supported the inclusion of an NA option for HHA. Other commenters stated that if this option is made available for HHA, it should also be made available to all types of providers when a patient has an unplanned discharge. One

questioned how the inclusion of NA for HHA could be reconciled with the HHA Conditions of Participation, which require HHAs to provide transfer summaries within two business days of a planned transfer to the receiving facility and within 2 business days of becoming aware of a transfer. Another commenter suggested that if the NA response option is included that these patients should be excluded from the measure denominator.

Response: We thank commenters for their feedback on an NA option for HHA. The NA response could account for the unique circumstances often faced by HHAs as they are sometimes not immediately informed of the patient's transfer. It should be noted that, while the NA option is available for HHA, the draft specifications indicate that these patients are not removed from the denominator.

16. Other Measure Specification Comments

Summary: Pertaining to the draft measure specifications, four commenters noted that there was ambiguity regarding the timing of the specifications, data collection, and data entry for the measure. For example, they wanted further clarification of the term "at the time of discharge/transfer" as well as specification about which clinician can complete the items.

Response: We understand the importance of providing thorough and clear guidance, primarily when we introduce new quality measures. With every measure and assessment release, we will ensure that thorough guidance for completing the data elements associated with the measures will be included in the coding guidance manuals for each provider setting. As is standard with all quality measures used in the quality reporting program (QRP), we will ensure that the guidance is applicable, usable and feasible for all stakeholders. The guidance for these measures will clarify that "at the time of discharge/transfer" refers to the period of time closest to the discharge or transfer as possible, as established by facility/agency policies or standards of practice for information transfer, which may be based on facility/agency, State, or Federal guidelines. Clinicians who typically conduct or coordinate the patient/resident assessments within each of the PAC settings, with appropriate participation of other health professionals, can complete the items.

Summary: Three comments received were regarding the differences in populations by payer across settings. All three comments opposed the inclusion of different populations across PAC settings and one comment stated that this was contrary to the intent of the IMPACT Act, which requires standardization of measures across settings.

Response: We appreciate the comments addressing the different measure populations by payer and will take these comments into consideration as we further develop these measures.

Summary: Several other comments were also received about the measure specifications. Two comments were received regarding measure exclusions, one suggested that unplanned discharges be a measure exclusion. One commenter stated that the measure would quickly hit a measurement ceiling. One commenter questioned whether there would be anyway to validate that all contents of the medication profile were actually transferred. One commenter suggested that the patient should not be provided the medication profile when going to a home or community setting with home health or hospice; in these cases, only the next provider should receive the medication profile.

Response: We thank commenters for the additional feedback and suggestions. We will consider additional exclusions and recommendations that patients not be provided with the medication profile when they are discharged to home with home health or hospice as we continue to refine these

measures. Further, as we move forward with additional testing of the measures, we will take into consideration comments about a measurement ceiling and validation.

Preliminary Recommendations and Next Steps

Comments received pertaining to the definition and guidance for a medication profile, alignment with existing health IT standards, measure exclusions, as well as other aspects of the measure development will be taken into consideration as CMS modifies and tests the measures. CMS plans to pilot test these measures in the Summer of 2018.

Public Comment Verbatim Report

The following table details the verbatim comments received. We did not make any changes or edits to the content. However, we did exclude one comment because it contained information that was private or disclosed personal health information (PHI). Additionally, we received and excluded three comments that were out of scope for measure development.

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
1	3/22/18	Medication profile transferred to patient	The measures should ensure that patients or their representatives have the ability to make corrections to their medications profiles as needed, particularly when information is transmitted via electronic medical record. Given the complexity of medication regimens, the potential for frequent changes in medications, and the high potential for miscommunication and/ or incorrect documentation due to human error, measures should include acceptable ways for patients to document such corrections and for providers to verify accuracy of patient medications profiles transmitted. Thank you for the opportunity to provide comments.	Helene Dujardin	dujardhk@gmail.com	Individual
2	4/02/18	Medication profile transferred to patient Medication profile transferred to provider	I am commenting as an individual, Elin. S. Kropp MD, retired, previously regional medical director, Queens, VNSNY Hospice Care. Best reached at elinkropp@hotmail.com. In the draft re med profile transfer measures there is a first measure to hold providers accountable to transfer medication profile information to another care setting to which the patient is being transferred. There is a second measure for transfer of medication profile information to the patient, family, caregiver when the patient is being transferred home. I would submit that in efforts to increase an individual's access to his/her own medical records, which is clearly related to patient ability to make decisions, understand care, and be aware of safety issues, that the transfer of medical profile information should ALWAYS be provided to the patient, family and/or caregiver as well as to the new care setting, regardless of where the patient is being transferred to, be it another care setting or to home. Thank you for your attention to this comment.	Elin Poneman, MD	elinkropp@hotmail.com	Individual
3	4/24/18	Medication profile transferred to patient	This is our response to the Medication Profile items: 4.1.1 Patient Information, Item #6. Patient active diagnoses and any other diagnoses that have medication implications:	Kristin Reed, RN, COS-C Visiting nurses	Kristin.Reed@kansasvna.org	Home health agency

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
		Medication profile transferred to provider	This item needs to be clarified two-fold in our opinion. First, "other diagnoses that have medication implications" how is this going to be determined as far as which diagnoses have "medication implications?" We feel this should be the physician's decision or possibly the pharmacist but certainly not the HHA clinician's. Many medications are prescribed for different or off-label uses of which the HHA's might not be aware. The second area that we would like clarified would be if the list of diagnoses from the Electronic Health Record (EHR) is going to be programmed to pull over to the Medication Profile? This would be of concern to us if that is what will happen. In this day of EHR and specialized ICD-10 coding the diagnoses lists are extremely long and bulky. The diagnoses that print to our Plans of care sometimes take up half of a piece of paper due to the number of codes. 4.1.1 Patient Information, Item #9, Patient preferences (e.g. preferred packaging such as no childproof lids, form of medication, such as time-released medication. In the two examples that are listed above, the Home Health Agency does not have control over either one of these items. The childproof lids are usually addressed with the pharmacy, and the form of medication, whether it's time released or not, is generally the physician's decision possibly in consultation with the pharmacist. Certainly not the HHA. 4.1.2 Medication Information (Complete for each medication) #21 When the last dose of the medication was administered by discharging/transferring provider Even though this says *If applicable, we want to make sure that this is not intended for Home Health Agencies since we do not generally see the patient for 24-48 hours and the patient will generally need to have taken his/her meds before that. 4.1.2 Medication Information (Complete for each medication) #25 Relevant lab test results to guide medication management (e.g., serum creatinine)			

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			Again, we would like clarification for the requirement of this item due to the fact that Home Health Clinicians are unable to order lab tests and are at the mercy of the Physician or NPP in being able to draw lab for monitoring purposes. Thank you for the opportunity to make comments about this important change in our practice.			
4	4/20/18	Medication profile transferred to patient Medication profile transferred to provider	I am submitting comments as a nurse in the home health setting. I am NOT representing my employer. Specific comment for draft Section 4.1.2 Medication information. 1. I believe one of the most dangerous and time-consuming issues when patients transition from the hospital or other facility to home is when new medications or altered/changed from previous medications are listed. The patient is not familiar with the new or changed med and do not resume it when they come home. Or they duplicate it. For example, patient is on furosemide 40mg, potassium chloride 10meq, lipitor 20mg, and cymbalta 10mg at home. While hospitalized the furosemide and potassium are decreased and hctz 10mg is added, when the patient transitions to snf the formulary does not include cymbalta or lipitor so trazadone and pravastatin replace those meds. When the patient then goes home there are bottles in the home of 40mg furosemide, potassium and cymbalta and the patient is quite confused. The discharge summary from the snf, if one is ever sent, does not list the cymbalta or lipitor. The patient assumes he should continue with it and take the new trazadone. The discharge med sheets from all the different EHR's are very very confusing to the elderly. A simple sheet listing med, dose, frequency and purpose would be sufficient for the patient themselves. For example: 40mg once daily by mouth for cholesterol. 2. A comprehensive med list would be one from all settings that followed the patient. Admission meds (taking at home), hospital meds, SNF meds, discharge meds. However, that is unreasonable and would never be complete, realistically speaking.	Barbara Dale, RN, CWOCN CHHN COS-C Director of Wound Care	bdale@qualityhomehealth.com	Individual and home health agency nurse

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			A simple fix would be to add a check box for new, changed, or discontinued. This would enlighten the new PAC setting of the existence of all old meds and changes made. 3. Lastly, the new measure somehow should contain an item questioning whether a med list was received from the outgoing facility. The new measure should be more than whether the existing setting sent a med list.			
5	5/01/28	Medication profile transferred to patient Medication profile transferred to provider	The Association for Professionals in Infection Control and Epidemiology (APIC) appreciates the opportunity to provide input into the proposed quality measures to fulfill the IMPACT Act domain of Transfer of Health Information and Care Preferences When an Individual Transitions: 1) Medication Profile Transferred to Provider; and 2) Medication Profile Transferred to Patient. We are pleased that CMS continues to demonstrate its commitment to improving the quality of patient care across the healthcare continuum. As more complex care is provided in post-acute care settings, facilitation of communication across the spectrum of healthcare is essential to ensure residents/patients are properly prepared for transitions of care and their providers have the information necessary to provide safe care. We applaud the agency for emphasizing person-centered care by establishing standardized processes that include care settings such as skilled nursing facilities, inpatient rehabilitation facilities, long term acute care hospitals, and home health agencies. Providing standardized information during care transitions is essential, since this is often the time when critical and valuable information is lost, which can create complications and adverse events for residents/ patients. APIC is a nonprofit, multidisciplinary organization representing over 15,000 Infection Preventionists whose mission is to create a safer world through prevention of infection. Due to our interest in antimicrobial stewardship and reduction of multidrug-resistant organisms, our comments are focused solely on antimicrobials.	Nancy Hailpern Director, Regulatory Affairs APIC – Association for Professionals in Infection Control and Epidemiology	nhailpern@apic.org	Infection control and epidemiology association

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			Types of medications to be included in the medication profile APIC supports the inclusion of information regarding all antimicrobials (i.e.: antibacterial, antifungal, and antiviral agents) Types of medications to be included in the medication profile APIC supports the inclusion of information regarding all antimicrobials (i.e.: antibacterial, antifungal, and antiviral agents) <u>Data elements to include in a medication profile</u> APIC believes it is important to include the following elements in the transfer of medication profiles for all antimicrobials: • indication • dose • duration • start and stop dates • route of administration, and prescriber. We believe it is equally important to highlight the next dose due at all transitions of care. <u>Whether discontinued medications should be included in the medication profile</u> Although we recognize the burden of documentation at care transitions, APIC supports the inclusion of discontinued antibiotics that were administered during the current episode of care in the transfer medication profile. Prior antibiotic exposure is a risk factor for the development of drug-resistant organisms and *Clostridium difficile*, which can be serious lift-threatening infections to which older adults are at increased risk. Having ready access to the antibiotic history may aid with early diagnosis of *Clostridium difficile* infection, or infections which are not treatable with first-line antibiotics. This information can be key in guiding treatment choices and timely infection prevention and control response, including initiation of contact isolation precautions, thus reducing the risk to others in the care setting.			

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			Whether it is feasible and important to include an assessment of a patient's ability to understand/accept his or her condition and the importance of taking medications as prescribed Our members believe that when a resident/patient is transitioning to home they must clearly understand the dose, duration, route, and timing of all antimicrobials. Equally important is the completion of all antimicrobials. Missed doses or incomplete courses of antimicrobials can lead to inadequately treated infections and/or the development of resistant organisms. Thank you for the opportunity to provide input on the critical medication information that should be communicated during transitions of care. Comprehensive information sharing when a resident/patient is discharged or transferred to another location is important to assure quality and continuity of care. We look forward to continuing to work with CMS as the agency continues this essential work. If you have any questions or need additional information, please contact Nancy Hailpern, APIC Director of Regulatory Affairs at 202-454-2643 or nhailpern@apic.org.			
6	5/01/18	Medication profile transferred to patient Medication profile transferred to provider	There are items that we had concerns with: 1. Which data elements in the medication profile should be designated 'if applicable'. We need more information as to what would make the additional information 'applicable' in order to comment. 2. Differences, if any, in what information should be included in a medication profile provided to a healthcare provider as compared to a medication profile provided to the patient/family/caregiver. Information provided to the patient/family/caregiver should be provided in a 'patient friendly' or 'non-clinical' format 3. Whether discontinued medications should be included in the medication profile. If included, provide suggestions of parameters for inclusion in the medication profile (e.g., medications that were initiated and discontinued during the PAC stat, or medications discontinued within the past week, etc.)	Steven Waits, BSN Chief Clinical Officer Alacare Home Health and Hospice	Steven.Waits@alacare.com	Home health agency

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			We would prefer to see all medications (including those discontinued) in the last 60 days of care. This would make it clear that any medications the patient was taking had a discontinuation date. 4. Whether it is feasible and important for the patient's primary physician contact information to be included on the medication profile. Yes 5. Whether it is feasible and important to include an assessment of a patient's ability to understand/accept his or her condition and importance of taking medications as prescribed. No. This is too subjective and should be evaluated individually at each stop in the patient care continuum. 6. Whether it is feasible and important for the prescriber of each medication to be identified in the medication profile No. 7. Data elements to include in the medication profile. Providing too many elements including elements that do not have a clear value could negatively impact the ability to review the profile. Items such as 'medication indications and contraindications' should be reviewed for value to include. 'Relevant lab tests' is another item that needs to be reviewed. Unless the lab tests are part of a specific physician's order, there is not a consistent source for that information that is easily obtained. This is a clinical decision that should be driven by the physician. 8. Specifically on the proposed creation of the two OASIS assessment items (below), there would be a timing issue as the clinician would be documenting the answer prior to the agency's ability to actually complete the task. It would require the clinician to mark the 'expected' outcome vs what occurred. Thus, data obtained from this question would be invalid.			

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			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) OTHER COMMENTS/NOTES: The medication profile transmitted should be the current medication profile at the time of discharge. We frequently get the medication profile from the transferring entity that was the active profile on admission to their facility. This profile does not contain the most updated information and many times causes more confusion than benefit. On the questions related to existing IT standards and electronic transfer of medications, we would defer those questions to our vendor.			
7	5/01/18	Medication profile transferred provider	THP Comment: Regarding the "Medication Profile Transferred to Provider" measure, we believe this is a critical quality improvement step and should be promoted for all patient transfers and/or discharges. We also recommend that the proposal include a data point documenting source(s) of a medication list, which is value in documenting how a medication list was assembled, including what sources were used, to assess potential validity of the final list (i.e. Primary Care Provider (PCP) contacted or PCP Electronic Medical Record used; only pt report, pharmacy validated, etc).	Stephanie Raymond, Regulatory, Affairs Analyst Tufts Health Plan	stephanie_raymond@tufts-health.com	Healthcare system

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			I look forward to receiving a confirmation of receipt regarding this comment. Please do not hesitate to reach out if you have any questions or require further clarification.			
8	5/01/18	Medication profile transferred provider	I am writing to comment specifically on two aspects of the proposed metric. First, not only should the medication profile include the prescribing physician(s), but it should have to be transferred to the succeeding attending physician whenever there is a succeeding attending physician (which there will be in most circumstances). It is not enough to send the medication profile to the next organizational provider when the next attending physician is the responsible party and since, in most situations, that person can be known and can receive communications in a timely and secure way. This would allow the succeeding prescriber to raise any questions in a timely way and to assess the urgency of further testing, monitoring, and examination. It also provides useful and inexpensive redundancy in the transmission of the information. Second, this seems likely to hit a ceiling fairly quickly. In the development of the metric, one would want to know something of current performance and regional/site variation. The measure steward should be ready to recommend discontinuation of using this metric when it becomes highly standard performance. As to the rest of the questions, it seems that the working team has made reasonable assessments and compromises in defining the profile and the transmission characteristics.	Joanne Lynn, MD Director, Program to Improve Eldercare	Joanne.Lynn@altarum.org	Research organization
9	5/02/18	Medication profile transferred to patient Medication profile transferred to provider	The American Psychiatric Association (APA), the medical specialty society representing over 38,000 physicians who specialize in the treatment of mental illnesses, including substance use disorders, is pleased to have the opportunity to review and comment on the quality measures “Medication Profile Transferred to Provider” and “Medication Profile Transferred to Patient.” We support the developers’ efforts to develop measures that can be used across settings as part of the post-acute care transfer of health information in alignment with the IMPACT Act.	Samantha Shugarman, MS, American Psychiatric Association	sshugarman@psych.org	Psychiatric association

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			We support the overall intent of these quality measures to improve patient safety, continuity of care, and care coordination after discharge from more acute-care settings. However, we question the definitions included in the measure and how that impacts the quality of care assessed using these measures. In section 4, page 9 of the Draft Specifications, "Medication Profile" is described and includes details on the informational source. Assuming the list of sources is comprehensive, it doesn't seem to be include limitations to these sources. We request the inclusion of time limits when using external sources. Also, by better defining "current medications," this measure can help to reduce the frequency of patients transitioning out of acute care with a new medication list, who also have an outpatient pharmacy, family member, etc. acting on the old list. In the absence of clear cut instructions, medications from the old list are started in addition to the new, causing the patient to suffer from adverse consequences. We request increased detail on the time frame these measures intend to capture. We also question the definition of "Verbal" in the Route of Transmission Item Definitions. As defined, a PAC provider may verbally provide information to the receiving provider or other care giver. While there are methods that "could be used" to demonstrate verbal communication has occurred, we are concerned by the rate of error related to mishearing what is communicated, a misspelling, or other errors that cannot be tracked between the originating facility and the receiving setting. We believe it would be useful to require a timely follow-up communication that includes one of the other methods described in the Route of Transmission. Mindful of the burden this additional step would require, we think Verbal communication is necessary, but solo-verbal communication as an approved method of communication and its link to potential negative consequences is enough to warrant its pairing with other routes defined by the measure. APA is supportive of efforts made to align and harmonize with existing quality measures. We are interested in knowing whether			

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			the developers communicated with the PCPI over their facility-level measure entitled "Timely Transmission of Transition Record." This measure assesses whether a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.			
10	5/02/18	Medication profile transferred to patient Medication profile transferred provider	On behalf of our nearly 3,300 post-acute care members, including skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs) and home health agencies (HHAs), the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) and its contractors' draft specifications for the two transfer of health information measures under development. The measures are being developed to meet CMS's statutory obligations under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. The sharing of relevant patient information with other providers and patients/caregivers is paramount to maintaining a strong and integrated continuum of care, and the AHA appreciates that CMS is thoughtfully working to meet the statutory requirements of the IMPACT Act. This letter includes feedback on the evolution of these measures as well as questions and recommendations for the developers as they continue to refine the specifications. Evolution of Transfer of Information Measures The AHA appreciates the marked improvement in these measures since they were first introduced to the National Quality Forum's Measure Applications Partnership (MAP) in 2016. In that iteration, the measures were titled "Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from/Discharge or End of Care to Other Providers/Settings." We and others on the MAP (as well as those in subsequent public comments) voiced significant concerns with the validity and feasibility of the measures, and the MAP recommended that the measures be refined and resubmitted for consideration. It appears that several	Caitlin Gillooley, MPH American Hospital Association	cgillooley@aha.org	Hospital association

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			of these concerns have been explicitly addressed in the new measures. Primarily, the previous version of the measures placed the burden of accountability for transferring patient information on the receiving providers, when in fact these providers have little control over the information sent to them. In the specifications under consideration, the transferring/discharging provider is held accountable for providing the medication profile to the subsequent provider or the patient/caregiver. This is a preferable method of attribution, and we support the adjustment. In addition, the previous measure counted as successful episodes of care where "at least one information type" was transferred at the relevant point of care. Not only would this specification fail to ensure that relevant information was shared (and thus likely would have little impact on patient outcomes), the low bar for success would virtually guarantee that the measure would become topped out quickly. We appreciate that the new specifications include a minimum set of vital patient information that must be transferred in order for providers to be considered successful. However, we have questions about the specific items to be included in the medication profile, which are enumerated below. Concerns Regarding Measure Specifications Some concerns that were raised in regard to the prior versions of these measures remain, and others have arisen in this iteration of the measures. An overarching concern is that these measures only assess whether information was transferred. They do not evaluate the quality of the information (e.g., the items in the medication profile match patient preferences listed elsewhere) or that the receiving providers or, more importantly, patients understood that information. While we understand that CMS is only statutorily required to introduce a measure addressing the domain of "accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers,"			

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			these measures as specified will not show a reliable connection between the care provided and patient outcomes. Another concerning aspect of the newly specified measures is the inclusion of "verbal" as an acceptable route of transmission of the medication profile. Allowing providers to consider a conversation in-person or over the phone regarding the medication profile is insufficient to ensure that the information is received. Without paper or electronic records, subsequent providers and patients/caregivers might as well have no information at all. In addition, a verbal review of the items included in the medication profile likely is already part of the discharge or transfer process, and thus transferring the information verbally would not fill an inappropriate gap in care. Because providers could continue to record their verbal interactions with patients at the point of discharge/transfer in progress notes, and thus satisfy the measures, performance likely would become topped out without any beneficial change in practice. Because of these issues, we recommend that the verbal route of transmission be removed as an acceptable route of transmission on its own, or only used as a supplement to transmission of a written or electronically transmitted medication profile. One issue that is not addressed in the development of the measures from their previous iterations is the different measure populations by payer source. As specified, the measures would be based on different types of stays depending on the setting: for LTCHs, all patient stays regardless of payer would be counted; for SNFs, relevant stays include Medicare Part A covered stays; for inpatient rehabilitation facilities and HHAs, Medicare Part A and Medicare Advantage stays would be included. Considering that the purpose of the IMPACT Act is to require data that is "standardized and interoperable…by using common standards and definitions," the variation in the denominators seems incongruous. In addition, because Medicaid is a major source of funding for long-term care (and HHA measures include Medicaid patients), we believe that Medicaid stays also should be included.			

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			Another concern is that there appears to be significant overlap in the items required for inclusion in the medication profile that also would be present in the discharge summary. It is our understanding of these measures that, if implemented, CMS would require providers to supply both a discharge summary and the medication profile upon discharge/transfer. This requirement would result in duplicative processes for providers as they would have to record information in multiple places; reconciling the multiple pieces of documentation is likely to result in confusion. Thus, the AHA recommends that the medication profile only include information that would not otherwise be reliably documented in the discharge summary. These items comprise: • Name and date of birth (for identification purposes); • Primary physician name and contact information; • Known medication allergies and sensitivities; • Patient preferences; • Adherence strategies; • Name of drug that patient is accustomed to (rather than all generic and proprietary names); • Dose, route of administration, frequency, directions/special instructions; • When last dose was administered; and • When final dose should be given. Further, as CMS moves towards implementation, the AHA urges the agency to consider how it will validate measure performance. As currently written, there is no validation mechanism specified or suggested. The lack of ability to follow up and ensure information was received can compromise the validity and usefulness of these measures. Areas for Clarification In addition to the concerns above, we also request that the specifications include clarifications on a number of items to ensure			

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			smooth and consistent implementation of collection and reporting processes. First, several items in the medication profile are noted "if applicable." While clinicians populating the medication profile likely will be able to intuit which items are applicable, clinicians will not necessarily be the only staff providing the profile or completing the item required for measure calculation. Additional guidance on the applicability of other items would help remove any subjectivity of determining whether the item should be included in the profile; information on where to find the information to enter it into the profile would also be helpful (especially if the items are subject to frequent change, like weight, and thus might conflict with other information being sent to subsequent settings, like the discharge summary). In short, the data collection protocol should define "if applicable" to clearly demonstrate when missing information is acceptable and should provide additional clarification around reconciling multiple data sources. Second, developers should consider providing more information around the inclusion of the "home under the care of a home health agency and hospice" in both measures. Conceptually, we have no concern with completing both measures (i.e., transferring the medication profile to both the patient and the provider) when the patient is transferred to these settings. However, it would be helpful if the collection protocol included assurance to providers on when they must complete both measures as opposed to one or the other. Third, the measure developer and CMS might consider whether it could be appropriate to collect both measures regardless of the site to which the patient will be transferred/discharged. In other words, overall information sharing might be improved by evaluating providers on whether they give complete medication profiles to both the subsequent facility and the patient or caregiver. Finally, several of the items required for inclusion in the profile include definitions/explanations; we suggest offering clear			

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			instructions for filling out each item, as these measures cover four care settings that serve a patient population with a wide range of characteristics. Specifically, the "primary physician name" should include instructions on whether this item indicates the patient's primary care physician (i.e., the community physician, if known) or the attending physician at the discharging/transferring site. We thank you for the opportunity to comment on these draft measure specifications. If you have any questions concerning our comments, please contact me or have a member of your team contact Caitlin Gillooley, associate director of policy.			
11	5/02/18	Medication profile transferred to patient Medication profile transferred to provider	To Whom This Concerns: We are pleased to have the opportunity to contribute to the public commentary regarding the above-named two quality measures. We appreciate the efforts of the Centers for Medicare and Medicaid Services (CMS) to improve post-acute care (PAC) services provided to Medicare beneficiaries. These proposed measures address a high-risk event in the care transitions of PAC patients and residents. This public commentary on behalf of Partners Continuing Care (Partners Healthcare at Home and Spaulding Rehabilitation Network) reflects our experiences and scope of services across our not-for-profit PAC settings: two Inpatient Rehabilitation Facilities (IRF), one Long Term Care Hospital (LTCH), one Skilled Nursing Facility (SNF), and one Home Health Agency (HHA). As such, our comments will be inclusive of the four PAC settings, or make distinctions as needed. Overall, we strongly support the goals of the IMPACT Act to standardize documentation, interoperability of electronic health records and quality measurement across PAC settings. We commend the efforts of RTI in seeking early input from the field while the measures are in development, and we have willingly supported development of measures by participating in several pilots and beta tests over the past years.	Monica Baggio Tormey, BS, RHIA, CHP, CHC, CHRC / ChxHIM, Spaulding Rehab Network	Mbaggiotormey@partners.org	Health care system

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			We now offer constructive feedback and recommendations in this spirit of collaboration and mutual interest in improving the care of PAC patients and residents, and harmonizing quality metrics across the continuum. I. Measure titles We believe it would add clarity to the measure title of Measure #1 "Medication Profile Transferred to Provider" to include the word "next" or the word "subsequent," i.e. "Medication Profile Transferred to Next Provider." Rationale: Patients and residents in post-acute care (PAC) settings often transition across a continuum, sometimes in a forward (or less acute) direction and sometimes in a reverse (or more acute) direction. Similarly, we believe it would add clarity to the title of Measure #2 "Medication Profile Transferred to Patient" to add a phrase more specific to the patient's transition from a PAC setting and discharge to home, i.e., "Medication Profile Transferred to Patient upon Discharge to Home." Patients in post-acute settings sometimes require interruptions in care and need to return to an acute setting. It would be overwhelming to a patient or resident to receive a copy of the medication profile at this time, and perhaps unsafe, as their medication profile is likely to change again. The requirement for a medication profile for the patient upon acute transfer also places additional burden on the staff when their focus is on a rapid, safe and complete handoff to the next provider. II. Measure and specifications • Potential impact and any unintended consequences of the measures (either positive or negative): Comment: We agree with the comment in Section 3.2 of the Draft that "The communication of health information, such as that of a medication profile, is critical to ensuring safe and effective patient transitions.," as evidenced by manifold studies and stories which are worrisome and compel this as a priority. These two proposed measures meet the criteria for a standardized patient assessment			

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			data element (SPADE), due to the known risk of medication-related errors at such points in time. We remain concerned, however, in terms of unintended consequences on clinical providers who are also documenting and collecting data on other measures which are also addressing this same risk of care transitions, such as the Medication Reconciliation (MR) measure which has been in place for many years and has become as standard for care in those organizations accredited by The Joint Commission. The Drug Regimen Review (DRR) measure contemplated by CMS as part of the IMPACT Act also attempted to address this risk area yet created confusion in the field in terms of the differences between these two measures, their intention, frequency, and definitions, particularly in the SNF setting. The introduction of a third measure with a similar intention should be introduced carefully and thoughtfully, and consistent and dovetailed with extant measures such as MR. The use of multiple data points to assess and measure the same domain is redundant and inefficient, resulting in more time and money spent on staff and documentation rather than providing quality, hands-on patient care. We reiterate that a medication review process upon transition of care is essential for patient safety but believe that the benefit versus burden must be considered. In the end, we support a smaller core set of non-duplicative standardized patient assessment data element (SPADE) items. Recommendation: The specifications should offer clarity as to the definitions and timing of any DRR or MR or Transfer of Health Information-Medication Profile, and lead to harmonization of a core set of non-duplicative items. • Potential benefits, if any, to aligning PAC discharge destinations/locations/status/disposition across PAC assessment instruments: Comment: We remain optimistic about the potential of SPADE, including discharge specifications, to improve interoperability			

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			between settings and to provide a basis for electronic health records which continue to develop in the PAC setting. III. Medication profile (4.1) We refer to the draft definition of a medication profile and data elements provided on pages 9-10 of the Draft Medication Profile Transferred Measures Specifications, as we comment. • The definition of a medication profile: Comment: In general, we support the definition, and the inclusion of total parenteral nutrition (TPN) and oxygen. It is important to include those that will be discontinued after discharge so that the patient or resident can compare the discontinued list with their prescriptions bottles at home. The inclusion of medications which were held during the stay/episode and planned to be continued/ resumed after discharge is troublesome and needs clarification, as there can be many instances where certain medications are held for clinical reasons (e.g. anticoagulants held due to INR; insulins held due to blood glucose level; digoxin held due to pulse, and the like). It seems a great deal of unnecessary work to record each and every medication adjustment that was made for clinical reasons. • The feasibility of collecting the medication profile data elements: Comment: Overall, this would be burdensome for home health to have to collect such data on all patients. This would appear to be more a function of the ambulatory setting or pharmacy. More specifically: Item 3, Primary physician name and contact information. Not every patient has a primary care physician, although inclusion where one exists is important. Items 4, 5, 9 and 10, with *if applicable contingency—"If applicable" needs further definition, else some providers may omit these data points in the interest of time, and validity issues will arise. For example, require the weight, height and date taken for only those medication classes which have weight-based dosing. Items 9, 10 and 11 are not included in the current build of our enterprise-wide electronic health record (EHR). As noted by prior			

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			commenters, significant time and resources have been allocated at health care facilities to build, customize, and modify electronic medical records (EMRs) to meet the data collection requirements of the IMPACT Act and each addition and/or change to the EMR requires significant education and training, involving hundreds of employees across multiple clinical departments. Partners Continuing Care – Public Comments May 3, 2018 Page 4 Item 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. We believe this has limited applicability, as most patients and residents in PAC settings receive medications as administered by a nurse. While patient rights and organizational policies may allow for "self-medication" or orders that "patient may use own meds," such cases are not common in PAC settings. Packaging information is generally not applicable to the inpatient setting and not usually included in a profile. On occasion, packaging preferences may be addressed by the dispensing community pharmacy. It is the responsibility of the pharmacy filling the RX to obtain a signed patient waiver regarding "no childproof lids." All pharmacies required patients to sign a waiver even if the physician were to include this preference in the medication order. It may be more appropriate for physicians or nurses to inform patients that they can sign this waiver when they fill their prescriptions. Whether a medication is time-released or not is part of the basic medication dosage information embedded in the RX. Our pharmacists rely on the ordering physician to designate this option, based upon many factors, such as what would be more beneficial, time released or not, other medications the patient is taking, potential interactions, etc. Finally, medication information is provided to patients in multiple formats by default, and the questions in Example Q2B explicitly asks which methods were used. There is no reason to include this in a patient's profile.			

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			Item 10, Patient adherence strategies *if applicable. Patients or residents in inpatient settings may not have had opportunity to exercise non-adherence. The use of this probe should be limited to Home Health settings, if used at all. Item 11, Patient ability to understand/accept condition(s) and importance of taking medications as prescribed. This needs more clarification and structure as to what documentation is required for this. A patient's ability to understand requires objective documentation. Such information is generally found in the other parts of the record and discharge information, in the patient education and learning section, e.g. patient's preferred method of learning new information. This probe will be N/A for those patients and residents who are deemed incapable of participating. Item 17, Special instructions (e.g., crush medications) *if applicable: Many medication instruction sheets or package inserts are silent on the topic of crushing; some have prohibitions. In the absence of affirmative manufacturing support for the practice, physicians would not include instructions to crush a medication that is otherwise contradicted by the manufacturer. Other instructions may be appropriate, but such instructions are more suited to be provided by the dispensing pharmacy, such as the need for refrigeration or shielding from light, cold, changing to a liquid form etc. Item 18, (for held medications) Reason for holding medication and when medication should resume. The former practice of "holding" medication has been discontinued for safety reasons and logistical concerns. Instead, providers Stop a medication and Restart a medication. If the intention of this element of the profile is to advise the subsequent provider or the discharged patient to Hold a medication (e.g. hold digoxin for pulse less than 50; hold insulin for blood glucose less than 90) that is different and should be explained better. If the intention is that sliding scale medication parameters are utilized, that should be stated more clearly.			

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			Item 19, Purpose/Indications/Contraindications – This data element is not standard in many EHRs. Item 20, Prescriber (for prescribed medications only) – please clarify if the intention is to record the multiple prescribers that preceded the PAC stay (e.g. the patient/resident's cardiologist, podiatrist, PCP, ophthalmologist, etc.) or if the inpatient attending physician's name is sufficient. If the former, that is a significant amount of work for providers. Item 21, When the last dose of medication was administered. This data point is always included in the transfer documentation. It would be redundant to repeat it here. Item 23, Patient education provided about potential risks/ side effects/ contradictions and when to notify prescriber (for profile provided to patient/family/caregiver). This is a standard element of discharge to home, but it is not a standard of care to provide this booklet or computer-generated multi-page handout to a subsequent care provider. Discharging providers should be able to reference the materials provided, and not include another copy on the profile. Further, this information would be incomplete in the event of an unplanned, acute transfer from PAC setting to acute setting. Item 24, Patient adherence with the medication therapy. As noted in our comments on Item 10: Patients or residents in inpatient settings may not have had opportunity to exercise non-adherence. The use of this probe should be limited to Home Health settings, if used at all. Item 25, Relevant lab test results to guide medication management … *if applicable. Relevant and recent lab results are always included in the discharge or transfer information to the subsequent provider. There is no need to duplicate it in the medication profile. Further, it is unclear how the inclusion of relevant lab test results in the profile provided to the patient or resident being discharged to home would provide them benefit. While we believe in patient autonomy and inclusion in participative decision-making, it is the prescribing physician who has a duty to know the relevant lab			

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			results and s/he should receive them as part of the discharge or transfer information. • Differences, if any, in what information should be included in a medication profile provided to a healthcare provider as compared to a medication profile provided to the patient/family/caregiver Comment: As we note in our comments on the Measure Titles, patients and residents in post-acute settings sometimes require interruptions in care and need to return to an acute setting. It would be overwhelming to a patient or resident to receive a copy of the medication profile at this time, and perhaps unsafe, as their medication profile is likely to change again. The requirement for a medication profile for the patient upon acute transfer also places additional burden on the clinical staff at a time when their focus is on a rapid, complete and safe handoff to the next provider. See also our comments regarding item number 25 and laboratory results. Recommendation: Do not require that a medication profile be provided to a patient or resident who is being transferred to acute care. • Whether discontinued medications should be included in the medication profile. If included, provide suggestions of 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.) Comment: It is important to include those that will be discontinued after discharge so that the patient or resident can compare the discontinued list with their prescriptions bottles at home. This is important for a home health reconciliation. • Whether it is feasible and important for the patient's primary physician contact information to be included on the medication profile (Item 3)			

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			Comment: Yes, it is generally feasible when the patient or resident has a PCP and is especially important in the Home Health setting. • Whether it is feasible and important to include an assessment of a patient's ability to understand/accept his or her condition and the importance of taking medications as prescribed. (Item 11) Comment: This needs more clarification and structure as to what documentation is required for this. A patient's ability to understand requires objective documentation. Such information is generally found in the other parts of the record and discharge information, in the patient education and learning section, e.g. patient's preferred method of learning new information. This probe will be N/A for those patients and residents who are deemed incapable of participating. • Whether it is feasible and important for the prescriber of each medication to be identified in the medication profile (Item 20) Comment: It is not feasible and would be a significant amount of work for the providers to do a forensic reconstruction of all the prescribers who contributed to the patient's or resident's chronic medications over the years. (e.g. the patient/resident's cardiologist, podiatrist, PCP, ophthalmologist, etc.). In terms of provider burden, this information is not available in our current EHR After Visit Summary, nor do we believe it is important. • For transfers from HHA to a subsequent provider, are there any issues with adding the response option of "NA – The agency was not made aware of this transfer timely"? Are there specific instances when this response option should be considered an allowable response? Are there specific instances when this response option should not be considered an allowable response? Comment: HHAs absolutely need a "N/A" response option here. HHAs often do not know until after the fact of the patient transfer and sometimes only when the patient has already returned home from a hospital stay. Under the new CMS Conditions of			

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			Participation, HHAs now must include a medication list in the transfer summary if one is done. IV. Route of transmission of the medication profile (4.1.3) Definitions of routes of transmission of the medication profile are included on pages 10-11. We comment on: • Whether consumers will find value in knowing the routes by which the information profile was transmitted (e.g., verbal communication) Comment: We do not believe consumers will find any value in knowing the routes of information transfer. Rather, this data point will inform policymaking as to the need to offer more support for EHRs in PAC settings which were left behind by the Meaningful Use provisions. As noted on page 6 of the Draft Specifications, "There is limited information about the types of information transferred by PAC providers at transitions and the route or mode (e.g., paper-based, verbal, and electronic) used to transfer this information." This data point will inform that gap for policymakers, not for patients. • Whether the route of transmission information would inform consumer choice of providers/facilities. Comment: No, it would not. • Although not required for this measure, if PAC providers would be able to transfer the medication profile electronically through their EHRs/EMRs Comment: As we note above, many of the smaller, non-chain, non-profit PAC providers would be unable to transfer the information electronically. • Sufficiency of existing health IT standards to support interoperable exchange of the medications and data elements proposed in the draft medication profile Comment: Many PAC providers do not have access to electronic health records or systems that facilitate communicating this information. PAC settings, unlike acute and ambulatory care			

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			settings, were not included in CMS's meaningful use program and therefore do not have funding mechanisms in place to incentivize the use of electronic health records. Therefore, many do not currently have the digital tools necessary to allow for the smooth and appropriate transfer of health information. The development of Health Information Organizations (HIO) as discussed on page 10 of the Draft Specifications has left the PAC sector behind. The intent of the data elements for Transfer of Medication Profile is reasonable. However, CMS should work to provide increased access to electronic records prior to using these data elements for measurement. We could not agree more with the final paragraph of the Draft Specifications, Section 3.3, Background and Current Gaps, as interoperability is discussed. There are implications for public policy, strategy development by the Office of the National Coordinator on Health Information Technology (ONCHIT) and investment in PAC IS infrastructure. Other comments: Section 5.10 Denominator Details. We continue to be perplexed as to why LTCH hospitals must collect IMPACT data "regardless of payer," while the other three PAC sectors collect data only on public payer sources.			
12	5/02/18	Medication profile transferred to patient Medication profile transferred to provider	Dear Director Love and Deputy Director Saunders, The New York State Health Facilities Association (NYSHFA) and the New York State Center for Assisted Living (NYSCAL) represents nearly 400 members, with 60,000 employees, providing provide essential long-term care to over 44,000 elderly, frail, and physically challenged women, men and children in New York State. NYSHFA/NYSCAL recognizes the critical importance of collaborative efforts to improve healthcare and outcomes for beneficiaries, residents, and their families. Thank you for the opportunity to provide feedback on the transfer of health information and care preferences domain under the quality measures specified in the Improving Medicare Post-Acute Care Transformation Act of 2018	LAUREN POLLOW Government Affairs NYS Health Facilities Association	Lauren@nyshfa.org	Provider association

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			(IMPACT Act). Our comments are brief and focus on the Medication Profile Transferred to Provider measure. NYSHFA supports the draft measure specifications outlined with two suggested additions: 1. Where the patient's primary care physician contact information is included in the medication profile, this should also include a pharmacist's information if feasible (4.1.1 Patient Information); and, 2. Under the Medication Information section (4.1.2), clinical staff have reported that it is relevant to include information regarding discontinued medications and adverse reactions to medications. NYSHFA fully appreciates the effort to ensure providers are accountable for transferring important medication information during transitions. Because CMS is collecting standardized information regarding the route of transmission, we are optimistic any findings would be used to justify additional funds for investment in Electronic Health Record (EHR) and HIE adoption. As you are aware, there are many barriers to EHR adoption for post-acute providers as cited in the background/current gaps section of the Measure Justification. These barriers, along with expectations such as the Office of the National Coordinator (ONC) Certification and additional costs associated with RHIO connectivity on a state-to-state basis, pose adoption challenges to long-term care providers. Long-term care providers did not receive the same investment as hospitals and physician offices in terms of incentive funding for EHRs but are managing the same risks in terms of medication errors and discrepancies. Thank you for your consideration, and please let us know if you have any questions			
13	5/02/18	Medication profile	The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 13,500 non-profit and proprietary skilled nursing centers, assisted living	Daniel E. Ciolek, PT, MS, PMP	dciolek@ahca.org	Provider association

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		transferred to patient Medication profile transferred to provider	communities, sub-acute centers and homes for individuals with intellectual and development disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day. We appreciate the opportunity to comment on: Project Title: 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 - Medication Profile Transferred to Provider / Medication Profile Transferred to Patient. We understand that the Centers for Medicare & Medicaid Services (CMS) has contracted with RTI International and Abt Associates to further develop a cross-setting post-acute care transfer of health information and care preferences quality measure in alignment with the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). We understand that the specific comments you are requesting are so that you can obtain specific input on the draft measure specifications and data elements for the following potential measures: 1. Medication Profile Transferred to Provider 2. Medication Profile Transferred to Patient We have reviewed the March 16, 2018 call for public comment document: *Draft Specifications for the Medication Profile Transferred Measures for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies* that was posted at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment- Instruments/MMS/Downloads/IMPACT_Medication-Profile-Transferred_Draft-Measure- Specifications.pdf, and offer the following comments for each of the draft measures. We look forward to ongoing engagement with CMS, RTI International and Abt Associates to implement meaningful standardized cross-setting data elements and measures that limit	American Health Care Association		

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			burden, align with quality and payment policies, and allow skilled nursing providers to continue delivering high-quality care to beneficiaries. Should you have any questions regarding our comments, please contact Daniel E. Ciolek, Associate Vice President, Therapy Advocacy, at dciolek@ahca.org or 302-740-7888. The March 19, 2018 Centers for Medicare and Medicaid Services (CMS) call for public comment indicated that "The purpose of this work is to develop measures reflective of transfer of health information and care preferences at transitions for post-acute care (PAC) settings per the IMPACT Act and to support the CMS quality missions." CMS further stated that "This measure development is conducted to meet the mandate of the IMPACT Act, to address the domain: "(E) Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions— ''(i) from a hospital or critical access hospital to another applicable setting, including a PAC provider or the home of the individual; or ''(ii) from a PAC provider to another applicable setting, including a different PAC provider, a hospital, a critical access hospital, or the home of the individual." Section 2a of the IMPACT Act further mandates the development and use of standardized patient assessment data elements (SPADEs) across PAC settings." A.2 Overview of AHCA/NCAL Comments AHCA/NCAL have been and continue to be strong supporters of the vision and objectives of the IMPACT Act. We believe that the most effective quality measures are those that reflect meaningful outcomes, especially for high-impact clinical domains. We also recognize the clinical importance of timely and accurate communication of health information and, as reasonable, a resident's care preferences at transitions of care both when the			

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			resident is admitted to, and discharged or transferred from a SNF. Timely and effective information exchange at transitions of care is necessary to maintain patient-centered care planning across the continuum of care and to help prevent medication errors and avoidable adverse health events. However, we believe that the draft measures as described fall short of the intent of the IMPACT Act, could create significant administrative burden, and have very limited utility with regards to improving care for residents admitted to SNFs. For example, the draft measures do not contain any requirements that would help improve the communication of "Medication Profile" information from an admitting hospital to the SNF as is described from the following IMPACT Act provision: "(E) Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions— ''(i) from a hospital or critical access hospital to another applicable setting, including a PAC provider or the home of the individual; We note that a recent AHCA/NCAL analysis of MDS data from 2012-2017 indicates that approximately 88 percent of all SNF admissions from all payers each year are directly from an acute care hospital, while less of 1 percent result from transfers from Inpatient Rehabilitation Facilities (IRFs) and Long-Term Care Hospitals (LTCHs) combined. Additionally, although the MDS data does not collect information on admissions to SNF from a Home Health Agency (HHA), anecdotal reports and the fact that only 6 percent of SNF admissions are from the community per year suggests strongly that very small percentages of SNF admissions reflect individuals transitioning to a SNF from an HHA. These figures indicate strongly that the draft measures would increase SNF burden while providing little to no utility to improving SNF medication management upon admission from another provider, as less that 5 percent of SNF			

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			admissions would be from other Post-Acute Care (PAC) providers subject to these draft measures. Additionally, while these draft measures appear on the face require nominal administrative effort to complete two item fields per measure, we are concerned that the "devil is in the details". For example, the draft measures contain a list of 25 unique pieces of information to be conveyed to a downstream provider and/or the beneficiary or their representative at the time of discharge or transfer from a SNF. However, 14 of these pieces of information would need to be identified for each individual medication for that patient. Many SNF patients require multiple medications which would mean there could be hundreds of data points that would be included within a "Medication Profile". We note that many of these data points are currently required to be included in patient discharge/transfer documentation from a SNF, and these requirements have been further updated in the recent November 2017 revision to the SNF Requirements of Participation (RoPs). We also note that the SNF RoPs explicitly state that the provider has the flexibility in how this information is conveyed to downstream providers and/or the patient/representative upon discharge/transfer from a SNF. Ideally, such information that is already contained into the SNF clinical records could be efficiently exchanged through interoperable health information exchange (HIE) technology. However, until such technology is more universally accessible and used, we do not believe that any "Medication Profile" measure adopted should require these specific data elements to be incorporated into a single and duplicative document if the SNF documentation conveyed at transitions of care includes all of the required elements. We appreciate that CMS has acknowledged the current HIE interoperability limitations as published in the April 27, 2018 display copy of CMS-1696-P: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program, Proposed			

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			Rule. Specifically, in this proposed rule, CMS issued a Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers. While we plan on submitting comments regarding advancing interoperability to that solicitation, we believe that CMS should also consider aligning these two draft measures with the interoperability issues raised in the FY 2019 SNF PPS proposed rule before formally specifying these draft measures for adoption in the SNF QRP program. In summary, while we believe that these draft measures fall short of the vision of the IMPACT Act, we believe that if the issues and suggestions we have raised in these introductory comments, could help move these draft measures closer to something that is both meaningful, and does not result in unnecessary burden that takes clinicians away from patient care. In Section B below, we offer our comments in response to specific questions posed in this solicitation. Finally, in Section C, we offer our thoughts and recommendations about specific draft measure details where no specific feedback was requested. B. Specific Input on the Draft Measure Specifications and Data Elements Requested for the Two Potential Measures In the public comment solicitation, CMS and its measure development contractors (RTI International and Abt Associates) requested feedback on a number of specific topics related to the potential measure titles, measure specifications, and details of the potential items to be included in the "Medication Profile" measures. This section of the AHCA/NCAL comments include detailed responses to each of the 21 requested feedback items. Requested feedback items related to "Measure Titles" (2 items) • Whether the measure titles clearly capture the measure concept across the PAC settings			

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			• Any other suggestions for the measure titles B.1. Whether the measure titles clearly capture the measure concept across the PAC settings AHCA/NCAL Comment: While we agree that the term "Transferred" is consistent with the IMPACT Act language, we believe that the term may be confusing to providers/patients/families/caregivers as well as the public. For example, the 11/22/2017 update of the Medicare State Operations Manual, Appendix PP – Guidance for Surveyors of Long Term Care Facilities contains definitions for 42CFR 483.15(c) Transfer and Discharge under tag F622 that are different and conflict somewhat with the proposed usage in these draft measures. CMS should consider using alternative consumer-friendly terminology that may be more effective in capturing the measure concept. We believe that the words "Given to," "Shared with," or "Conveyed to" may be more consumer-friendly and should be considered. Additionally, we believe that the term "Information" should be added to the name as the tag F622 interpretive guidance under 42CFR 483.15(c)(2) states "Facilities may choose their own method of communicating transfer or discharge information, such as a universal transfer form or an electronic health record summary, as long as the method contains the required elements." The word "Information" is more consistent with the SNF Requirements of Participations (RoPs) and more clearly captures the concept that a "Medication Profile" is not a discrete static document, but could represent the totality of information given at the time of discharge or transfer from a provider. B.2 Any other suggestions for the measure titles AHCA/NCAL Comment: We suggest that the Draft Specifications Sections 2.1, 5.1, and 6.1 measure names be relabeled with one of the word options we offered above. For example, the title could be renamed "Medication Profile Information Given to Provider" and "Medication Profile Information Given to Patient".			

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			Requested feedback items related to "Measure and Specifications" (3 items) • Potential impact and any unintended consequences of the measures (either positive or negative) • Potential measure exclusions • Potential benefits, if any, to aligning PAC discharge destinations/locations/status/disposition across PAC assessment instruments B.3. Potential impact and any unintended consequences of the measures (either positive or negative) AHCA/NCAL Comment: As described, these draft measures appear to be an aspirational attempt to reflect best practice in ideal situations where detailed clinical data can be shared through interoperable health information technology (HIT) exchange. Most items described are redundant to or are more specific and burdensome than existing SNF regulatory requirements at 42CFR §483.15(c) Transfer and Discharge, and §483.21 Discharge Summary. For example, here is the specific list of required SNF documentation at transfer or discharge at §483.15(c)(2)(iii): (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;			

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			(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Given current HIT interoperability limitations, adding a process of additional verification of every item prior to coding the proposed new MDS items beyond existing requirements appear to be excessively burdensome and could have significantly negative impacts on patient health, particularly in cases of urgent "unplanned" transfers to an emergency room, inpatient hospital (including CAHs), or other "unplanned" discharges. There is not sufficient time to verify all the listed "Patient Information" and "Medication Information" items described in the draft measures, particularly when a patient is transferred to another provider in an urgent care situation, or in cases of resident/representative requesting discharge without providing adequate notification. A quality measure reporting performance of the patient-specific transfer of "Medication Management" items should not mandate provider documentation activity superfluous to the patient's immediate care needs, particularly in situations that could result in a delay in the patient receiving necessary urgent care. We note that the State Operations Manual survey guidance for tag F622 regarding SNF regulations at §483.15(c)(2)(iii) recognizes this difference, and specifically states the following: NOTE: It may not be possible to convey all care plan information prior to urgent transfers, however, this information must be conveyed as close as possible to the actual time of transfer. Additionally, the Tag F622 SNF surveyor guidance differentiates the definition of a "Transfer" and a "Discharge" from a SNF (see CMS definitions below), and the essential information that should be conveyed for each situation that should be taken into consideration for the draft measure definitions. The important distinction in the			

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			CMS definition of "Transfer and Discharge" above is whether the patient is expected to return to the SNF or not. "Transfer and Discharge": Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected. The important distinction in the CMS definition of "Transfer and Discharge" above is whether the patient is expected to return to the SNF or not, and CMS applies a standard of more detailed information in cases of a "planned" discharge to another provider when return is not expected. As the Draft Specifications Section 3.3 Background and Current Gaps discussion reveals, while electronic health records (EHRs) and other health information organizations (HIOs) technology can "…simplify the process of extracting necessary information when a patient/resident is transferred to and from PAC, and electronic continuity of care and summary of care documents provides a standardized way to exchange critical information between PACs and other providers," the truth about the current environment is, as also stated in Draft Specifications Section 3.3, "…PAC providers were not eligible to participate in the Medicare and Medicaid Electronic Health Record Initiative Programs, and lag behind hospitals and physician offices in both EHR and HIE adoption." Environmental barriers to EHR and HIO interoperability include geographic limitations in high-speed internet access. Even when a provider has the technology at the facility-level, it may not be able to be used in an individual patient's situation because the provider that the patient is being transferred to, or the patient/representative does not have EHR or HIO capabilities. Such environmental and institutional barriers would			

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			create a measure bias against SNFs, particularly those located in rural and other geographically disadvantaged providers. As we noted in Section A.2 of these comments, CMS has recognized these challenges in the FY 2019 SNF PPS proposed rule posted on April 27, 2018. In the proposed rule, CMS requested feedback on improving the environment and incentives to better assure that health information exchange of meaningful data, including information included in a patient's "Medication Profile". Until at such time that the institutional disparities in EHR and HIO access and adequate interoperability standards are established and implemented, we recommend that any mandatory "medication profile" information necessary to reflect successful performance should be limited a set if essential items necessary for a subsequent provider/physician to be able to make appropriate decisions related to immediate medication management, or for patients/caregivers to be able to safely self-administer medications in cases where they are being discharged to the community without being directly transferred into another provider's care. Other draft measure items listed that may reflect aspirational best practice, but do not meet the standard as essential items necessary for "planned" or "unplanned" discharges/transfers, or that require detail more than SNF RoPs could be excessively burdensome, and could be defined as "optional" for the "Medication Profile" measure performance at this time. This could mitigate our concerns regarding "unplanned" transfers/discharges while establishing aspirational documentation details for paper-based "medication profiles" as well as ongoing efforts to establish and implement interoperability standards for EHR and HIO technology. B.4. Potential measure exclusions Section 5.3, 5.11, 6.11 AHCA/NCAL Comment: If the CMS decision is to proceed with the extensive and burdensome list of potential items listed in Draft Specifications Sections 4.1.1 and 4.1.2, then we would recommend that an			

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			exclusion for unplanned discharges (e.g. emergency room, hospital admission, patient/representative self- discharge with minimal notice (e.g. 24 hours or less)) be available across all PAC settings. We note that the current MDS assessment (definition below) already includes item A0310.G "Type of Discharge" that could be used for this purpose without adding burden. A0310.G. Type of discharge. - Complete only if A0310F = 10 or 11. 1. Planned. 2. Unplanned. If the CMS decision is to proceed with a reasonable limited item set for "Planned" and "Unplanned" discharges/transfers (as we discuss throughout these comments), then the urgency of such an exclusion may be reduced or eliminated. B.5 Potential benefits, if any, to aligning PAC discharge destinations/locations/status/disposition across PAC assessment instruments AHCA/NCAL Comment: There are numerous benefits to improving information across PACs (as described in Draft Specifications Section 2.4), and to reduce/eliminate communication gaps at care transitions (as described in Draft Specifications Section 3.3), particularly related to information that can most positively impact improvements in care and reductions in adverse events and the costs of care. However, the data that is collected must be meaningful and useful to all settings and should not impose unneeded burden that detract from patient care. Requested feedback items related to "Medication Profile" (12 items) • The definition of a medication profile • The types of medications to be included in the medication profile			

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			• Whether the medication profile description captures the most important sources of medication profile information • The feasibility of collecting the medication profile data elements • Data elements to include in a medication profile. (Please provide rationale for any new data elements not included in the draft definition.) • Which data elements in the medication profile should be designated “if applicable." • Differences, if any, in what information should be included in a medication profile provided to a healthcare provider as compared to a medication profile provided to the patient/family/caregiver • Whether discontinued medications should be included in the medication profile. If included, provide suggestions of 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.) • Whether it is feasible and important for the patient’s primary physician contact information to be included on the medication profile • Whether it is feasible and important to include an assessment of a patient’s ability to understand/accept his or her condition and the importance of taking medications as prescribed • Whether it is feasible and important for the prescriber of each medication to be identified in the medication profile • For transfers from HHA to a subsequent provider, are there any issues with adding the response option of “NA – The agency was not made aware of this transfer timely”? Are there specific instances when this response option should be considered an allowable response? Are there specific			

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			instances when this response option should not be considered an allowable response? B.6. The definition of a medication profile AHCA/NCAL Comment: We are very concerned that the draft "Medication Profile" definition terminology "comprehensive summary of information" implies that a paper or electronic document must be created that is separate from but contains information that is duplicative of existing discharge and transfer documentation requirements. Specifically, SNF State Operations Manual tag F622 interpretive guidance under 42CFR 483.15(c)(2) states "Facilities may choose their own method of communicating transfer or discharge information, such as a universal transfer form or an electronic health record summary, as long as the method contains the required elements." We request that the definition be clarified to indicate that the "Medication Profile" represents information that shall be contained in the providers overall discharge or transfer documentation rather than a separate "comprehensive summary of information "as implied in the current draft definition. Separate and duplicative documentation for every discharge or transfer would be excessively burdensome. We agree with the types of medications listed in Draft Specifications Section 4.1. However, the "Patient Information" items listed in Draft Specifications Section 4.1.1 and "Medication Information" listed in Draft Specifications Section 4.1.2 is significantly more detailed than necessary to assure immediate continuity of medication administration upon transfer/discharge. Additionally, it is more detailed that the 11/22/2017 update to the SNF RoPs and related State Operations Manual survey guidance tags F622 and F661 discussed elsewhere in these comments. As elaborated in our comments in multiple locations in this document, we believe that the burden associated with gathering and transferring information about all 25 potential items into a discrete document or form prior to the transfer/discharge, particularly in situations with limited notice or in urgent care			

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			situations, is unrealistic and could result in in delays in needed care and unintended negative outcomes. Additionally, the effort of validating that all such required information was in fact included in the patient's transfer/discharge documentation to complete the potential new MDS items to be added for this measure (including 14 items for each medication) could be extensive. We offer suggested modifications in in our Section B.11 comments below as well as in Table 1 in that same section. B.7 The types of medications to be included in the medication profile AHCA/NCAL Comment: We agree that the "types" of medications included in the potential "medication profile" to be transferred at discharge/transfer should include, as described in Draft Specifications Section 4.1 "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." This is consistent with SNF transfer and discharge documentation and discharge summary requirements at §483.15(c)(2) and §483.21(c)(2). B.8. Whether the medication profile description captures the most important sources of medication profile information AHCA/NCAL Comment: We believe the list of potential "Documentation Sources" for "Medication Profile" information listed in Draft Specifications Section 4.1 "electronic and/or paper records, including discharge summary records, a Medication Administration Record (MAR), Intravenous Medication Record (IVAR), home medication list, and physician orders" is reasonable and consistent with SNF transfer and discharge documentation and discharge summary requirements at §483.15(c)(2) and §483.21(c)(2).			

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			B.9. The feasibility of collecting the medication profile data elements AHCA/NCAL Comment: As elaborated in numerous locations in this document, we believe that the burden associated with gathering and transferring all the potential items into a discrete document that is duplicative of information already contained in the required SNF discharge/transfer documentation prior to the transfer/discharge, particularly in situations with limited notice or in urgent care situations, is unrealistic and could result in delays in needed care and unintended negative outcomes. Additionally, the effort of validating that all such required information was in fact included in the patient's transfer/discharge documentation to complete the potential new MDS item to be added for this measure (including 14 items for each medication) could be extensive and cannot be reasonably achieved universally until EHR and HIO interoperability barrier issues are resolved. B.10. Data elements to include in a medication profile. (Please provide rationale for any new data elements not included in the draft definition.) AHCA/NCAL Comment: We believe that the data elements to be included in a "Medication Profile" should be consistent with regulatory documentation requirements and surveyor guidance for transfers and discharges and should not add burden, particularly for "unplanned" discharges. For example, SNF regulations at §483.15(c)(2)(iii) regarding transfer and discharge documentation states: (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident.			

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			(B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. The items in bold text above are consistent with the draft "Medication Profile" items. In addition, the State Operations Manual tag F622 guidance related to §483.15(c)(2)(iii) provides additional SNF transfer and discharge documentation details as follows: Information Conveyed to Receiving Provider The regulations at §483.15(c)(2)(iii) address information that must be conveyed to the receiving provider when a resident is transferred or discharged. The specific information which must be conveyed depends upon whether the resident is transferred (expected to return), or is discharged (not expected to return). If the resident is being transferred, and return is expected, the following information must be conveyed to the receiving provider: • Contact information of the practitioner who was responsible for the care of the resident; • Resident representative information, including contact information; • Advance directive information; • Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to:			

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			o Treatments and devices (oxygen, implants, IVs, tubes/catheters); o Precautions such as isolation or contact; o Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions; • The resident's comprehensive care plan goals; and • All information necessary to meet the resident's needs, which includes, but may not be limited to: o Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; o Diagnoses and allergies; o Medications (including when last received); and o Most recent relevant labs, other diagnostic tests, and recent immunizations. • Additional information, if any, outlined in the transfer agreement with the acute care provider (See §483.70(j) for additional information). NOTE: It may not be possible to convey all care plan information prior to urgent transfers, however, this information must be conveyed as close as possible to the actual time of transfer. For residents being discharged (return not expected), the facility must convey all of the information listed above, along with required information found at §483.21(c)(2) Discharge Summary, F661. Communicating this information to the receiving provider is one way the facility can reduce the risk of complications and adverse events during the resident's transition to a new setting. Facilities may choose their own method of communicating transfer or discharge information, such as a universal transfer form or an electronic health record summary, as long as the method contains the required elements. The transferring or discharging facility may transmit the information electronically in a secure manner which			

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			protects the resident's privacy, as long as the receiving facility has the capacity to receive and use the information. Communication of this required information should occur as close as possible to the time of transfer or discharge. In another example, SNF regulations at §483.21(c)(2) regarding discharge summary documentation for "planned" discharges states: §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post- discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post- discharge plan of care must indicate where the individual plans to reside, any			

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			arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. The items in bold text above and below are consistent with the draft "Medication Profile" items. In addition, the State Operations Manual tag F661 guidance related to §483.21(c)(2) provides additional SNF discharge documentation details for "planned" discharges as follows: GUIDANCE §483.21(c)(2) Overview The discharge summary provides necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the resident's plans for care after discharge. A discharge summary must include an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another. The discharge summary may help reduce or eliminate confusion among the various facilities, agencies, practitioners, and caregivers involved with the resident's care. In the case of discharge to a non-institutional setting such as the resident's home, provision of a discharge summary, with the resident's consent, to the resident's community-based physicians/practitioners allows the resident to receive continuous and coordinated, person-centered care. For residents who are being discharged from the facility to another health care facility, the discharge summary enables the receiving facility to provide appropriate and timely care. The medical record must identify the receiving facilities for which or physicians/practitioners to whom the discharge summary is provided.			

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			Content of the Discharge Summary Recapitulation of Resident's Stay Recapitulation of the resident's stay describes the resident's course of treatment while residing in the facility. The recapitulation includes, but is not limited to, diagnoses, course of illness, treatment, and/or therapy, and pertinent lab, radiology, and consultation results, including any pending lab results. Final Summary of Resident Status In addition to the recapitulation of the resident's stay, the discharge summary must include a final summary of the resident's status which includes the items from the resident's most recent comprehensive assessment identified at §483.20(b)(1)(i) – (xviii) Comprehensive Assessment. This is necessary to accurately describe the current clinical status of the resident. Items required to be in the final summary of the resident's status are: • Identification and demographic information; • Customary routine; • Cognitive patterns; • Communication; • Vision; • Mood and Behavior patterns; • Psychosocial well-being; • Physical functioning and structural problems; • Continence; • Disease diagnoses and health conditions; • Dental and nutritional status • Skin condition; • Activity pursuit; • Medications; • Special treatments and procedures; • Discharge planning (as evidenced by most recent discharge care plan)			

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			• Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS; and • Documentation of participation in assessment. This refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care/direct access staff members on all shifts. NOTE: In addition to the above, pursuant to §483.15(c)(2)(iii), the facility (transferring nursing home) must convey the following information to the receiving provider when a resident is discharged (or transferred) from that facility: • Contact information of the practitioner (at the transferring nursing home) responsible for the care of the resident; • Resident representative information, if applicable, including contact information; • Advance directive information; • All special instructions or precautions for ongoing care, as appropriate; • Comprehensive care plan goals; and • All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. For concerns related to the above, see guidance at F622, §483.15(c)(2)(iii). Timing of the Discharge Summary The discharge summary contains necessary medical information that the facility must furnish at the time the resident leaves the facility, to the receiving provider assuming responsibility for the resident's care after discharge. The discharge summary may be furnished in either hard copy or electronic format, if the provider			

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			assuming responsibility for the resident's care has the capacity to receive and use the discharge summary in electronic format. Delays in preparing and forwarding the discharge summary hinder the coordination required to provide optimal care to the resident. The medical record must contain the discharge summary information and identify the recipient of the summary. NOTE: In situations where there is no continuing care provider (e.g., resident has no primary care physician in the community), the facility is expected to document in the medical record efforts to assist the resident in locating a continuing care provider. Reconciliation of Medications Prior to Discharge A resident's discharge medications may differ from what the resident was receiving while residing in the facility. Facility staff must compare the medications listed in the discharge summary to medications the resident was taking while residing in the nursing home. Any discrepancies or differences found during the reconciliation must be assessed and resolved, and the resolution documented in the discharge summary, along with a rationale for any changes. For example, a resident who was receiving rehabilitative services may have required antibiotic therapy postoperatively but does not need to continue the antibiotic at home. The discontinuation of the medication should be documented in the discharge summary. Discharge instructions and accompanying prescriptions provided to the resident and if applicable, the resident representative must accurately reflect the reconciled medication list in the discharge summary. Post-Discharge Plan of Care The post-discharge plan of care details the arrangements that facility staff have made to address the resident's needs after discharge, and includes instructions given to the resident and his or her representative, if applicable. The post-discharge plan of care must be developed with the participation of the Interdisciplinary team and the resident and, with the resident's consent, the			

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			resident's representative. At the resident's request, a representative of the local contact agency may also be included in the development of the post-discharge plan of care. The post-discharge plan of care should show what arrangements have been made regarding: • Where the resident will live after leaving the facility; • Follow-up care the resident will receive from other providers, and that provider's contact information; • Needed medical and non-medical services (including medical equipment); • Community care and support services, if needed; and • When and how to contact the continuing care provider. Instructions to residents discharged to home For residents discharged to their home, the medical record should contain documentation that written discharge instructions were given to the resident and if applicable, the resident representative. These instructions must be discussed with the resident and resident representative and conveyed in a language and manner they will understand. We would like to emphasize that the SNF regulations and interpretive guidance above clearly indicate that: 1) it may not be possible to convey all information prior to "unplanned" transfers, but the information "…must be conveyed as close as possible to the actual time of the transfer," and, 2) there is a higher level of documentation detail required for discharges when return is not expected than for transfers where return is expected. We believe that the draft "Medication Profile" measures must account for these situational differences either by limiting the required items to only those that apply to both situations, or by excluding "Unplanned" discharges from the measure denominators. B.11. Which data elements in the medication profile should be designated "if applicable."			

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<tr><td></td><td></td><td></td><td>AHCA/NCAL Comment:

It is not clear to us what the definition of the term “if applicable” means as defined in Draft Specifications Section 4.1.2 and as applied in Sections 4.1.1 and 4.1.2. In most cases it appears that including an “if applicable” item in a “Medication Profile” at transfer/discharge would only apply if the information was necessary to start, change, or discontinue a medication by a provider/physician following-up on the care after the transfer/discharge from a SNF (or any PAC provider) was completed as part of a medication review/reconciliation process. In other cases, the potential “if applicable” items are related to patient preferences, education, and adherence behaviors that are not clearly defined. We recommend revising the definition of “if applicable” to address this concern, and adding definitions for “Planned” or “Unplanned” transfer or discharge items.

As we have indicated elsewhere in our comments applicable to Draft Specifications Sections 4.1, 4.1.1, and 4.1.2), we believe it would be more appropriate for the “Medication Profile” to contain a limited number of essential items that would be consistent with regulatory documentation requirements to be considered mandatory for successful performance of the measure requirements, but that other supplemental aspirational items that would reflect best practices in ideal patient transfer/discharge situations would be listed as “optional” for successful measure performance. To that end, we recommend that the 25 potential items in Draft Measure Specifications be identified as applicable to either “Planned” or “Unplanned transfers/discharges or to be considered as “Optional” aspirational best practice items for purposes of current measure performance until the interoperability limitations in EHRs and HIOs can be resolved.

Table 1. AHCA/NCAL Suggested “Planned” or ‘Unplanned” Discharges/Transfers v. “Optional” Medication Profile” Items

<table>
<tr><th>Draft Potential “Patient Information”</th><th>AHCA/NCAL Potential “Patient Information”</th></tr>
<tr><td>1. Patient name</td><td>Planned or Unplanned</td></tr>
<tr><td>2. Patient date of birth</td><td>Planned or Unplanned</td></tr>
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3.	Practitioner responsible for the care of the resident and contact information	Planned or Unplanned
4.	Height and date taken **If applicable*	Planned
5.	Weight and date taken **If applicable*	Planned
6.	Patient active diagnoses and any other diagnoses that have medication implications	Planned or Unplanned
7.	Known medication and other allergies	Planned or Unplanned
8.	Known drug sensitivities and reactions	Planned or Unplanned
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*	Optional
10.	Patient adherence strategies (e.g., alarms, drug diaries) **If applicable*	Optional
11.	Patient ability to understand/accept condition(s) and importance of taking medications as prescribed	Planned
	Draft Potential "Medication Information" (Complete for each medication)	**AHCA/NCAL Potential "Medication Information" (for each medication)**
12.	Name (generic and proprietary names if applicable) and strength	Planned or Unplanned
13.	Dose	Planned or Unplanned
14.	Route of medication administration	Planned or Unplanned
15.	Frequency	Planned or Unplanned
16.	Directions	Planned or Unplanned
17.	Special instruction (e.g., crush medications) **If applicable*	Planned or Unplanned
18.	(For held medications) Reason for holding medication and when medication should resume	Planned or Unplanned
19.	Purpose/Indications/Contraindications	Planned or Unplanned
20.	Prescriber (for prescribed medications only)	Optional
21.	When the last dose of the medication was administered by discharging/transferring provider **If applicable*	Planned or Unplanned
22.	When the final dose of the medication should be given **If applicable*	Planned or Unplanned
23.	Patient education provided about potential risks/side effects/contradictions and when to notify prescriber *(for profile provided to patient/family/caregiver)*	Planned
24.	Patient adherence with the medication therapy	Optional
25.	Relevant lab test results to guide medication management (e.g., serum creatinine) **If applicable*	Planned or Unplanned

B.12. Differences, if any, in what information should be included in a medication profile provided to a healthcare provider as compared to a medication profile provided to the patient/family/caregiver

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			AHCA/NCAL Comment: We believe that the patient/representative should be provided essential "Medication Profile" information they could use to safely self-administer medication after discharge as well as to deliver to their primary physician or other caregiver after discharge. These items should include at a minimum these items determined to be essential to continue the current care plan regime until a subsequent provider or physician assumes subsequent medication management and medication reconciliation responsibilities. If limited to the "Planned" or "Unplanned" discharge items we propose, then we see no differences in the "Medication Profile" information furnished to a healthcare provider as compared to that provided to the patient/representative. We note that this draft item is redundant to existing SNF regulatory interpretive guidance in the State Operations Manual tag F661 which states: Instructions to residents discharged to home For residents discharged to their home, the medical record should contain documentation that written discharge instructions were given to the resident and if applicable, the resident representative. These instructions must be discussed with the resident and resident representative and conveyed in a language and manner they will understand. B.13. Whether discontinued medications should be included in the medication profile. If included, provide suggestions of 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.) AHCA/NCAL Comment: We agree that medications discontinued within the past week (or within the current PAC setting if stay less than 7 days) should be included in the "medication profile" list in Draft Measure Specifications Section 4.1.2 for booth "Planned" and "Unplanned" transfers or discharges.			

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			B.14. Whether it is feasible and important for the patient's primary physician contact information to be included on the medication profile AHCA/NCAL Comment: The current SNF regulatory requirements at §483.15(c)(2)(iii)(A) requires that for both "Planed" and "Unplanned" transfers and discharges that this information be shall be included, and defines the information as the "Contact information of the practitioner who was responsible for the care of the resident". We request that the definition of this item be changed to reflect the regulatory definition. B.15. Whether it is feasible and important to include an assessment of a patient's ability to understand/accept his or her condition and the importance of taking medications as prescribed AHCA/NCAL Comment: No. this could be listed as an "Optional" item. See comments in Section B.11 of this document. B.16. Whether it is feasible and important for the prescriber of each medication to be identified in the medication profile AHCA/NCAL Comment: No. This could be listed as an "Optional" item. While it is important for the physician to be aware of current and recently discontinued medications, the current physician or in collaboration with a PAC provider is responsible for determining the current medication needs (including medication reconciliation activities) and can follow-up with the prior PAC provider contact as we discuss in our Section B.10 and B.11 comments related to Draft Specifications Section 4.1.2, item 20. B.17. For transfers from HHA to a subsequent provider, are there any issues with adding the response option of "NA – The agency was not made aware of this transfer timely"? Are there specific instances when this response option should be considered an			

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			allowable response? Are there specific instances when this response option should not be considered an allowable response? AHCA/NCAL Comment: We see no reason to treat "unplanned" discharges differently across PAC settings. Emergency or otherwise rapidly occurring "unplanned" transfers to emergency rooms, hospitals, other providers, or discharges to a resident's home all create significant burdens upon providers. In such situations, there may not be sufficient time to collect all 25 elements of the potential information for each medication described for these measures. If a HHA has "NA" option for information related to a "timeliness" of discharge planning preparations for the purposes of qualifying the resident transfer/discharge for an exclusion from the measure denominator, as presented in Draft Measure Specifications Section 5.8, then all PACs should have a "NA" option as well related to "unplanned" discharges. Requested feedback items related to "Route of Transmission of the Medication Profile (4 items) • Whether consumers will find value in knowing the routes by which the information profile was transmitted (e.g., verbal communication) • Whether the route of transmission information would inform consumer choice of providers/facilities • Although not required for this measure, if PAC providers would be able to transfer the medication profile electronically through their EHRs/EMRs • Sufficiency of existing health IT standards to support interoperable exchange of the medications and data elements proposed in the draft medication profile B.18. Whether consumers will find value in knowing the routes by which the information profile was transmitted (e.g., verbal communication)			

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			AHCA/NCAL Comment: No. Such information is not an indicator of the quality of the information exchanged or care provided, but instead more likely reflects current geographic and other disparities in access to health information technology beyond the control of the individual provider. For example, if a provider is in a market where there are few upstream or downstream providers with compatible technology, they would be disadvantaged by such reporting. These disparities by setting, by geographic location, and provider size are in part the result of historical government policies that provided funding to hospital-based and physician offices to establish EHR and HIO systems while ignoring providing similar support for skilled nursing and home health providers. B.19. Whether the route of transmission information would inform consumer choice of providers/facilities AHCA/NCAL Comment: We strongly oppose including potential Draft Specifications Section 5.8 Item Q1B and Section 6.8 Item Q2B into the measures. As we commented elsewhere in this document, numerous facility-level technical and environmental factors can negatively impact a provider's ability to transfer information via EHR or HIO means at a per-patient level, even if the provider has invested in, and is fully prepared to exchange such data. This reporting requirement at a per- beneficiary level of detail would be extremely burdensome and subject to much error and would provide no meaningful data about an individual provider's efforts and public reporting could be punitive. There is a significant difference between whether a provider has the "capacity" to share information through EHR or HIO technology versus whether limitations of other providers or patient preference dictates the need for information exchange via paper or verbal means at the individual patient level. Draft Specifications Section 3.3 describes the results of surveys of individual providers regarding their use of health information			

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			exchange technology. We believe that it would be extremely less burdensome and more useful for CMS to conduct provider-level "surveys" of provider use of EHRs, HIOs, paper, and verbal communication methods to transfer "Medication Profile" information to identify and target efforts to resolve remaining EHR and HIO interoperability barriers before considering including such patient-specific items that may be beyond the control of the facility at this time. Additionally, we strongly oppose such public reporting of routes of transmission as defined in Draft Specifications Section 4.1.3 as until technology funding disparities described in detail in Draft Specifications Section 3.3 and Section B.21 of this document are adequately addressed. B.20.Although not for this measure, if PAC providers would be able to transfer the medication profile electronically through their EHRs/EMRs AHCA/NCAL Comment: Yes. As we discussed earlier in our comments, we believe that the ideal and aspirational strategy to achieve the least burdensome, most useful, an most effective transfer of "Medication Profile" information at transitions of care would be through technology as defined in item 1 - EHR and item 2 - HIO of Draft Specification Section 4.1.3, and the measure should be constructed in a way that encourages technology where currently available, but implements the measure incrementally until the technological and environmental infrastructure can support universal use of technology for transfer of "Medication Profile" information. B.21. Sufficiency of existing health IT standards to support interoperable exchange of the medications and data elements proposed in the draft medication profile AHCA/NCAL Comment: No. We do not believe there are sufficient existing HIT standards, as defined in item 1 - EHR and item 2 - HIO of Draft Specification Section 4.1.3, to support interoperable exchange of the			

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			medications and potential data elements described in the draft medication profile. Our position is supported by information on current gaps specific to SNFs published in a recent Office of the National Coordinator for Health Information and Technology September 2017 report titled Electronic Health Record Adoption and Interoperability among U.S. Skilled Nursing Facilities in 2016 https://www.healthit.gov/sites/default/files/electronic-health-record-adoption-and- interoperability-among-u.s.-skilled-nursing-facilities-in-2016.pdf. Despite a lack of government support comparable to that provided to hospitals and physicians, SNFs have been reducing the technology gap (only 31 per cent do not have an EHR or HIO). However, per the ONC report, interoperability remains a huge barrier as "Nine percent of SNFs reported that their staff was able to easily integrate patient health information from outside sources into their EHR, that is, without scanning or manual entry. However, only seven percent of the facilities reported the ability to engage in all four interoperability domains." These gaps are substantial and justify judicious and an incremental approach to implementing any technology components into these potential "Medication Profile" measures. C. AHCA/NCAL Input on the Draft Measure Specifications and Data Elements Not Specifically Requested for the Two Potential Measures C.1. Draft Specifications Sections 5.2 and 6.2: "Measure Type" AHCA/NCAL Comment: We agree that these should be process measures as a direct clinical outcome cannot be attributed to successful performance. C.2.Draft Specifications Sections Section 5.3 and 6.3: "Target Populations" AHCA/NCAL Comment: We do not believe the definition is sufficient. Please specify what the term "another provider" means in Draft Specifications Section 5.3. For example, Draft Specifications Section 6.3 suggests that "hospice" is not a "provider" while Medicare policy defines			

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			"hospice" as a "provider". As you address this, would you be considering an emergency room or acute care hospital as a "provider" for this measure? If so, we reiterate our concern about the time delays and documentation burden due to the extent of the detail to be gathered and included in the "medication profile" shared with the emergency department or acute care hospital in urgent care situations. Such situations highlight the need to include only essential information as mandatory in the "medication profile" that will inform the subsequent provider/physician to review other available transfer documentation. Additionally, we believe that the current MDS reporting requirements are insufficient for the operation of Draft Specifications Sections 5.3 and 6.3. Please refer to limitations of the MDS A2100. Discharge Status item set we describe in Section C.5 below as it pertains to the ability to document discharge/transition to various locations not identified, or not uniquely identified on the MDS. C.3. Draft Specifications Sections 5.8 and 6.8: "Items Used in Quality Measure Calculation and Reporting" AHCA/NCAL Comment: As discussed throughout our comments, the time and effort involved in collecting all 25 potential items of information for each medication to include in a separate and duplicative "comprehensive summary of information" of "Medication Profile" documentation required in the patient profile at transfer/discharge, including "unplanned" events could result in delayed care and negative outcomes. Additionally, the process of verifying each element for each discharge to complete the potential new MDS items in the current technical environment is unrealistic and burdensome. See our detailed comments in Section B.19 of this document for our suggestion of an alternative approach that would eliminate the need for items Q1B and Q2B. C.4. Draft Specifications Sections Section 5.9 and 6.9: "Denominator Statement"			

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			AHCA/NCAL Comment: The denominator statement says, "All patient/resident stays/episodes…" which is inconsistent with the Draft Specifications Section 5.10 and 6.10 "Denominator Details" for SNF which state "…the total number of SNF Medicare Part A stays…" Additionally, as stated elsewhere in our comments, we do not believe the term "provider" is adequately defined. C.5. Draft Specifications Sections 5.10 and 6.10: "Denominator Details". AHCA/NCAL Comment: We strongly disagree with limiting the denominator for SNF to Part A stays only. The draft measure proposes to limit the SNF denominator to Medicare Part A stays, while the other PAC settings include other payers (e.g. Medicare Advantage, Medicaid, all payers). This approach does not reflect standardization across PAC settings as mandated by the IMPACT Act. Also, with a rapidly diminishing proportion of SNF stays being associated with Medicare Part A coverage, we believe the limited SNF denominator population described would not be reflective of the SNF's performance for most transfers/discharges. For example, a recent AHCA/NCAL evaluation of SNF MDS data indicate that from 2012 to 2017, the percentage of all SNF admissions related to Part A SNF PPS stays steadily declined from 61% to 50% and we expect this trend to continue based upon the growth of Medicare Advantage and other Alternative Payment Models (APMs). We are also concerned that the current MDS coding options are insufficient for these draft measures. Specific to Draft Specifications Section 5.10, the current MDS discharge item (A2100. Discharge Status – see below) does not currently identify "intermediate care," "home under care of an organized home health service organization," "hospice in an institutional facility," "swing bed," "Medicaid nursing facility", or "critical access hospital" as distinct discharge destinations. Including these items			

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			as described would require changes to the MDS assessment and related training materials. MDS Item A2100. Discharge Status. Complete only if A0310F = 10, 11, or 12 01.Community (private home/apt., board/care, assisted living, group home). 02. Another nursing home or swing bed. 03. Acute hospital. 04. Psychiatric hospital. 05. Inpatient rehabilitation facility. 06. ID/DD facility. 07. Hospice. 08. Deceased. 09. Long Term Care Hospital (LTCH). 99. Other. Similarly, specific to Draft Specifications Section 6.10, the current MDS discharge item (A2100. Discharge Status) does not currently identify "transitional living or home under care of an organized home health service organization" as a discharge destination. We do not understand what is meant by "transitional living" and we seek clarification as to the rationale for including "home under care of an organized home health service organization" in the denominator population of both draft measures. It is also unclear to us why "hospice" as a discharge destination is included in both draft measures but appears to be split into two types of hospice in Draft Specifications Section 5.10. In addition, and regardless of how the above items are redefined or the MDS is modified, we strongly believe that this measure denominator should not include any SNF patients whose care transitions between payers or from a bed in a certified part to an uncertified part of the same facility. In such cases, the medication documentation remains in the same facility and in many cases, the patient is being cared for by the same healthcare personnel. The draft definition does not explicitly address this concern. C.6. Draft Specifications Sections 5.11 and 6.11: "Denominator Exclusions AHCA/NCAL Comment: As we commented in Section B.17 and elsewhere, we believe that a denominator exclusion would be needed for "unplanned" discharges unless the list of 25 potential items applicable to this			

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			measure is reduced to a manageable number of mandatory items specific to "planned" or "unplanned" discharges/transfers, while additional items would be deemed "optional" for measure performance at this time until EHR and HIO interoperability barriers are overcome. C.7.Draft Specifications Sections 5.12 and 6.12: "Numerator Statement" AHCA/NCAL Comment: The "Numerator Statement" implies all "patient/resident stays/episodes" which is inconsistent with the Draft Specifications Section 5.10 and 6.1 "Denominator Details" for SNF which state "…the total number of SNF Medicare Part A stays…" Additionally, as stated elsewhere in our comments, we do not believe the term "provider" is adequately defined. C.8. Draft Specifications Sections 5.13 and 6.13: "Numerator Details" The "Numerator Details" implies all "patient/resident stays/episodes" which is inconsistent with the Draft Specifications Section 5.10 and 6.1 "Denominator Details" for SNF which state "…the total number of SNF Medicare Part A stays…" See our Section C.5 comments specific to Draft Specifications Sections 5.10 and 6.10 regarding inconsistencies between the draft discharge locations and the information currently available on item A2100 of the MDS assessment. C.9.Draft Specifications Sections 5.14 and 6.14: "Quality Measure Calculation" AHCA/NCAL Comment: We agree with the potential quality measure calculation approach. C.10. Draft Specifications Sections 5.15 and 6.15: "Risk Adjustment" AHCA/NCAL Comment:			

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			We agree the potential measures should not be risk-adjusted as the items are process measures and to not represent clinical outcomes that can be impacted by clinical characteristics or care delivery. C.11.Draft Specifications Sections 5.16 and 6.16: "Score" AHCA/NCAL Comment: We support the potential measures scoring approaches related to type (percent), interpretation (higher = better), and level of analysis (facility/agency) of measure score.			
14	05/03/18	Medication profile transferred to patient Medication profile transferred to provider	To Whom It May Concern: On behalf of the American-Speech-Language-Hearing Association, I write to comments on the draft measure specifications for two measures associated with the transfer of a patient's medication profile as required by the Improving Post-Acute Care Transformation (IMPACT) Act. Audiologists and speech-language pathologists work in the four post-acute care settings where these measures will be implemented; therefore, we have a keen interest in ensuring measures will achieve the goal of improving the quality and outcomes of care for patients while minimizing the administrative burden on facilities and clinicians. The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 198,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiologic treatment, including hearing aids. Speech-language pathologists identify, assess, and treat speech, language, and swallowing disorders. The two medication profile transfer measures cover the transfer of information from one health care setting to another (e.g., hospital to skilled nursing facility (SNF), SNF to home health) and from the facility to the patient. ASHA maintains that ensuring this	Sarah Warren, MA American Speech-Language-Hearing Association (ASHA)	swarren@asha.org	Speech-language-hearing advocacy association

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			information is transferred safely is important for uniform transition from one setting to another and to prevent adverse medical events, such as the prescription of contraindicated medicines to a patient. ASHA appreciates that two of the data elements in the patient information requirements are patient adherence strategies (e.g., alarms), patient ability to understand/accept condition(s), and importance of taking medications as prescribed. ASHA believes that assessing a patient's cognitive status to adhere to a prescribed medication regimen is critically important and appreciates its inclusion. The medication information section also includes important details, such as route of administration and special instructions. Capturing this information is important because understanding how to safely administer the medication(s) is essential, particularly for patients with swallowing complications. In addition, ASHA recommends adding to the patient information section an acknowledgment of sensory deficits, such as hearing loss and swallowing precautions, to ensure such deficits are May 3, 2018 accounted for in the dissemination of medication instructions and the mechanism for administering medications. In Section 4.1.3, Route of Transmission Item Definitions, ASHA recommends the inclusion of illustrations as a mechanism for transmitting information to patients with aphasia and dementia who may have trouble with either verbal or written instructions. ASHA is concerned about the current process in the IMPACT Act that adds new measures or items to the existing assessment tools (e.g., Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI)) that greatly increases the length and time associated with completing these assessment tools. For example, in one year the IRF PAI went from seven to 18 pages to accommodate additional data collection requirements associated with the IMPACT Act. ASHA strongly encourages the Centers for Medicare and Medicaid Services (CMS) and its contractors to not only identify new items in an effort to comply with the requirements of			

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			the law, but to also determine what items could be eliminated or streamlined to minimize the burden. Finally, ASHA maintains our concern that a measure associated with cognitive function and improvement in cognitive function has yet to be fully implemented. We recognize that CMS and its contractor are beta testing items associated with the IMPACT Act, including a measure for cognition. Unfortunately, the beta testing measures for cognition address expression and understanding, which does not capture the full range of cognitive function required to ensure quality patient outcomes. In previous comments and meetings with CMS staff, ASHA has recommended assessing cognition with assessment items found in the CARE-C tool. We remain committed to seeing this recommendation implemented as quickly as possible. Thank you for the opportunity to comment on these draft measures. ASHA remains committed to working with RTI and CMS as you continue efforts to implement the IMPACT Act. If you or your staff have questions, please contact Sarah Warren, MA, ASHA's director for health care policy, Medicare, at swarren@asha.org.			
15	5/03/18	Medication profile transferred to patient Medication profile transferred to provider	On behalf of the membership of the Pharmacy Health Information Technology Collaborative (Collaborative), we are pleased to submit comments for the Draft Specifications for the Medication Profile Transferred Measures for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies. Pharmacists are users of health IT and are supportive of interoperability standards, especially those utilizing certified EHR technology (CEHRT). The Collaborative supports the use of particular standards which are important to pharmacists for working with other health care providers, transitions of care, allergy reactions, immunization (historical and administered), immunization registry reporting, medications, medication allergies, patient problems, smoking status, reporting to public health	Shelly Spiro Pharmacy HIT Collaborative	shelly@PharmacyHIT.org	Pharmacy association

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			agencies, clinical decision support services/knowledge artifacts, drug formulary checking, and electronic prescribing. The Collaborative has been involved with the federal agencies, including the Office of the National Coordinator (ONC) and the Centers for Medicaid and Medicare Services (CMS), developing the national health information technology (HIT) framework since 2010. Although the Collaborative supports goals for enhancing HIT to improve patient outcomes, particularly with regard to interoperability, we have concerns with some of the elements in the draft specifications. The following are our comments regarding the Draft Specifications for the Medication Profile Transferred Measures. 4.1 Medication Profile This section appears to be solely documenting a medication profile to a patient; it's not tied to medication reconciliation. The Collaborative recommends that it also be connected to medication reconciliation. To be effective, it should be connected to both and be included as a data element. 4.1.1 Patient Information and 4.1.2 Medication Information The Collaborative believes the proposed data elements need to be reconciled and aligned with ONC's draft U.S. Core Data for Interoperability (USCDI) and medication reconciliation. The USDCI are based on the adopted 2015 Edition Common Clinical Data Set (CCDS) definition that also includes Clinical Notes and Provenance.1 CCDS is part of ONC's 2015 EHR certification requirements. The purpose of the USCDI is to achieve the goals established by the 2016 enactment of the 21st Century Cures Act. The Collaborative also believes it is vitally important that RTI's draft specifications			

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			should align with the Cures Act, even though the IMPACT Act is different. On April 27, CMS published five proposed rules concerning the FY 2019 prospective payment system and quality reporting programs for segments of Medicare. The most significant and comprehensive of these proposals are the Hospital Inpatient Prospective Systems for Acute Care Hospitals and Long Term Care Hospital Perspective Payment System Proposed Policy Changes (1,883 pages) and the Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule FY 2019, SNF Value-Based Purchasing Program and SNF Quality Reporting Program. In these proposed rules, CMS states the proposed changes are to implement certain statutory provisions of the 21st Century Cures Act. These proposed rules adopt USCDI. Additionally and importantly, the Medicare and Medicaid EHR Incentive Programs will become the Promoting Interoperability Programs (no longer called EHR Incentive Programs). The intent of these proposed changes is to make the transfer of health information more streamlined and interoperable. The draft USCDI Version 1 Data Classes proposes 21 data elements. RTI's proposal lists 11 and omits several data elements that are critical for health care providers, especially, pharmacists (e.g., laboratory values/results, problems, care team members, immunizations, provenance, health concerns, assessment and plan of treatment, preferred language, clinical notes).2 Each data element should have a definition or description so that health care providers know and understand what is being collected. For example, what does #24, "Patient adherence with medication therapy," mean? Is this a yes/no answer? Does it require a written explanation about adherence or non-adherence? We recommend that RTI work with the Collaborative on defining these data elements. For #10, "Patient adherence strategies," we recommend adding digital health to the list, as there are now apps for that.			

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			A key component to the medication profile is medication reconciliation, which is missing from the proposal. The Collaborative strongly recommends that medication reconciliation be included as a data element and connected to the medication profile. Capturing Data It appears there is no standardized template or mechanism proposed or recommended in the draft specifications for capturing data. How will data be collected? The Collaborative recommends that RTI review standardized templates that are currently used in HIT for the collection of health information. For example, one of the standards that the ONC included in its 2014 EHR Certification for Meaningful Use Stage 2 was the Health Level Seven (HL7) Consolidated Clinical Document Architecture (C- CDA). C-CDA defines the structure of certain medical records, such as discharge summaries and progress notes, as a better way to exchange this information between providers and patients. The draft specifications also need to ensure that standardized vocabularies are incorporated to collect clinical and drug information, including observations. As an example, how will drug allergies/intolerance be captured in a way to create a medication profile for sharing and exchanging? Based on the draft patient information list (#8 "Known drug sensitivities and reactions), it's not clear how that will be done. There has to be a method to drive the collection of these data elements. Using standardized vocabularies and notes (e.g., HL7 C-CDA) would help in that. Vocabularies that are widely used by federal agencies and health care providers are: Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT), RxNorm, and Logical Observation Identifier Names and Codes (LOINC). These standardized vocabularies facilitate the exchange of a patient's health information and enable interoperability and clear communication between systems, regardless of software and hardware compatibility.			

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			The Collaborative recommends that RTI work with standard setting organizations in this regard. Sharing Information at Transition of Care Critical to meeting the IMPACT Act's goal of "accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions…" is ensuring that the information shared is understandable. Hospitals may be able to capture electronically, but others may not be able to understand what is being received (see previous comments regarding capturing data). Additionally, a patient's medication profile that is sent to the patient or family caregiver needs to be sent in the patient's preferred language. This is not included in RTI's proposed data elements nor is how the information will be sent (e.g., paper, electronically). The Collaborative recommends that the patient's preferred language and method of sending information be included in the patient information data elements (see also comment regarding USCDI data elements). Another aspect that appears to be missing from the proposal are pharmacists, particularly, community pharmacists. The proposal focuses exclusively on skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, and home health agencies. It is vitally important that pharmacists are included as recipients of and contributors to the medication profile transferred measures. Pharmacists provide more patient care today than before, and interoperable solutions are more important now than ever. This is especially critical for transitions of care, which community pharmacists are also a part. Pharmacists play an important role at points of transition of care in assuring orders created by providers are correct, especially, in post-acute and long-term care settings. Pharmacists are involved in the transition of care and medication			

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			reconciliation for patients, making it vitally important that pharmacists have access to current problem lists at the points of transition to match medications for patients to use. This is particularly important for medication therapy management (MTM) services pharmacists provide under Medicare Part D. The Collaborative recommends that proposed medication profile transferred measures be aligned with MTM, and as mentioned previously, be included as recipients of and contributors to the medication profile. As with post-acute care (PAC) providers, pharmacists were not eligible to participate in the Medicare and Medicaid Electronic Health Records (EHR) Incentive program. Although pharmacists were not eligible for the incentive program, they have adopted and are meaningful users of health IT and EHRs. Timeframe for Completing Implementation Process The Collaborative recommends establishing an action plan to use EHRs and exchanging information and a timeframe for finalizing and implementing the draft specifications. It is not clear what the implementation plan is or how long this process will take. Although the IMPACT Act sets October 1 as the effective date, we do not believe that date is doable at this time and may necessitate asking CMS to delay that date. The Pharmacy HIT Collaborative comprises the major national pharmacy associations, representing 250,000 members, including those in pharmacy education and accreditation. The Collaborative's membership is composed of the key national pharmacy associations involved in health information technology (HIT), the National Council of Prescription Drug Programs, and nine associate member encompassing e-prescribing, health information networks, transaction processing networks, pharmacy companies, system vendors, pharmaceutical manufacturers, and other organizations that support pharmacists' services.			

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			As the leading authority in pharmacy health information technology, the Pharmacy HIT Collaborative's vision and mission are to ensure the U.S. health IT infrastructure better enables pharmacists to optimize person-center care. Supporting and advancing the use, usability, and interoperability of health IT by pharmacists for person-centered care, the Collaborative identifies and voices the health IT needs of pharmacists; promotes awareness of functionality and pharmacists' use of health IT; provides resources, guidance, and support for the adoption and implementation of standards driven health IT; and guides health IT standards development to address pharmacists' needs. For additional information, visit www.pharmacyhit.org.			
16	5/3/08	Medication profile transferred to patient Medication profile transferred to provider	On behalf of Adventist Health System (AHS), we appreciate the opportunity to comment on the measures for the Transfer of Health Information and Care Preferences When an Individual Transitions. Our organization includes 46 hospital campuses located across nine states and comprises more than 8,200 licensed beds. AHS provides inpatient, outpatient and emergency room care for four million patient visits each year. The Center for Medicare and Medicaid Services (CMS) seeks feedback on two proposed measures that are a part of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. Our comments are responding to the four areas addressed in the Medication Profile Transferred Draft Measure Specifications document. These areas are: • Medication Profile Transferred to Provider Measure • Medication Profile Transferred to Patient Measure • Medication Profile • Route of Transmission **Medication Profile Transferred to Provider Measure** The purpose of this measure is to improve the timely transfer of a current medication profile to other providers. The measure calculates the proportion of the transfer of a medication profile to another provider for all patient or resident stays. The measurement	Marissa Lopez Adventist Home Health System	Marissa.Lopez@AHSS.ORG	Home health system

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			would take place when a patient or resident is discharged or transferred to another facility. **AHS supports the adoption of this measure and believes that it will improve care coordination and communication between health care providers.** Additionally, we believe this measure could be improved by capturing the amount of time the transmission of records takes to get to another provider. The best clinical decisions can only be made if providers have access to the most relevant and timely data. Although the measure requires post-acute providers to send the medication profile at the time a patient is discharged or transferred to another facility, the route of transmission will affect the timeliness of the transfer. As the measure is currently written, a provider will be scored as successful for transferring the information, regardless of whether the records are delivered in a day or week. We recommend that CMS consider a mechanism to track the timeliness of the transmission of records. Doing so will allow this measure to be more meaningful and better aligned with its purpose—to improve the *timely* transfer of a medication profile. **Medication Profile Transferred to Patient Measure** The purpose of this measure is to improve the timely transfer of a current medication profile to patients, families and caregivers. This measure calculates the proportion of all patients, family or caregivers that were provided a medication profile. This measurement would take place when a patient or resident is discharged or transferred to another facility. **AHS supports the adoption of this measure because it will give patients and their families better access and control over their medical records.** To ensure the meaningfulness of this measure, AHS recommends that CMS revise the routes of transmission allowed for this measure. Many post-acute patients are seniors who do not have the sufficient computer literacy to access an Electronic Health Record (EHR). In addition, many have a variety of mental health illnesses, such as dementia or Alzheimer's, that may limit their ability to retrieve the medication profile electronically. We recommend that the options for the route of transmission be			

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			modified to consider the previously mentioned limitations. For example, the EHR option should either be excluded or used in combination with another route. **Medication Profile** CMS developed a medication profile that lists patient information for the current prescribed and Over the Counter (OTC) medications, nutritional supplements, vitamins and homeopathic and herbal products Adventist Health System administered to the patient or resident. It also includes information about the patient that is relevant to the medications. AHS commends CMS for developing a comprehensive patient profile. As requested, we have provided our feedback on a number of the questions listed on pages 9-10 of the Medication Profile Transferred Draft Measure Specifications document. ***Types of medications to be included in the medication profile.*** We ask CMS to clarify if the medication profile would have information about opioid medication. If so, the timeliness of the transfer of such information would be even more important to prevent the potential of inappropriate use of opioids. ***Whether the medication profile description captures the most important sources of medication profile information.*** AHS recommends that the medication profile captures a patient's ability to self-administer medication. Patients in Post-Acute Care (PAC) facilities often lack the cognitive ability or dexterity to take medication on their own. Therefore, the medication profile should include an element that captures whether the patient is able to take the top off a medication on their own. This is currently done in Long Term Care facilities that use a self-administration competency assessment. This would help the clinical staff provide the necessary resources for patients to adhere to their medication regime. ***Whether discontinued medications should be included in the medication profile. If included, provide suggestions of parameters for inclusion in the medication profile (e.g. medications that were initiated and discontinued during the PAC stay, or medications***			

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			discontinued within the past week, etc.). Discontinued medications should not be included on the medication profile given to patients. While PAC providers may benefit from this information, it may lead to confusion among patients and cause them to take additional medications that negatively impact their health. If discontinued medications are included for the patient profile, we recommend that this be given only to providers. ***Whether it is feasible and important for the patient's primary physician contact information to be included on the medication profile.*** Adventist Health System Comment Re: Medication Profile Measures April 16, 2018 Page 4 Including the patient's primary care physician contact information in the patient profile would be helpful for providers to improve care coordination. ***Whether it is feasible and important for the prescriber of each medication to be identified in the medication profile.*** Including the prescriber of each medication would be unnecessary in a clinical care setting and cause additional burden and confusion. ***For transfers from an HHA to a subsequent provider, are there any issues with adding the response option of "NA – The agency was not made aware of this transfer timely"? Are there specific instances when this response option should be considered an allowable response? Are there specific instances when this response option should not be considered an allowable response?*** AHS recommends that this element be removed from the patient profile. We believe there would *not* be a specific instance where this option would be applicable. If this measure is implemented, CMS would need to define "timely" to ensure the accuracy and standardization of reporting. **Route of Transmission** The medication profile needs to be delivered in a meaningful way to both the provider and the patient. We commend CMS for exploring how the routes of transmission will affect how patients			

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			and providers receive information. The feedback that CMS requests on the route of transmission is provided below. ***Whether the route of transmission information would inform consumer choice of providers/facilities.*** AHS does not believe that this measure would affect consumer choice because a list of providers and/or facilities from which the patient can choose from, is not included. Additionally, the providers discharging the patient will determine the route of transmission, not the patient. ***Although not required for this measure, if PAC providers would be able to transfer the medication profile electronically through their EHRs/EMRs.*** Currently, most PAC providers do not have the software capability to track patient medications through their EHRs/EMRs system. In addition, many of these providers do not have any patient portals developed. The route of transmission between PAC facilities would likely be a paper-based method. ***Sufficiency of existing health IT standards to support interoperable exchange of the medications and data elements proposed in the draft medication profile.*** Interoperability does not currently exist in the PAC setting. Providing the medication profile through EHRs/EMRs will be difficult due to the multiple software used by providers. **Conclusion** AHS welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like additional information, please contact Julie Zaiback-Aldinger, Director of Public Policy and Community Benefit, at Julie.Zaiback@ahss.org.			
17	5/3/18	Medication profile transferred to patient	The Alliance for Nursing Informatics (ANI) advances nursing informatics leadership, practice, education, policy and research through a unified voice of nursing informatics organizations. ANI has reviewed the request for comment issued by CMS asking for	Ragnhildur I. Bjarnadottir, MPH, PhD, RN	rib@ufl.edu	Nursing informatics association

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		Medication profile transferred to provider	input on the CMS IMPACT Act Quality Measures. In that spirit, we offer our comments as nursing stakeholders. ANI fully endorses the objective to promote transmission of medication information for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, Hospice and Home Health Agencies via the two quality measures of "Medication Profile Transferred to Provider and Medication Profile Transferred to Patient". In addition, we endorse the objective of transferring medication profiles to patients being discharge to their private home, as this is a particularly vulnerable time when errors may be more likely to occur and less likely to be detected. **Overall comments** *Patient perspective* ANI appreciates the emphasis on including patient-centered information but finds that the topic of care preferences could be more strongly addressed in the reviewed document. We were concerned that we were unable to find information of whether any of the alpha 2 pilot testing was conducted from a patient perspective. As written, the example of assessment items in Q2A for when medication profiles are transferred to patient provide a weak minimum for promoting patient safety. For example, it does not assess patient understanding, patient ability to follow instructions or whether the lists were provided using medication terms familiar to patients (e.g. generic vs. brand). In the same vein, the inclusion of patient portals as a source of data as well as a route of transmission for medication profiles is important to ensure the inclusion of the patient at every stage. ANI commends the thorough attention to Provider-to-Provider accountability in information transfer but emphasizes the importance of including Provider-to-Patient accountability, not only at discharge but throughout the care trajectory. *Inclusive language*	Alliance for Nursing Informatics (ANI)		

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			Additionally, ANI strongly recommends clear inclusivity in language and data attribution to nurses and other care providers in inter-professional teams. Our healthcare environment is changing rapidly, and as an example nurse practitioners now have prescriptive authority in all 50 states. Keeping this in mind, ANI emphasizes that the development of improved quality measurement and public reporting will not be effective if the measures are not inclusive of all care team members Finally, we highlight the dependency between, and need to align, these proposed measures and standardization of patient assessment data elements for Post-Acute Care (PAC) settings for care coordination and interoperability. Implementation of a core set of standardized patient assessment data elements (SPADES) across PAC settings for the currently used assessment instruments will enable fuller comparability of PAC assessment data and has important implications for Medicare beneficiaries, families, providers, and policymakers alike. Existing efforts to develop standardized assessment data elements for PAC settings that meet the requirements of the 2014 IMPACT Act, include a requirement to increase reliability, feasibility, usability, and use for the two CMS IMPACT Act Quality Measures. ANI fully supports existing efforts to guide data item standardization around the following areas: cognition and mental status; medication reconciliation; care preferences; pain (medical condition); and impairments in hearing, vision, and continence. These data elements are critical to both measures. Standardized assessment items will contribute to assessment data comparability across PAC providers, data exchange and interoperability, care coordination, payment analysis, and longitudinal outcome analysis. ANI fully supports use of existing clinical standards including ANA recognized interface terminologies and reference terminologies to ensure information continuity across settings, including patient-facing communication. **Measure titles** ANI applauds the inclusion of patient preferences into this measure and recommends that the title of the measure communicates the			

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			breadth of information included. ANI suggests consideration of including the term preferences in the measurement name. **Measures and Specifications** These two measures address gaps and disparities in care supporting CMS quality priorities by ensuring transfer of health information and care preferences to providers, patients and their caregivers, thereby improving post-acute care in accordance with the IMPACT Act. These measures address high impact areas related to safety, while also addressing a key priority shared by both patients and providers: promotion of effective communication and coordination of care. Given the apparent and obvious need for communication of the medication profile between settings, providers, and patients, as defined for this measure, there appear to be no exclusions. A fundamental component of these measures rests upon the development, implementation, and maintenance of standardized patient assessment data elements for PAC settings to facilitate care coordination, interoperability, and improve patient outcomes. With few exceptions, the data elements used in the instruments (MDS, IRF-PAI, LCDS, and OASIS), are not currently standardized nor interoperable. Although the concepts are similar, the individual items vary, which will place increased documentation burden on providers, while potentially compromising feasibility, usability, and use across settings. If an instrument is used by one setting (MDS) and is then communicated to another setting that uses LCDS, it may cause confusion in interpretation and subsequently place extra burden on the receiver to harmonize the different data elements. In addition to these aforementioned measures/instruments (i.e. MDS, IRF-PAI, LCDS, and OASIS), numerous relevant clinical standards (e.g. SNOMED--CT, LOINC, RxNORM) are mandated for interoperability and exchange of medication-related information. Further, the HL7 CCD-A document standards are intended to facilitate transfer of information about medications. The use of existing clinical and interoperability standards should be included when considering the potential development of these and future measures in order to reduce			

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			documentation burden and automate data collection for quality measure and public reporting. ANI strongly endorses the development of quality measures to address medication profiles transferred to patients in particular. ANI anticipates such a measure can have a significant impact on improving care quality and patient satisfaction, and supporting shared decision making. However, ANI wants to highlight two additional considerations for this measure that are specific to information transfer to patients. Firstly, the current measure only addresses patients when they are discharged or 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". ANI emphasizes the importance of including the patient and family and providing them with information at every transition within the care trajectory, including: 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. Secondly, ANI underscores the importance of ensuring that information given to patients and families is clear and readily understood by them. This requires additional efforts to map SPADEs across PAC settings to terms and codes that can be understood and accepted by patients of varying backgrounds, education and literacy levels. **Medication profile** *Definition of medication profile* ANI appreciates the comprehensive definition of a medication profile, and the explicit inclusion of supplements, homeopathic and herbal remedies. Overall, ANI emphasizes the need for more detailed definitions of the terms and concepts included in the medication profile. ANI endorses the inclusion of the data sources mentioned in the document, and emphasizes the importance of including both patient portals and other patient-reported data, as well as relevant nurse documentation, such as documentation of medication reconciliation.			

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			Data elements ANI strongly endorses the inclusion of patient preferences for packaging or consumption as a data element, but finds that this element was only modestly addressed in the document. ANI emphasizes the importance of carefully considering how care preferences are defined and how they can be captured across settings, particularly in the context of the person-defined preferences and the digital divide. Similarly, ANI agrees that it is important to include adherence strategies and a patient's ability to understand and accept their condition as data elements. However, to accomplish this will require a clearer definition of these terms, as well as addressing how this data can be accurately captured across settings. Finally, there may be some overlap in these three data elements (patient preferences, patient adherence strategies, patient ability to understand/accept condition(s) and importance of taking medications as prescribe) without clearer definitions. ANI strongly endorses the inclusion of information about when the last dose of the medication was administered by discharging/transferring provider and finds that this data element should not be designated "if applicable". Similarly, ANI emphasizes the importance of patient education and recommends that the data element "Patient education provided about potential risks/side effects/contradictions and when to notify prescriber" be included in all transfers, not only when the profile is provided to patients and families. ANI strongly endorses the inclusion of recently discontinued medications in the medication profile, along with rationale for discontinuation. It is particularly important for patient safety to communicate when a medication has been initiated and discontinued due to ineffectiveness, patient reported symptoms or adverse outcomes. ANI recommends that this policy measure should include or reference a resource that defines each of the medication information terms for clarity across settings and across diverse care team members. ANI further recommends that the name and strength of medication be listed as two separate data elements. Similarly, ANI recommends the separation of purpose, indications and contraindications into three separate			

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			elements. Further, ANI recommends that at each transfer, any medication that is to be stopped, started or continued should be captured and shown. Finally, ANI emphasizes the importance of consistency between concepts discussed in the definition and overview of medication profile and the data elements listed. **Route of transmission of the medication profile** Overall, we concur with the definitions provided for route of transmission of the medication profile. However, we note two areas that require greater emphasis. Firstly, more attention within the proposed measure is warranted to describe the patient portal as an information source, with complete information of the medication profile. Secondly, documentation sources mentioned, such as discharge summary records, a Medication Administration Record (MAR), Intravenous Medication Administration Record (IVAT), home medication list, and physician orders, should be more closely aligned with the routes of transmission described, as the available or appropriate transmissions routes may vary across documentation sources. In summary, ANI supports the spirit and intent of these proposed measures with greater attention to the capture of care preferences, the role of patient portals, Provider-to-Patient accountability, inclusivity in language for inter-professional teams, and gaps in existing standards to support operationalization of these measures. ANI commends CMS' careful consideration of these quality measures and appreciates the opportunity to contribute to the conversation on this important topic for a safe, high quality healthcare system that puts patients first. We are available and interested in supporting future public responses on this public health safety issue. Sincerely, Charlotte Weaver, PhD, RN, MSPH, FHIMSS, FAAN Mary Beth Mitchell, MSN, RN, BC, CPHIMS ANI Co-chair ANI Co-chair			

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			Email: caweaver2011@gmail.com Email: marybethmitchell@texashealth.org The Alliance for Nursing Informatics (ANI), cosponsored by AMIA & HIMSS, advances nursing informatics leadership, practice, education, policy and research through a unified voice of nursing informatics organizations. We transform health and healthcare through nursing informatics and innovation. ANI is a collaboration of organizations that represents more than 5,000 nurse informaticists and brings together 25 distinct nursing informatics groups globally. ANI crosses academia, practice, industry, and nursing specialty boundaries and works in collaboration with the more than 3 million nurses in practice today.			
18	5/3/18	Medication profile transferred to patient Medication profile transferred to provider	The National Association for Home Care & Hospice (NAHC) is the nation's largest trade association representing home health and hospice agencies including Visiting Nurse Associations, government-based agencies, multi-state corporate organizations, health system affiliated providers, and freestanding proprietary agencies. NAHC members serve several million Medicare home health and hospice beneficiaries each year. NAHC appreciates the opportunity to submit the following comments on the cross-setting post-acute care transfer of health information and care preferences quality measures. **Section 4: Definitions and Acronyms Medication profile** NAHC recognizes that many of the data elements included in the medication profile may provide valuable information; however, the desire to gather comprehensive information in a medication profile must be balanced with the burden for providers to collect the information. Only those elements that are required to be on a Medication profile should be included. **Patient information**: Items 9-11 should be eliminated. Receiving providers will ascertain this information as part of the admission and evaluation process, and not likely rely on the medication profile for the information. Therefore, in most cases, including the information on a medication profile will be extraneous, leading to	Mary K. Carr, VP, Regulatory Affairs	mkc@nahc.org	National Home care and hospice trade association

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			an unnecessary collection burden. Additionally, items 9-11 are unnecessary information for a medication profile provided to patients/caregivers. 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 **Medication Information:** • Eliminate or clarify item 16. "Directions". The difference between item 16 "Direction" and item 17. "Special instructions" is unclear. • Item 18. "Reason for holding …." should be, if applicable. Also, there is not a distinction in the item between whether a dose was held, or an entire medication category might have been held. • Eliminate item 20. "Prescriber" this item does not provide valuable information to either the receiving provider or the patient/caregiver. • Item 24. "Patient adherence ….." should be, if applicable. Facility providers will not likely know this information since medications are administered to patents and might not be relevant when a HHA transfer a patent to a facility. The item should not be included the medication profile provided to a patent/caregiver. **Route of Transmission:** NAHC does not support including this question as part of the comprehensive assessment. There is no correlation between the route of transmission and quality of care provided by post-acute			

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			care providers. CMS plans to publicly report the route of transmission by the individual post- acute care providers, claiming it is important for consumers, stakeholders, and policy makers to understand how the information is being transmitted in transitions of care. However, it is unclear why it is important for the public to have this information or what the public might gain from having the information .The value placed on any of the routes of transmission will depend on an individual's abilities, resources, and preferences. It cannot be assumed that one route is preferred above another, and therefore, reporting the route of transmission without context is not meaningful. **Section 5: Measure #1: Medication Profile Transferred To Provider Measure Specifications and Measure exclusions** Home health agencies may indicate if the agency was not able to provide a medication profile at transfer to a subsequent provider if the agency was not made aware of the transfer timely. NAHC supports this option for HHAs but is concerned that if this option is not accounted for in the measure calculation, the measure rate for HHAs could be artificially low. Unlike the facility-based providers, some portion of HHA patients might not receive a medication profile at transfer for reasons out of the agency's control. This could have unintended consequences for HHAs when used as a cross setting measure with other post- acute care providers. **Recommendations:** Exclude any patient from the measure calculation where a HHAs reports in Q1A, option 3 - NA (home health transfer only) –The agency was not made aware of this transfer timely. **Section 6: Measure #2: Medication Profile Transferred to Patient Measure Specifications Target population** The target population includes 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. It is unclear why a patient/caregiver when being admitted to home health or hospice			

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			is required to receive a medication profile. The patient would continue to receive care of by another health care provider. **Recommendation:** Exclude the requirement to provide the patient/caregiver with a medication profile when care will continue to be provided by a home health agency or hospice. Please do not hesitate to contact me with any questions.			
19	5/3/18	Medication profile transferred to patient Medication profile transferred to provider	To RTI International, Abt Associates, and the Centers for Medicare and Medicaid Services: On behalf of Gundersen Health System, we are writing in response to the request for comments relating to various policies, programs, and proposals in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) proposed measure changes. In this letter, we address the continued implementation and measure changes of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) and its impact on Skilled Nursing Facilities (SNF), Inpatient Rehabilitation Facilities (IRF), Long-Term Care Hospitals, and Home Health Agencies. In addition, we provide feedback on the two proposed measures regarding medication profile transfers, and comments on how patient information is distributed. Gundersen Health System is an integrated health system providing services throughout nineteen counties in western Wisconsin, southeastern Minnesota and northeastern Iowa. Our system includes a primary hospital in La Crosse, four critical access hospitals and over 50 clinics throughout the region. With over 7,000 employees, we are the largest employer in the region. As a Healthgrades Top 50 hospital in overall care, clinical specialty services, and patient experience, we are committed to supporting public policy that helps to enrich every life through improved community health, outstanding experience of care, and decreased cost burden.	Liz Rogers Gundersen Health System	emrogers@gundersenhealth.org	Health care system

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			We are pleased to offer comments for the IMPACT Act measure changes illustrated and detailed in the following sections. Proposed IMPACT Act Measure Updates Comment: • Gundersen is appreciative and applauds CMS's commitment to scale back the scope of data collection and reporting associated with the transfer of health information quality measure. Transfer of Health Information. The Transfer of Health Information measures were issued in November 2016, encompassing a far wider range of patient data elements beyond medication information, including but not limited to functional and cognitive status, medical conditions and comorbidities, and discharge instructions. In addition, one of those measures also proposed to hold PAC providers accountable for the information transfer behavior of upstream referral sources, which the providers have little ability to influence. Hence, we appreciate the agency's consideration of the stakeholder feedback it received in response to the first iteration, and we think the revised measures address several prior concerns. Comments: • Gundersen supports both new proposed measures, the Medication Profile Transferred to Provider and the Medication Profile Transferred to Patient. However, we request CMS clarify and revise the duplicative aspects of the documentation. A quality measure for the purpose of sharing information oversteps what is practical in health administration, and what is in the patients' best interest. These measures seem to be in conflict with CMS's goal to scale back data collection as mentioned in the previous section. Medication Profile Transferred to Provider. 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			

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			that the patient/resident was discharged or transferred. 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. Medication Profile Transferred to Patient. 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. 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 Additional questions Gundersen has for CMS regarding the new measures: • How will CMS collect Medication Profile data elements? Will they be classified as standardized patient assessment data elements (SPADEs) and thus be mandatory reporting on PAC patient assessment instruments pursuant to the QRPs' data completion thresholds? • If so, would the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) need to be revised to include medication information? This would be duplicative information and circumvents CMS's goal to cut back data collection. • How would the measures integrate with medication reconciliation or discharge planning processes already in place at IRFs and other hospitals? • What are the qualifications of clinical personnel allowed to complete the Medication Profile? Revisions of the Medication Profile Definition CMS is proposing to define a Medication Profile as a "comprehensive summary of information for the current			

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			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". 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 twenty-five applicable data elements including patient information and complete medication information. Comment: • While we support some of the revisions of the Medication Profile Definition, we have concerns regarding certain profile items. IRFs already communicate the twenty –five data elements through medication reconciliation, discharge planning processes, or other clinical practices. Information is located in sources such as the discharge summary, a Medication Administration Record (MAR), home medication lists or the physician orders. We think a Medication Profile, for the purposes of a cross-setting PAC standardized IMPACT Act measure, should focus on the core and essential medication information, and not duplicate the comprehensive summary of medication information IRFs already communicate to subsequent providers and patients. We suggest that a cross-setting Medication Profile concentrating on the core or essential medication information could be defined as: "A medication profile is a patient-specific list of prescribed medications the transferring/discharging care team intends the patient to continue taking upon transfer/discharge, including			

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			sufficient detail (dose/frequency/end date, if predetermined) to allow the profile to guide subsequent patient/provider behavior." Below, we have evaluated the proposed Medication Profile data element items and provided comments and suggestions to avoid duplication and overburdening information:			

Proposed Medication Profile Item	Gundersen Comments and Recommendations
Patient Information on the Medication Profile	
1. Patient name	We support including this item.
2. Patient date of birth	We support including this item.
3. Primary physician name and contact information	We recommend CMS revise this item to refer specifically to the PAC physician overseeing the patient transition, since they will be whom the downstream physician would need to contact regarding information in the Medication Profile. As the item is currently written, it is unclear if "primary physician" refers to the patient's primary care physician, the primary physician at the PAC setting, or the attending physician from an upstream acute care hospital.
4. Height and date taken **If applicable*	Because these data are already included elsewhere in the medical record or discharge summary, we would not support their additional inclusion in a Medication Profile.
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	We recommend these items be collapsed into one and limited to "Known medication allergies and intolerances." For instance, some medications have known side effects such as nausea or discomfort, but that should not be misinterpreted by the next site of care as a reason to not administer the medication. We are concerned that requiring providers to document all known sensitivities and reactions on the Medication Profile could result in unintended misinterpretations. A required Medication Profile list should be focused to those pieces of clinical information on which there is uniform consensus on their importance.
8. Known drug sensitivities and reactions	

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			9. Patient preferences (e.g., preferred packaging such as no childproof lids, form of medication such as time-released medication, how medication information is provided to patient) **If applicable*	We do not support including these items because the subsequent care setting will prepare the patient's medications and hence these types of "patient preferences" would not be highly useful or meaningful. For example, if a patient is at home and receiving prescriptions from a pharmacy patient preferences regarding packaging is kept on file at the outpatient pharmacy. In addition, medication formulation like 'time release' is not a patient preference, but rather a clinical decision made by the provider. We recognize that the IMPACT Act requires CMS to collect data on care preferences, however we encourage the agency to determine and define other care preferences data items that would be much more meaningful to patients and providers.			
			10. Patient adherence strategies (e.g., alarms, drug diaries) **If applicable*	We do not support including this item in the Medication Profile. These are medication management strategies better reflected in the patient's comprehensive care plan. They are not suited for the Medication Profile which should be focused on transmitting essential medication information.			
			11. Patient ability to understand/accept condition(s) and importance of taking medications as prescribed	We do not support including this item. It assesses a patient's cognitive function and their ability to understand the information being presented, and hence is outside the scope of Medication Profile. IRF already have discharge planning processes for a clinician to review the medication list with patients/family/caregivers and take the necessary steps to ensure that they understand it.			
			Medication Information Items – To Be Completed for Each Medication				
			Proposed Medication Profile Item	**Gundersen Comments and Recommendations**			
			12. Name (generic and proprietary names if applicable) and strength	We support the intent of this item but recommend that it be changed to "Name (generic only **OR** proprietary names) and strength." This item should focus on communicating a drug name and not become a recitation of all of the drug's known identifiers. Various national standards indicate that medications should not be referred to by brand name only.			

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13. Dose	We support including this item.
14. Route of medication administration	We support including this item.
15. Frequency	We support including this item.
16. Directions	We support including this item.
17. Special instruction **If applicable*	We support this item being If applicable.
18. (For held medications) Reason for holding medication and when medication should resume	We support including this item. It is critical to accurately document those drugs that are part of the patient's routine medication regimen but were temporarily held/suspended, and need to resume at a later date. These medications and their resumption dates should be highlighted for the next site of care in the Medication Profile.
19. Purpose/Indications/Contraindications	We recommend CMS revise this item to "Purpose (i.e., condition being treated)" and remove "Indications/Contraindications."
20. Prescriber (for prescribed medications only)	Similar to Item #3, we request CMS revise this item to refer specifically to those medications prescribed by the PAC physician when the patient was under their care.
21. When the last dose of the medication was administered by discharging/ transferring provider **If applicable*	While we agree that this is a key piece of information, the specific timeliness of administered drugs is better captured through a MAR than in the Medication Profile. Furthermore, we are concerned that retaining this item could unintentionally structure the Medication Profile to become a prescriptive protocol that must be completed as close to the point of discharge as possible, so as to capture the most current data. However, this would defeat the purpose of having the Medication Profile be completed in a comprehensive and deliberate manner, which is an especially relevant consideration for those providers using paper medical records.
22. When the final dose of the medication should be given **If applicable*	We recommend this is combined with Item #15 - Frequency and be an optional field, e.g., "Frequency (including planned stop date/when the final dose should be given, if known)".
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	We do not support including these items in the Medication Profile. These are medication management strategies better reflected in the patient's comprehensive care plan, and are not suited for the Medication Profile which should be focused on transmitting essential medication information.

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			25. Relevant lab test results to guide medication management (e.g., serum creatinine) **If applicable* — We do not support including this item in the Medication Profile. Providers have different routines regarding lab tests so there would be a high degree of variance in institutional practices that would not lend itself to meaningful reporting on a standardized reporting item. In addition, this item detracts from the value of the physician's clinical judgement since it is not a standard of practice for physicians to base their orders solely on lab results. Aligning Item Responses across PAC Settings Comment: • We recommend CMS revise the Not Applicable (NA) option for the Medication Profile Transferred to Subsequent Provider and make it available as a response for all PAC settings. For measure Q1A, CMS proposes a response option that is available only to HHAs as follows: **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? 1. Yes – Current medication profile provided to the subsequent provider 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.(emphasis added)* The Not Applicable (NA) option should not be limited to HHAs since patients in other PAC settings also experience unexpected discharge/transfers when they return to the acute care hospitals due to an emergent incident. This is recognized as the "interrupted stay" payment adjustment under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). In these cases, the IRF will certainly prioritize the patient's timely transfer to the necessary care setting, and it would be inappropriate for CMS to hold providers accountable to a reporting process over patient well-being.			

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			Transfer of Patient Information The proposed communication platforms (electronic medical records, health information exchange, paper, verbal) are appropriate and we do not have recommendations regarding these routes. To address CMS' questions to stakeholders on this topic, we offer the following feedback: • Consumers will not find high value in knowing the routes by which their medication profile was transmitted, nor is this information likely to inform their choice of PAC providers. There are many other criteria – such as quality and outcomes of care, location/proximity, etc. – that are far stronger drivers in a patient's decision regarding PAC providers. • The existing health IT standards do not support interoperable exchange of medication data elements. Even if a discharging provider/facility is able to electronically transmit medication (and other types of) information to a provider downstream, it is often the case that the second provider cannot receive and integrate the data into their EMR. The IMPACT Act recognizes the extant interoperability challenges and thereby mandates CMS to make interoperable standardized patient assessment and quality measurement data, as well as other measures and uses. CMS is already undertaking this work via its Data Elements Library (DEL) project, and Gundersen looks forward to engaging with the agency regarding efforts in this area. Conclusion On behalf of Gundersen Health System, we appreciate the opportunity to comment on the proposed measures for the IMPACT Act and share our thoughts on information transfers. We strongly support quality improvement and value-based care design and hope our comments provide a bridge to improve and advance existing programs. If you have any questions or need clarification, please feel free to contact us. We appreciate the outreach and look forward to			

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			continue working with the agency to better improve health policy for our patients and communities.			
20	5/3/18	Medication profile transferred to patient Medication profile transferred to provider	On behalf of the Association of Rehabilitation Nurses (ARN) – representing more than 5,000 rehabilitation nurses and more than 13,000 Certified Registered Rehabilitation Nurses (CRRN) that work to enhance the quality of life for those affected by physical disability and/or chronic illness, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) quality measure to satisfy the Improving Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions - Medication Profile Transferred to Provider / Medication Profile Transferred to Patient. **Overview of Rehabilitation Nursing** Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. Rehabilitation nurses base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/SNFs, long-term acute care facilities, comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and private practices. Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, and spiritual needs. We begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness and continue to provide support and care, including patient and family education, which empowers these individuals when they return home, to work, or to school. Rehabilitation nurses also often teach patients and their caregivers how to access systems and resources.	Sarah Nichelson, Association of Rehabilitation Nurses.	snichelson@rehabnurse.org	Advocacy

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			ARN supports efforts to ensure that people with physical disability and chronic illness have access to comprehensive quality care in the care setting that is most appropriate for them. Specifically, as a part of its mission, ARN stands ready to work with policymakers at the local, state, and federal levels to advance policies and programs that promote maximum independence for people living with physical disability and/or chronic illness. ARN supports new and existing quality measures that are clinically relevant and patient centric. Quality measures should not be overly burdensome for rehabilitation nurses and should be true quality indicators that are aligned across post-acute care (PAC) settings. **Measure Justification** *3.3 Background and Current Gaps* ARN thanks the agency for recognizing that "…PAC providers were not eligible to participate in the Medicare and Medicaid Electronic Health Record Incentive Programs and lag behind hospitals and physician offices in both EHR and HIE adoption." Here, the proposed measures appropriately list verbal and printed materials as an acceptable route of transmission. These two additions allow rehabilitation nurses to accurately document and provide follow-up care to their patients in the absence of an EHR and HIE. Another reason why verbal and printed materials should be an acceptable route of transmission is because institutions may have different EHR systems that are unable to exchange data. Another note to make about current gaps of acute setting transfers is that a primary care physician (PCP) rarely attend to hospitals or skilled nursing facilities for these patients. Acute and post-acute team members are relied upon to manage the patient. Additionally, PCPs are not consistently receiving the new medication regime. There are instances when a patient enters a rehabilitation facility with too many medications and the medication documentation changes are not consistent. There is a current focus on psychotropics in the elderly patient population, especially those patients with dementia. Frequently,			

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			hospitals will use antipsychotics on the elderly who "get confused and wander" but will not discontinue these medications when the patient is transferred to a PAC setting. Psychiatrists, psychologists and mid-level providers in acute settings should be a part of the conversations when it comes to medication recommendations for psychotropic medications. **Medication Profile** *4.1.1 Patient Information* ARN thanks CMS for its commitment to ensuring that a provider transfers important medication information at transitions. Accurate medication profile information helps keep a patient medication compliant, thereby reducing 30-day re-admission rates. In general, the data measures marked "if applicable" *should* be applicable captured data points in the medication profile. For example, capturing weight is an important in dispensing cardiac medications In particular, the data point "patient adherence strategies" should not be marked "if applicable" and should be captured for the medication profile. In a recent retrospective study, 20.0% of patients with combined low and intermediate adherence rates were re-admitted to the hospital. Only 9.3% of patients with a high adherence rate were re-admitted to the hospital. Other studies have estimated that between 33% and 69% of hospitalizations were related to medication non-adherence and cost up to $100 billion in additional health care costs. However, note that if a patient is taking a medication "as needed," it may not be necessary to collect this data point. Another note to make about patient adherence strategies is that it may be prudent to collect information on *why* the patient is in non-compliance with their medication regime. In addition to the current suggested data points, to collect, ARN suggests that CMS add the following data elements to the medication profile:			

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			1. Presence of support system (spouse, partner, children, and/or parents who are able to learn and are willing to participate in learning care and providing care); 2. Finances (does the individual qualify for aid such as low-income subsidy or have private funds to assist with care or is there a family/caregiver with the ability to stay home with the individual; how will the individual obtain equipment not covered under Medicare); 3. Physical ability of the caregiver (e.g. age of caregiver, presence of impairments in caregiver, weight and medical condition of caregiver) (if applicable); 4. Living conditions and home access (if applicable); 5. Community resources available for respite (if applicable); 6. Race 7. Ethnicity 8. Dual eligibility for Medicare and Medicaid (if applicable); 9. Cognition; and 10. Presence of pre-morbid assistance with self-care (if applicable) *4.1.2 Medication Information* ARN appreciates the comprehensive data points in the medication information profile. We also appreciate that the actual standardization questions are simple. However, there may be some feasibility issues in collecting all of the medication profile. Here, the feasibility of collecting this information will depend on the setting and situation. In acute care, inpatient rehabilitation, and skilled nursing facilities will often receive medication information from a medical surgical or neurology unit. The patient may not have been in a certain unit long enough for the hospital to gather the data points for medication information to pass on to the acute care setting. It may be difficult to obtain every piece of the data points and document them consistently. *4.1.3 Route of Transmission Item Definitions*			

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			ARN thanks the agency for its comprehensive route of transmission item definitions. However, ARN notes that the route of transition information varies depending on the provider and whether the PAC is in a health system or not in a health system. Medication reconciliation discrepancies can arise, for example, when the patient is being transferred from a hospital unit to the skilled nursing facility unit. There may be too many physicians reconciling medications. Note that in electronic health care sharing across the Health Information Exchange, expired or discontinued medications and data points may have nothing to do with PAC level of care. Discontinued medications and data points tend to create more work for PAC providers if it remains in the import across the exchange to the PAC setting. This complicates admission. Unfortunately, hospitals are also including these discontinued medication changes in the papers going home with patient. Then, the skilled nursing facility admits the patient a week later due to medication non-compliance and the associated side effects. **Conclusion** ARN very much appreciates the opportunity to provide comments to CMS regarding measures to satisfy IMPACT Act domains. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement quality measures that ensure continued access to quality care for Medicare beneficiaries with physical disabilities and/or chronic disease. If you have any questions, please contact me or have your staff contact our Health Policy Associate, Jeremy Scott (jeremy.scott@dbr.com or 202-230-5197). We thank you for your consideration of our concerns, recommendations, and requests.			
21	5/3/18	Medication profile transferred to patient Medication profile	Measure— Quality measure: transfer of health information and care preferences … medication profile transferred to provider …. I am submitting comments as an individual:	Kathleen Mikrut Director of Pharmacy Services RML Specialty Hospital 5601 S Countyline Rd Hinsdale, Il 60521	KMikrut@rmlspecialtyhospital.org	Individual

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		transferred to provider	Kathleen Mikrut Director of Pharmacy Services RML Specialty Hospital 5601 S Countyline Rd Hinsdale, Il 60521 Having the opportunity to accept patient transfers from many hospitals into our LTAH hospital and with pharmacy conducting the medication reconciliation process, I recommend the following: 1. Types of medications to be included in the medication profile: I discourage the inclusion of oxygen in the medication profile. a. Typically, oxygen is not included in a hospital med profile, nor is it under the oversight of pharmacy. b. Joint Commission excludes oxygen as a drug 2. Discontinued meds on the medication profile, No a. The medication profile would become unmanageable if DC'd meds were included b. Having accepted many medication profiles that include DC'd meds, there are pages and pages of DC'd meds which clog up the admission process 3. Assessment of patient's ability to understand/accept condition and importance of taking meds as prescribed, No This information is unnecessary for transfers to another level of institutional care 4. Height & weight The data is important, but date it was last taken is not necessary. a. Upon a transfer admission, the ht & wt from the referring hospital is used, regardless of the date b. Until - the patient's ht & wt is taken at the LTACH 5. Feasibility for the prescriber of each med identified on the medication profile, No			

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			This would add useless information unnecessary for a successful medication reconciliation process			
22	5/3/18	Medication profile transferred to patient Medication profile transferred to provider	Dear RTI International: The Federation of American Hospitals (FAH) thanks RTI International for the opportunity to comment on the Medication Profile Transferred to Provider and the Medication Profile Transferred to Patient measures. The FAH agrees that post-acute care providers should measure and track effective care coordination and communications across settings. These measures serve as a key first step in a multi-step process and these measures in conjunction with other initiatives such as tailored patient education and web-based pharmaceutical treatment algorithms will drive improvements and reduce adverse events. While we support the measures' intent, the FAH recommends that the Medication Profile be simplified. Specifically, some of the elements required for the medication profile are duplicative with other discharge and transition documents (e.g., active diagnoses) and reducing the number of required data elements would ensure feasibility and reliability of data collection. In addition, some of the elements add significant provider burden while not demonstrably providing higher value. The revised Medication Profile could include the following: • Patient Information o Name o Date of Birth o Primary physician contact information o Height and weight and date recorded o Patient discharge diagnoses o Known drug allergies and sensitivities • Medication Information o Name o Dose o Route of administration o Frequency o Directions and special instructions *if applicable	Claudia A. Salzberg, PhD, Federation of American Hospitals	csalzberg@fah.org	Hospital association

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			o For held or inactive medications, reason for hold and if/when medication should resume *if applicable o Prescriber (for prescribed medications) o Timeline for final dosing of a medication after discharge *if applicable o Education provided to patient about potential risks/side effects and when to notify prescriber The FAH understands that medication profiles provided to the patient have been shown to increase their sense of responsibility towards their medical care as well as their sense of knowledge. However, it remains unclear whether inclusion of discontinued medications in the patient medication profile would add value, particularly without paired patient education, or lead to unintended consequences such as unproductive information overload. We recommend that this not be included in the patient profile until more evidence of the effects of this data element can be assessed. The FAH also recognizes that electronic capture and transmission of these data across settings would be optimal to reduce data collection burden and increase the timeliness of information. While adoption and availability of electronic systems and interoperability remains limited in the post-acute setting, the FAH appreciates that CMS created a measure that allows the transmission of data through other means. However, the FAH encourages CMS to continue to facilitate and incentivize broader adoption of these technologies and address the potential digital divide created by low levels of EHR adoption in post-acute care settings. The FAH appreciates the opportunity to comment on this quality measures. If you have any questions regarding our comments, please do not hesitate to contact me or a member of the FAH staff at (202) 624-1500.			
23	5/03/18	Medication profile transferred to patient	Dear Administrator, Verma: The Defeat Malnutrition Today coalition appreciates the opportunity to comment on the IMPACT Act quality measures	Meredith Ponder Defeat Malnutrition Today	mponder@matzblancato.com	Advocacy association focusing on malnutrition among older adults

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
		Medication profile transferred to provider	related to transfer of health information when individuals transition care settings. Defeat Malnutrition Today is a coalition with over 75 members who are committed to defeating older adult malnutrition across the continuum of care. This is a diverse alliance of community, healthy aging, nutrition, advocacy, health care professional, faith-based, and private sector stakeholders and organizations who share the common goals of achieving the recognition of malnutrition as a key indicator and vital sign of health risk for older adults and working to achieve a greater focus on malnutrition screening, diagnosis, and intervention through regulatory and/or legislative change across the nation's health care system. High-quality nutrition and malnutrition care for older adults should be at the top of the U.S. national agenda as we develop population health strategies to improve health and to deliver consistent quality healthcare at an affordable cost. The *National Blueprint: Achieving Quality Malnutrition Care for Older Adults1* released in 2017 pointed to the increasing body of statistics and health economics data showing the human and economic costs of malnutrition. We are pleased to see that these measures would include nutritional supplements, vitamins and total parenteral nutrition (TPN) in the electronic health records and medication profile given to providers, patients and patients' caregivers. We advocate that these records should also contain a nutrition care plan when called for by a professional on the patient's care team. **The malnutrition problem** Malnutrition, a nutrition imbalance that affects both overweight and underweight patients, is unfortunately a common issue across all care settings. In the acute care hospital setting, it is estimated that approximately 20 to 50 percent of admitted patients are malnourished or at-risk of malnutrition.23456 Chronic disease increases the risk of malnutrition in older adults. Studies estimate the prevalence of malnutrition in cancer patients is 30-87 percent,			

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			7 in chronic kidney disease is 20-50 percent, and in chronic obstructive pulmonary disease is 19-60 percent. Further, malnutrition can cause adverse and costly outcomes. Research documents that malnourished older adults make more visits to physicians, hospitals, and emergency rooms. The nutritional status of malnourished patients can continue to worsen throughout an inpatient stay, which may lead to further increased costs. Studies show that malnutrition, as a contributing factor to post-hospital syndrome, can increase a patient's risk for a 30-day readmission, often for reasons other than the original diagnosis.10 For example, 45% of patients who fall in the hospital have malnutrition; costs for falls overall to Medicare totaled $31 billion in 2015. **Nutrition in electronic health records** For patients to receive better nutrition care overall, their providers outside the acute care setting must be aware of nutrition decisions made while in hospitals, and vice versa. Including nutritional supplements, vitamins and TPN in the electronic health records and medication profile given to providers, patients and patients' caregivers is an important first step. However, we feel that for patients to receive optimal care, a full nutrition care plan should be included in these discharge records if the patient has one from a professional on his/her care team such as a registered dietitian nutritionist. Having a nutrition care plan included can help patients, providers and caregivers coordinate food and medication dosages/timing. It can also call attention to special prescribed diets, oral nutrition supplements, and TPN in the patient's care needs, making sure that everyone is aware that the patient needs this care. Medically-tailored diets are increasingly common for older adults with chronic conditions, and a medication profile is a good place to note these special discharge instructions/care needs because it is likely to be read closely by patients and providers and because they make up such a vital part of a discharge plan. This plan should be carefully			

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			documented in records in easy-to-understand language for patients. We thank you for considering our comments, and please let us know if we can provide you with any further information. You may reach us at info@defeatmalnutrition.today.			
24	05/03/18	Medication profile transferred provider	Thank you for the opportunity to comment on the Draft Specifications for the two-proposed medication profile transferred measures for post-acute care settings. The Illinois HomeCare and Hospice Council (IHHC) is a trade association representing hospice, home health and home services providers (and allied vendors) serving patients in Illinois. IHHC members are keenly interested in the development of measures based on meaningful data that improve the quality of home health care and help patients and families make informed decisions about their post-acute care options. The following comments pertain to both proposed medication profile measures. Comment: For many of our member agencies, the transfer of documents such as medication lists and discharge summaries occur through electronic medical records systems. Field nurses completing OASIS may not able to personally confirm whether a document has in fact been transferred. Recommendation: When these assessment items are added to the OASIS, clarify in the OASIS guidance the extent to which the clinician completing the assessment may/must seek confirmation from other home health agency (HHA) staff that the medication profile has been appropriately transferred. Comment: IHHC appreciates that RTI and Abt have taken into account the unique position of home health in the post-acute care spectrum by allowing for HHAs to utilize a "not applicable" choice on the sample assessment item for Medication Profile Transferred to Subsequent Provider. It is a reality that HHAs are not always notified in a timely fashion when a patient is transferred to a	Katharine P. Eastvold Illinois HomeCare and Hospice Council	katharineeastvold@ilhomecare.org	State home care and hospice trade association

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			facility, and IHHC members agree with the decision not to penalize HHAs for failing to send the medication profile to the subsequent provider at the time of transfer in these cases. Another unique feature of home health, as opposed to the other three post-acute care settings subjects to the IMPACT Act, is that the patient does not reside in a facility operated by and under the continuous supervision of the provider. While home health nurses and/or therapists conduct thorough medication reconciliation on every patient, some home health patients may choose to take over-the-counter medications, herbal supplements and/or vitamins without informing HHA personnel. Recommendation: IHHC would like clarification in the guidance associated with the assessment items for this measure that the medication profile transferred to the provider and/or patient is accurate to the extent the HHA was informed of medication the patient was taking, and that HHA personnel made a good-faith effort to ascertain a complete and accurate list of medications. Comment: The measure specifications do not define "at the time of discharge/transfer." This leaves providers with uncertainty as to how immediately the transfer of the medication profile must occur in order for the clinician to respond "yes" on these assessment items. Recommendation: Define the required timeframe. The Home Health Conditions of Participation require HHAs to send a discharge summary to the health care practitioner who will be following the patient within five days of discharge, or to the receiving facility within two days of a planned transfer (or within two days of becoming aware of a transfer if the HHA was not initially notified). IHHC believes it would be reasonable to align medication profile transfer timeline requirements with the discharge/transfer summary timeline in order to streamline documentation mandates for HHAs. Comment: As many quality measures do, these proposed measures rely on the accuracy of self-reporting. However, because medication profiles would be a feature of transfers and discharges,			

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			this area of data collection offers the potential for information to be gathered by a provider about another provider's behavior, as opposed to only its own. Recommendation: In addition to measuring whether a particular post-acute provider has sent a medication profile to the provider or facility receiving the patient (or to the patient in the case of a discharge to home or assisted living), data could be collected at the Start of Care on whether the post-acute provider received a medication profile from the referring provider or facility. A receipt of medication profile measure could address only transfers among post-acute provider types subject to the IMPACT Act or could include transfers or referrals from any number of Medicare-participating provider types.			
25	05/03/18	Medication profile transferred to patient Medication profile transferred to provider	To RTI International and the Centers for Medicare and Medicaid Services: This comment letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA) in response to the Call for Public Comment on the Transfer of Health Information – Medication Profile quality measures under development for post-acute care (PAC) providers pursuant to the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The measures are: 1. Medication Profile Transferred to Subsequent Provider (Q1) 2. Medication Profile Transferred to Patient (Q2) AMRPA is the national trade association representing more than 600 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals (collectively referred to as inpatient rehabilitation facilities (IRFs) by Medicare), outpatient rehabilitation service providers, long-term care hospitals (LTCHs), and several skilled nursing facilities (SNFs). Inpatient rehabilitation hospitals and units (IRH/Us) provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from care provided in non-hospital post-acute settings. AMRPA	Mimi Zhang American Medical Rehabilitation Providers Association (AMRPA)	mzhang@amrpa.org	Advocacy

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			members help their patients maximize their health, functional ability, independence, and participation in society so they are able to return to home, work, or an active retirement. AMRPA has reviewed the report prepared by RTI International, Draft Specifications for the Medication Profile Transferred Measures for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies. The comments contained in this letter reflect feedback received from AMRPA's Quality Committee with input from pharmacists, administrators, physicians and other clinicians at rehabilitation hospitals and units. General comments On behalf of our members, AMRPA would like to first and foremost thank CMS and its measure developers for scaling back the scope of data collection and reporting burden associated with the Transfer of Health Information quality measures. When the first iteration of the Transfer of Health Information measures was issued in November 2016, it encompassed a far wider range of patient data elements beyond medication information, including but not limited to functional and cognitive status, medical conditions and comorbidities, and discharge instructions. In addition, one of those measures also proposed to hold PAC providers accountable for the information transfer behavior of upstream referral sources, which providers have little ability to influence. Hence, we appreciate the agency's consideration of the stakeholder feedback it received in response to the first iteration. Although the revised measures address several of our prior concerns, we respectfully submit that a number of additional revisions remain necessary. AMRPA supports the intent of the newly specified measures, Medication Profile Transferred to Subsequent Provider and Medication Profile Transferred to Patient. Our members agree that the accurate and successful transfer of essential medication information at PAC discharge/transfer is critical to ensuring that			

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			patient safety and quality of care are not compromised once a patient leaves a particular setting. While the draft report details the types of medication information included in these measures (in the form of 25 Medication Profile data elements), it fails to delineate how exactly the data elements will be implemented across PAC settings. Specifically, the draft specification report fails to adequately address the following operational questions: • How would CMS collect the Medication Profile data elements? Would they be categorized as standardized patient assessment data elements (SPADEs) and thus constitute mandatory reporting on PAC patient assessment instruments pursuant to PAC Quality Reporting Programs' data completion thresholds? While the report references that the IMPACT Act mandates the collection of SPADEs, it does not specify if the Medication Profile data items would indeed be categorized as SPADEs. • If the Medication Profile elements will be SPADEs, would the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) need to be revised to include medication data items? • If not, would CMS validate the completion of the Medication Profile data items against what providers self-report on the quality measures? How would the agency ensure validity for these process-based measures? • How would the measures integrate with medication reconciliation or discharge planning processes already in place at IRH/Us and other hospitals? • What are the qualifications of clinical personnel allowed to complete the Medication Profile? Medication reconciliation is a complex process at hospitals, and IRH/Us already dedicate extensive administrative resources and staff time from pharmacists, physicians, nurses, and other clinicians to ensure that it is being done appropriately. Accordingly, we view the current comment opportunity as the start of a dialogue with			

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			CMS regarding the optimal way to achieve the agency's objective of promoting effective medication information transfer at PAC discharge/transfer. AMRPA looks forward to working further with CMS and responding to its future proposals specific to the collection of the Medication Profile data items. As CMS continues to develop a reporting mechanism, we urge the agency to do so in a practical and minimally burdensome manner that adds value beyond IRH/Us' current medication reconciliation and/or discharge planning practices. This would be consistent with CMS' Patients over Paperwork and Meaningful Measures initiatives which aim to reduce providers' administrative burden, and specifically with regard to burden from quality measures. Our recommendation for CMS to focus on an "essential medication information" list, detailed further below, aims to achieve these goals. II. Medication Profile Definition CMS proposes that the Medication Profile transmitted at discharge/transfer "be 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," including total parenteral nutrition (TPN) and oxygen. To that end, CMS proposes the medication profile to include "at least all" of the 25 data elements, as summarized in the table below. According to our members, IRH/Us already communicate these data through medication reconciliation, discharge planning processes, and other clinical protocols. This information is located in sources such as the discharge summary, a Medication Administration Record (MAR), home medication lists or the physician orders. We think a Medication Profile, for the purposes of a cross-setting PAC standardized IMPACT Act measure, should focus on the core and essential medication information, and not duplicate the comprehensive summary of medication information IRH/Us already communicate to subsequent providers and patients. The profile should be limited to those pieces of			

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			medication information for which there is uniform consensus on their clinical importance. We posit that a cross-setting Medication Profile concentrating on the core or essential medication information could be defined as: "A Medication Profile is a patient-specific list of prescribed medications the transferring/discharging care team intends the patient to continue taking upon transfer/discharge, including sufficient detail (dose/frequency/end date, if predetermined) to allow the profile to guide subsequent patient/provider behavior." The table below contains our recommendations regarding the 25 Medication Profile data elements specified in the draft report and reflects those elements of medication information that our clinician members find as essential for transfer at patient discharge/transfer.			

Proposed Medication Profile Item	AMRPA Recommendations and Rationale (Recommended **changes/revisions to items are in bold,** and recommended *items for removal are in italics.*)
Patient Information on the Medication Profile	
1. Patient name	We support including this item.
2. Patient date of birth	We support including this item.
3. Primary physician name and contact information	**We recommend CMS revise this item to refer specifically to the PAC physician overseeing the patient transition**, since this physician will be whom the downstream physician would need to contact regarding information in the Medication Profile. As the item is currently written, it is unclear if "primary physician" refers to the patient's primary care physician, the primary physician at the PAC setting, or the attending physician from an upstream acute care hospital.
4. Height and date taken *If applicable	*Because these data are already included elsewhere in the medical record or discharge summary, we would not support their additional inclusion in a Medication Profile.*
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	**We recommend these items be collapsed into one item and limited to "Known medication allergies and intolerances."** Some medications have known side effects such as nausea or discomfort, but that should not be misinterpreted by the next site of care as a reason to not

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	administer the medication. We are concerned that requiring providers to document all known sensitivities and reactions on the Medication Profile could open a Pandora's box of unintended misinterpretations.
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 is provided to patient) *If applicable	*We do not support including these items.* A subsequent care setting will prepare the patient's medications and hence these types of "patient preferences" would neither be highly useful nor meaningful. If a patient is at home and receiving prescriptions from a pharmacy, patient preferences regarding packaging are kept on file at the outpatient pharmacy. Additionally, time-released medication is a clinical decision made by the provider, not a patient preference. AMRPA recognizes that the IMPACT Act requires CMS to collect data on patient care preferences. **We encourage the agency to define and focus on other care preferences data items that would be much more meaningful to patients and providers.**
10. Patient adherence strategies (e.g., alarms, drug diaries) *If applicable	*We do not support including this item in the Medication Profile*. These are medication management strategies better reflected in the patient's comprehensive care plan. They are not suited for the Medication Profile which should be focused on transmitting essential medication information.
11. Patient ability to understand/accept condition(s) and importance of taking medications as prescribed	*We do not support including this item*. It assesses a patient's cognitive function and ability to understand the information being presented and therefore is outside the scope of Medication Profile. IRH/Us already have discharge planning processes for a clinician to review the medication list with patients/family/caregivers and take the necessary steps to ensure that they understand it.
Medication Information Items – To Be Completed for Each Medication	
Proposed Medication Profile Item	**AMRPA Recommendations and Rationale**
12. Name (generic and proprietary names if applicable) and strength	**We support the intent of this item but recommend that it be clarified to require a generic name.** Various national standards indicate that medications should not be referenced by brand name only. This item should focus on the essential information needed to communicate a drug name and not burden providers to document all of the drug's known identifiers. **As a suggestion, the item could be revised to "Name (generic only OR if proprietary name, also include generic) and strength."**
13. Dose	We support including this item.
14. Route of medication administration	We support including this item.
15. Frequency	We support including this item.
16. Directions	**We think this information is already being captured by Items 13-15, and therefore recommend that Items 16 and 17 be designated as "If applicable."** This approach would allow the discharging/transferring provider to
17. Special instruction (e.g., crush medications) *If applicable	

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization

	document additional directions they feel are important to communicate to the next site of care (such as take with a meal, take with a full glass of water, etc.), but would not impose unnecessary reporting burden.
18. (For held medications) Reason for holding medication and when medication should resume	We support including this item. It is critical to accurately document those drugs that are part of the patient's routine medication regimen but were temporarily held/suspended, and need to resume at a later date. These medications and their resumption dates should be highlighted for the next site of care in the Medication Profile.
19. Purpose/Indications/ Contraindications	**We recommend CMS revise this item to "Purpose (i.e., condition being treated)" and remove "Indications/Contraindications."**
20. Prescriber (for prescribed medications only)	Similar to Item 3, **we request CMS revise this item to refer specifically to those medications prescribed by the PAC physician when the patient was under their care.**
21. When the last dose of the medication was administered by discharging/ transferring provider *If applicable	*We do not support including this item in the Medication Profile.* While we agree that this is a key piece of information, the specific timeliness of administered drugs is better captured through a MAR than in the Medication Profile. Furthermore, we are concerned that retaining this item could unintentionally structure the Medication Profile to become a prescriptive protocol that must be completed as close to the point of discharge as possible so as to capture the most current data. However, this would defeat the purpose of having the Medication Profile be completed in a comprehensive and deliberate manner, which is an especially relevant consideration for those providers using paper medical records.
22. When the final dose of the medication should be given *If applicable	**We recommend this is combined with Item 15 - Frequency and be an optional field,** e.g., "Frequency (including planned stop date/when the final dose should be given, if known)."
23. Patient education provided about potential risks/side effects/ contradictions and when to notify prescriber (for profile provided to patient/family/caregiver)	*We do not support including these items in the Medication Profile.* These are medication management strategies better reflected in the patient's comprehensive care plan.
24. Patient adherence with the medication therapy	
25. Relevant lab test results to guide medication management (e.g., serum creatinine) *If applicable	*We do not support including this item in the Medication Profile.* Providers have different routines regarding lab tests so there would be a high degree of variance in institutional practices that would not lend itself to meaningful reporting on a standardized item. In addition, this item detracts from the value of the physician's clinical judgement since it is not a standard of practice for physicians to base their orders solely on lab results.

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			III. Measure Specifications A. Inclusion Criteria: Aligning Beneficiary Populations One of the primary objectives of the IMPACT Act is to collect comparable data across all four PAC settings. This objective implies that the collected data and quality information are aligned across settings for there to be a true comparison. However, CMS' quality measures continue to fall far short of this goal because they capture vastly different Medicare beneficiary populations and are not fully standardized across settings. Specific to the Transfer of Health Medication Profile measures, the proposed beneficiary inclusion criteria are as follows: • IRH/Us: The denominator is the total number of Medicare Part A and Medicare Advantage (Part C) patient stays ending in discharge/transfer. • LTCHs: Total number of LTCH patient stays, regardless of payer, ending in a discharge/transfer to another setting. • SNF: Total number of SNF Medicare Part A covered resident stays ending in a discharge/transfer to another setting. • HHA: Total number of Medicare Part A, Medicare Advantage (Part C) and Medicaid home health quality episodes ending in a discharge/transfer to another setting. Without an alignment of assessed patient populations, any data collected through these measures may have systemic sampling biases that would not allow for an apples-to-apples comparison. AMRPA urges CMS to prioritize cross-setting standardization as it develops and implements IMPACT Act quality measures, and recommends the measures be applied to a uniform Medicare patient population that is inclusive of Medicare Parts A and C beneficiaries. Short of this, CMS should use a uniform patient population that is the lowest common denominator, which would be Part A beneficiaries, for purposes of cross-setting comparisons and for public reporting. This would result in an apples-to-apples comparison across settings, which is the purpose of this data collection. Failing to standardize the patient population across			

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			settings will result in selective sampling that skews the collected data and distorts or otherwise invalidates meaningful comparisons across measures and across PAC settings. B. Aligning Item Responses across PAC Settings For measure Q1A, CMS proposes a response option that is available only to HHAs as follows: 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? 1. Yes – Current medication profile provided to the subsequent provider 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.* (emphasis added) We do not think the Not Applicable (NA) option should be limited to HHAs since patients in other PAC settings also experience unexpected discharge/transfers when they return to the acute care hospital due to an emergent incident. This is recognized as the "interrupted stay" payment adjustment under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). In these cases, the IRH/U will certainly prioritize the patient's timely transfer to the necessary care setting, and it would be inappropriate for CMS to hold providers accountable to a reporting process over patient well-being. We recommend CMS revise the NA option to make it available as a response for all PAC settings. C. Clarifying Included Patient Subsets Per the specifications, both measures Q1 and Q2 include patients who are discharged/transferred to "home under care of an organized home health service organization or hospice." Since the two measures are intended to differentiate between patients who transfer to a subsequent provider versus those who return to home/community, this design would seem to double count a subset of patients. We request CMS revisit this measure specification to clarify or wholly remove the apparent overlap. In our view, patients who receive care in home-based hospice should be included in the home/community measure (Q2), whereas			

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			patients who receive care in institutional-based hospice should be included in the subsequent provider measure (Q1). IV. Routes of Information Transfer The proposed routes (electronic medical records (EMRs), health information exchange, paper, verbal) are appropriate and we do not have recommendations regarding these routes. To address CMS' questions to stakeholders on this topic: • We do not think consumers will find high value in knowing the routes by which their medication profile was transmitted, nor is this information likely to inform their choice of PAC providers. There are many other criteria (quality and outcomes of care, location/proximity, etc.) that are far stronger drivers in a patient's decision regarding their PAC provider. • The existing health IT standards do not support interoperable exchange of medication data elements. Even if a discharging provider is able to electronically transmit medication (and other types of) information to a provider downstream, it is often the case that the second provider cannot receive and integrate the data into their EMR. The IMPACT Act recognizes the extant interoperability challenges and thereby mandates CMS to make interoperable standardized patient assessment and quality measurement data. AMRPA understands that CMS is currently working on making items interoperable via its Data Elements Library (DEL) project and collaborates with health information technology (HIT) content standards bodies and HIT vendors as part of this project. If it is CMS' intent to promote the electronic transfer of medication information via a standardized Medication Profile, AMRPA recommends the agency leverage its partnerships with HIT and EMR vendors and determine how any new information transfer "standard" can be optimally implemented across provider settings. EMR vendors already work closely with most health care providers			

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			and would be able to offer CMS critical guidance regarding the design and feasibility of any standardized approach to cross-setting electronic data transfer. V. Conclusion AMRPA appreciates the opportunity to provide input on the development of cross-setting standardized PAC quality measures and their proposed specifications. We seek to ensure these elements achieve the objectives of the IMPACT Act while being minimally burdensome for PAC providers. If you have any questions, please contact Carolyn Zollar, J.D., Executive Vice President for Government Relations and Policy Development (czollar@amrpa.org) and Mimi Zhang, AMRPA Senior Policy and Research Analyst (mzhang@amrpa.org) at 202-591-2469.			
26	5/3/18	Medication profile transferred to patient Medication profile transferred to provider	RTI International / Abt Associates: I. TOH Measure Development Should Adhere to Agency Priorities As the nation's largest provider of inpatient rehabilitation services and the fourth largest provider of skilled home health care, we appreciate the opportunity to provide comments on RTI's and Abt's updated work on this quality measure domain regarding transfer of health information and care preferences. Our comments regarding the transfer of medication profile information focus primarily on balancing clinical time with paperwork and administrative burden. The Centers for Medicare and Medicaid Services ("CMS") has placed significant emphasis on the need to reduce administrative burden for Medicare providers generally ("Patients over Paperwork"), and specifically in regard to burdens stemming from quality measurement ("Meaningful Measures"). We believe those initiatives, and the motivations they represent, should guide the current development of quality measures. Our responses to select comment request topics from CMS are laid out below. II. ENCOMPASS HEALTH RESPONSES TO SPECIFIC COMMENT REQUESTS A. Definition of "Medication Profile"	Andrew C. Baird ENCOMPASS HEALTH	Andrew.Baird@encompasshealth.com	Inpatient rehabilitation facilities

ID	Date posted	Measure set or measure	Text of comments	Name, credentials, and organization of commenter	E-mail address	Type of organization
			We believe the current draft definition of medication profile, as outlined on pp. 9-10 of the measure specification, is overly burdensome and too prescriptive, making it inconsistent with the Patients over Paperwork and Meaningful Measure initiatives, both of which emphasize reducing provider burden in the interest of increasing quality time with the patient. For example, requiring a clinician to collect and summarize a patient's adherence to each individual medication, while also providing a more general summary for the patient's overall medication adherence, is duplicative, particularly if it must be done for medications that will be discontinued at discharge. If CMS, via the 25-item checklist proposed in the draft specification, intends to require all post-acute providers to undertake these highly specific steps regarding the transfer of medication information, we believe the agency should propose formal regulations requiring these actions instead of wrapping them into a quality measure We suggest replacing the proposed lengthy checklist-based definition regarding the necessary components of a qualifying medication profile with a more flexible narrative definition that permits those post-acute providers that already have medication communication procedures in place to maintain their practices while simultaneously requiring other post-acute providers that do not have medication communication capacity to implement one. Such an alternative definitional approach would preserve the best-practices that are already in place within sophisticated care environments, such as IRFs, while also offering opportunities for improvement in other care settings where medication information collection and transfer is less consistent or robust. This definitional approach would be sensitive to what already works but would also create an important standard for other providers to aspire to. To that end, we believe the following narrative definition of a medication profile would be more practical for providers while still meeting the goals and objectives of CMS to insure accurate and useful medication information transfer: A medication profile is a patient-specific list of medications that the transferring/discharging care team believes relevant to a patient's			

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			continued care, including sufficient detail (such as dose/frequency/end date, if predetermined) to allow the profile to guide subsequent patient/provider behavior. This alternate definition requires the transfer of key pieces of medical and clinical information specific to each patient and medication while reducing the possibility of technical non-compliance with the proposed measure specification, which is overly prescriptive for a quality measure. B. Types of Medications Included and Risk of Patient Confusion We believe medication profiles should cover a broad range of medications, whether prescribed or over-the-counter ("OTC"), but raise a concern with the proposal's assumption that the same medication information that should be prepared for and transferred to subsequent providers should also be given to patients. Specifically, including all the proposed information items for discontinued medications would create so much clinical material for a patient that the patient would be inundated with unnecessary material that could cloud the actual educational goals of pre-existing discharge documentation, thereby increasing the risk of confusion about what medications should be continued. We therefore suggest using our singular narrative definition above because it is patient-centered and avoids such a risk by allowing a care team to exclude those discontinued medications that are not relevant to a patient's continued care and instead focuses on medications that should be continued after discharge. Our suggested definition would cover most if not all of the types of medications in the RTI-proposed definition, and would help clarify that the medication profile should focus on medications that are to be continued post-discharge. In the alternative, if CMS is not comfortable with the suggested single definition that emphasizes the appropriate information for the patient, then we believe two distinct definitions of "medication profile" should be pursued and utilized simultaneously – one which details the information that should go to the patient when he/she is discharged home (excluding discontinued medications), and a			

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			separate definition for when a patient is discharged to a subsequent care setting (including discontinued medications). These patient and provider definitions could also be conveyed as flexible narrative definitions, similar to that suggested above. The rationale for this dual approach is that the information for discontinued medications is indeed important and valuable for medical professionals in subsequent care settings, but could actually increase the risk of confusion, and therefore of patient harm, when given directly to a patient. C. Feasibility of Collecting Medication Profile Data Elements The proposed checklist of 25 items is too long and too subjective to be considered practical for all post-acute providers. Collecting all of this information for each medication for each patient would drastically increase the amount of time required to prepare a patient for discharge and also overlaps in large part with information already contained and prepared in pre- existing discharge summaries of many post-acute providers. Furthermore, many of the items (including 4.1.1.10, 4.1.1.11, 4.1.2.19, 4.1.2.24) are highly subjective and potentially situation- specific and are therefore less useful to subsequent caregivers for whom the patient's status or clinical profile may be different than in the prior post-acute stay/episode. This comment request about the feasibility of "collecting data elements" begs the question of whether the lengthy checklist of items on pp. 9-10 of the measure specification are intended to be implemented directly onto the various post-acute patient assessment instruments ("PAI") (e.g., IRF-PAI, OASIS, etc.). The measure specifications do not indicate that these checklists would be actual items added to existing PAIs, but this comment request question, by referring to the items as "data elements" and asking about their feasibility, raises the prospect that they might indeed be added. We specifically request RTI and CMS to clarify this ambiguity. Nonetheless, for purposes of these comments, we assume that these items will not be added to the various PAIs because we			

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			expect CMS would be more explicit about adding such a lengthy checklist section to the existing PAIs. However, this assumption raises an additional question regarding how and whether CMS will seek to verify compliance with the self-reported completion of a medication profile transfer. In other words, does CMS envision reviewing medical records or other materials in order to verify the self-reported rates of successful medication profile transfer for individual providers? Without such verification, performance on this measure could easily be "faked." Accordingly, if CMS believes that the actions and tasks required by these checklist items should be required of all post-acute providers, then we believe the agency should be attempt their implementation in a more formal manner vis-à-vis feasibility/accuracy testing and formal notice-and-comment rulemaking. If the post-acute PAIs, which have already undergone exponential expansion in recent years, are to be significantly lengthened with new checklists, it, should be done cautiously and not merely as the byproduct of a quality measure. D. Data Elements to Include in a Medication Profile Checklist As referenced above, we suggest an overall alternate narrative definition of a medication profile that does not rely on a separate list of items which are not included on the PAIs. If CMS does not ultimately implement this suggested definitional approach and instead believes a separate non-PAI list is the most effective method to insure appropriate transfer of medication information, we believe only the following items should be included (this list reflects our responses to several of the comment requests regarding whether specific data elements should be included): • Patient Information o Name o Date of Birth o Primary physician contact information o Height and weight and date recorded o Patient discharge diagnoses o Known drug allergies and sensitivities • Medication Information			

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			o Name o Dose o Route of administration o Frequency o Directions and special instructions *if applicable o For held or inactive medications that are intended to resume after discharge, reason for hold and when medication should resume *if applicable o Prescriber (for prescribed medications) o Timeline for final dosing of a medication after discharge *if applicable o Education provided to patient about potential risks/side effects and when to notify prescriber This list represents a robust and useful set of information. It also avoids the subjectivity in some of the proposed items and the items which a post-acute provider likely does not have (such as medication storage preferences, which are largely moot for all institutional providers because nurses and pharmacists handle administer and store the medications unilaterally). If CMS ultimately decides to finalize some sort of checklist, it should be the same for both patient discharges to home and discharges to subsequent care. This would reduce confusion among clinical and pharmacy staff. The absence from this suggested list of items such as 4.1.9 (patient preferences), 4.1.10 (adherence strategies), and 4.1.11 (ability to understand adherence) does not reflect our views on the relative importance of such information, but in many instances reflects the fact that this type of subjective information is already covered in a discharge summary, and therefore does not need to be duplicated within a separate medication profile exercise. E. Whether Discontinued Medications Should be Included in the Medication Profile As stated above, when discharging a patient to home without any professional care, we believe including all of the proposed			

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			information items for each discontinued medication and any other medications that are not intended to be utilized after discharge risks confusing the patient and/or his/her family caregiver. With so much information to sift through, such confusion could result in a patient not understanding which medication to take when, and unintentionally taking a medication that causes harm. By transferring information for those medications that are intended to be taken after discharge, as well as other medications that the discharging care team deems as relevant to the patient's continued care, this risk is mitigated. However, when a patient is discharged to a subsequent care setting, we believe that it is important to include complete information on discontinued mediations as part of the information transfer. Encompass Health currently provides this information and understands that it can be useful and relevant for medical professionals and other professional caregivers in subsequent care settings. Accordingly, we urge CMS to adopt of two-prong approach to the medication profile – one prong geared towards information for patients and another prong geared towards information for subsequent medical professionals as applicable. F. For Transfers from Home Health to a Subsequent Provider where the HHA Was Not Timely Made Aware For home health agencies that are not timely made aware of a patient transfer to another provider, it is appropriate to include the response option "NA – the agency was not made of this transfer timely." Home health care, by virtue of being provided outside of a controlled environment, is a fundamentally different mode of care than that provided within institutional settings and a home health agency may not always be privy to a medical situation or event that arises quickly and results in an admission to another provider. Therefore, there may be legitimate instances where a home health agency is unable to take the time to prepare a medication profile. We encourage RTI and CMS to consider this option for other providers as well in order to account for instances where a patient may suddenly need to be rushed to a different level of care (most			

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			likely an acute care hospital or emergency department). In such instances, the preparation of a full medication profile may not be feasible prior to such a transfer. G. Whether PAC Providers Would be Able to Transfer the Medication Profile Electronically Through their EHRs/EMRs / Sufficiency of Existing HIT Standards To Support Interoperable Exchange of Medication Information For a number of reasons, the adoption of EHR/EMR capabilities within post-acute care settings has been mixed, and the existence of typical EHR/EMR capabilities is not uniform from market to market. Encompass Health has independently invested significant resources into developing and implementing a sophisticated Cerner EHR system. In addition, Encompass Health participates in a large national Health Information Exchange ("HIE"), as well as several local market-specific HIEs. We have not seen a critical mass of acute care hospitals or other post-acute care providers participating in these particular HIEs to date, so the ability to utilize them for true information exchange between distinct provider entities is currently limited. Whether that remains the case for the future will depend on how issues of interoperability and more universal adoption play out. Generally speaking, separate EHR/EMR systems currently do not have universal language for discrete exchange of data, such as dose info. However, most such systems can exchange most information in a document format (e.g., PDF). Additionally, any subjective information, such as general remarks about patient adherence, could be construed in free text fields, but because these are not commonly defined or universally utilized, it would be difficult for discrete EHR/EMR systems to absorb this information from one another. III. CONCLUSION Thank you for considering these comments on the updated Transfer of Health Information and Care Preferences measures.			

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			Should you wish to follow up or discuss any material contained in this letter, please reach out using our contact information below.			
27	05/3/18	Medication profile transferred to patient Medication profile transferred to provider	Dear Administrator, Verma: The National Association for the Support of Long Term Care (NASL) represents ancillary care and services providers in the long term and post-acute care (LTPAC) sector. NASL members include therapy companies that employ more than 300,000 physical therapists, occupational therapists, and speech-language pathologists who furnish rehabilitation therapy to hundreds of thousands of Medicare beneficiaries in nursing facilities as well as other long-term and post-acute care settings. Our members also include both vendors of health information technology (IT) that develop and distribute full clinical electronic medical records (EMRs), billing and point-of-care IT systems and other software solutions that serve the majority of LTPAC providers of assisted living as well as skilled nursing and ancillary care. In addition, NASL members include providers of clinical laboratory services, portable x-ray/EKG and ultrasound, complex medical equipment and other specialized supplies for the LTPAC sector. NASL also is a co-founder of the Long Term and Post- Acute Care Health Information Technology Collaborative (LTPAC Health IT Collaborative), which was formed in 2005 to advance health IT issues by encouraging coordination among provider organizations, policymakers, vendors, payers and other stakeholders. NASL is pleased to provide feedback regarding the proposed quality measure to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of Transfer of Health Information & Care Preferences When an Individual Transitions – Medication Profile Transferred to Provider / Medication Profile Transferred to Patient. NASL applauds the Centers for Medicare & Medicaid Services (CMS) and its contractors for the clinical discussion that is evident in reviewing the draft measure specifications and the recommendations for what should be part of a medication profile. Even so, we identified a few disconnects in terms of how some of the questions relate to specific care settings.	Donna Doneski National Association for the Support of Long Term Care (NASL)	donna@nasl.org	Provider association

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			The purpose of IMPACT Act is to standardize patient assessment data across post-acute care (PAC) settings, to include: Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs) and Home Health Agencies (HHAs). We question having variations in denominators (according to payer), which seems to conflict with the spirit of the law and may undercut the ability for the measure to be comparable from one setting to another. NASL appreciates that CMS is using the IMPACT Act-required measure on Transfer of Health Information & Care Preferences as a means to prioritize medication information. We agree that accurately communicating medication information when an individual transition from any care setting (to include hospitals) is essential. Because getting this right is important to the individual's well-being, NASL members – both clinicians and information technology experts – recommend CMS provide additional clarification on a number of items and solicit additional stakeholder input before implementation. NASL Comments on Specific Items Measure Titles • Whether the measure titles clearly capture the measure concept across the PAC settings • Any other suggestions for the measure titles NASL has been tracking the IMPACT Act since it was signed into law in 2014 and understands the correlation of the proposed measure titles to the "Transfer of Health Information & Care Preferences" domain. Still, we believe that the term "profile" does not convey the proposed content of the measure. If the proposed content is to be included, we suggest CMS consider a more apt, consumer-friendly name such as "Medication Synopsis" or "Medication Summary." Measure & Specifications Medication Profile • The definition of a medication profile			

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			• "… 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." NASL agrees with the definition above. • The types of medications to be included in the medication profile • "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." NASL agrees with the types of medication information to be included in the medication profile. With regard to inclusion of recently discharge medications, we think it is important to know past medications when those medications may have continuing and/or diminishing effects that could affect the patient's care or interact with other medications. However, the timeframe for identification of discharged medications and the burden of collecting this information is something that needs to be carefully weighed against the clinical benefit for the patient. • Whether the medication profile description captures the most important sources of medication profile information • "Documentation sources for medication profile information include electronic and/or paper records, including discharge summary records, a Medication Administration Record (MAR),			

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			Intravenous Medication Record (IVAR), home medication list, and physician orders." NASL recommends that CMS consider other documentation sources such as pharmacy records. We also would suggest changing the medication profile description to reflect that documentation sources for the information contained in the medication profile may include, but are not limited to, discharge summary records, a Medication Administration Record (MAR), Intravenous Medication Record (IVAR), home medication list, and physician orders." • The feasibility of collecting the medication profile data elements NASL believes that it should be feasible for providers actively treating a patient to collect the items noted in the draft measure. Even so, and even when utilizing electronic documentation, we remind CMS that this information may be "pulled" from various places within the EMR, meaning that vendors would need specifications and details with enough time to develop and test their ability to create a document with this information. Further, for individuals not currently using an EMR, the burden to collect the information is greater. • Data elements to include in a medication profile. (Please provide rationale for any new data elements not included in the draft definition. 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". 4.1.1 Patient Information 1. Patient name 2. Patient date of birth 3. Primary physician name and contact information 4. Height and date taken *If applicable			

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			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 4.1.2 Medication Information (Complete for each medication) 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			

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			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. NASL had an extensive discussion around these data elements and believes more stakeholder feedback is needed. NASL applauds CMS and its contractors for reaching out to our colleagues from the American Society for Consultant Pharmacists (ASCP), the Pharmacy HIT Collaborative and NASL IT vendor members to further research these data elements. We believe that the feedback provided by these and other groups will be useful in helping to clarify these data elements. NASL welcomes additional opportunities to work with CMS and its contractors on these data elements and measures.			

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			• Which data elements in the medication profile should be designated "if applicable." NASL reached out to our colleagues with the American Association of Nurse Assessment Coordination (AANAC) in evaluating which data elements in the medication profile should be designated "if applicable." We include AANAC's input on this item for your consideration. AANAC Comment #18: Clarify if held medications refer to medications that are on a hold status at the time of resident discharge/transfer only. #19: Clarify when "Contraindications" would be included in the medication profile. For example, does this pertain to a gradual dose reduction attempt for antipsychotic medication, and the physician has documented that further reduction is clinically contraindicated? Can additional examples be included for when a contraindication would be included in the profile? • Differences, if any, in what information should be included in a medication profile provided to a healthcare provider as compared to a medication profile provided to the patient/family/caregiver NASL supports patient-centered care. In the spirit of the patient owning personal medical information and transparent access to medical record information, we recommend that there be limited differences between the information given to providers and patients. For example, the content could be written in terms that retain the precision and language of the provider, but that is formatted in a more consumer-friendly way so that the patient/ family/ caregiver can understand the information. Use of electronic health records would assist providers by allowing for an easy translation of provider language into more consumer-friendly terms as we have seen with retail pharmacies that share the prescription information alongside consumer-friendly terms (e.g., "1 PO TID" could be translated into "once daily by mouth three times per day").			

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			• Whether discontinued medications should be included in the medication profile. If included, provide suggestions of 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.) NASL agrees that discontinued medications should be included in the medication profile. We again recommend that CMS consult stakeholders for additional input with regard to what parameters may be needed. For example, what is an appropriate timeline for including any discontinued medications? We know that certain medications have a longer half-life than others, which could have important consequences (e.g., possible adverse effects or other pharmacological reactions when combined with other medications) for a patient's ongoing treatment. We recognize that only the four PAC settings are subject to the IMPACT Act measures; however, we wish to underscore the importance of receiving information from any previous care setting. We understand from analysis done by our colleagues at the American Health Care Association (AHCA) that approximately 88 percent of all SNF admissions from all payers each year are directly from an acute care hospital, while less of 1 percent result from transfers from Inpatient Rehabilitation Facilities (IRFs) and Long-Term Care Hospitals (LTCHs) combined. Given that the IMPACT Act also references hospitals and critical access hospitals, NASL asks that CMS consider how it might encourage such upstream providers to likewise share transfer of health/medication profile when a patient transitions to a post-acute care setting. • Whether it is feasible and important for the patient's primary physician contact information to be included on the medication profile NASL suggests that CMS consider changing "patient's primary physician contact" to allow for the practitioner responsible for the			

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			care of the individual as a point of contact, which we believe would parallel requirements for SNFs (i.e., §483.15(c)(2)(iii)(A)). We also recommend that CMS consider noting when a medication has been prescribed by a specialist. • Whether it is feasible and important for the prescriber of each medication to be identified in the medication profile Since this is a medication summary, we do not believe it is important to have the prescriber of each medication identified in the profile. That information should be part of the full medical record. • For transfers from HHA to a subsequent provider, are there any issues with adding the response option of "NA – The agency was not made aware of this transfer timely"? Are there specific instances when this response option should be considered an allowable response? Are there specific instances when this response option should not be considered an allowable response? NASL questions the disconnect that seems inherent in allowing an NA option for the different settings since the goal of the IMPACT Act is to standardize patient data across settings. We also ask for clarification with regard to the term "timely." Route of transmission of the medication profile • Whether consumers will find value in knowing the routes by which the information profile was transmitted (e.g., verbal communication) We do not believe consumers will find value in how information is communicated, so long as it is communicated. Rather than asking this question on each and every assessment, NASL believes that CMS and PAC providers might be better served by surveying how information is transferred on an annual basis rather than requiring it as another item on the MDS, OASIS, IRF PAI and LCDS. • Whether the route of transmission information would inform consumer choice of providers/facilities			

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			Access to patients' records informs consumer choice, not how that information is transmitted from one provider to the next. We do not believe this would influence consumer choice. If CMS is looking for insight into the utilization of electronic record use among providers, we would suggest that CMS ask for the primary route of transmission. Because discharges may use a combination of methods, allowing for multiple selections in responding this item will not provide much workable data for CMS. • Although not required for this measure, if PAC providers would be able to transfer the medication profile electronically through their EHRs/EMRs NASL encourages the transfer of medication profile electronically. This could be electronically communicated using the Consolidated Clinical Document Architecture (CCDA), which is an industry standard for sharing clinical data such as medication lists. All EHRs certified for Meaningful Use have the ability to clinically reconcile medications as discrete data from a CCDA. There are other technology standards, such as HL-7's Fast Healthcare Interoperability Resources (FHIR) standard, also promote discrete data exchange. Using FHIR resources would allow for a consolidated medication list to be drawn from multiple sources. • Sufficiency of existing health IT standards to support interoperable exchange of the medications and data elements proposed in the draft medication profile NASL would encourage additional work with regard to more tightly defining these data elements and standards for capturing all of the components of the mediation profile. For example, items 9, 10, and 11 of the Patient Information section include elements that we understand are not currently defined in standards such as the CCDA. We believe it is important to have more defined standards around all of the elements included in the medication profile. • Profile Document – Item Q1A NASL recommends changing the language to read as follows:			

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			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? 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 – The provider was not made aware of this transfer timely. We also recommend a closer review of this language as it relates to all settings and clarification around the term "timely." Conclusion In addition to better defining the data elements for this measure specification, NASL believes that changes to workflow may need to be considered as well. For example, the data elements referenced in the draft measure might be captured as notes or as part of a care plan, and not necessarily part of a medication list/profile as currently defined. How this information is captured – whether electronically or on paper – is an important consideration in being able to incorporate all of these data elements into a full medication profile. NASL is pleased to submit these comments to CMS and we reiterate our desire to work with the agency to more fully develop and refine this measure.			
28	5/3/18	Medication profile transferred to patient Medication profile transferred to provider	Dear Measure Development Team, The National Association of Long Term Hospitals (NALTH) is pleased to submit comments on quality measures in the domain of: Transfer of Health Information and Care Preferences When an Individual Transitions. NALTH is the only hospital trade association devoted exclusively to the needs of patients who require services provided by long term care hospitals (LTCHs). NALTH is committed to research, education, and public policy development to further the interests of the very ill and often debilitated patient populations who receive services in LTCHs throughout the nation.	Lane Koenig, PhD KNG Health Consulting	lane.koenig@knghealth.com	Provider association

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			On behalf of our member hospitals, we wish to express our gratitude for the opportunity to share our comments. We have carefully reviewed the draft data element specifications for two measures: • Medication Profile Transferred to Provider • Medication Profile Transferred to Patient NALTH believes that transfer of health information and care preference when a patient is discharged or transferred to a provider, home or other living arrangements is important for improving transitions in care and ensuring the safety of patients. In addition, we believe the information to be reported as specified in the draft specification is feasible to collect. However, we do not see the value of these two measures in terms of their ability to either help assess quality of care or explain patient complexity. In light of these limitations, we question whether the burden to providers of gathering and reporting this information is worth the benefit of collecting it. From our perspective, what is most important is not whether the information was transferred, but whether the medication profile information received from a patient's discharging setting is complete. For example, NALTH members have reported challenges in obtaining information from short-term acute care hospitals (STACHs) regarding preadmission medications and dosages and a list of the medications and dosages a patient was receiving in the STACH just prior to transition. The post-acute facility does not have any control over the medication profile information sent by the STACH. Medication information may have to be collected from three or four sources to complete the profile. The completeness and clarity of the medication profile transmitted from the LTCH or any other post-acute care provider to a patient and/or next care setting upon discharge is important. Therefore, we recommend that the Centers for Medicare & Medicaid Services (CMS) remove from consideration the current measures and, instead, consider measures and approaches to collect information from downstream referral sources, patients and their families on the accuracy, timeliness and clarity of the communication of			

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			medication profile information received by downstream providers, patients, and their families. Furthermore, we believe that electronic health record technology has not yet reached the necessary level for consumers to be able to utilize the information provided to them to make an informed choice. While we acknowledge that the 21st Century Cures Act has provided new opportunities to enable the sharing of health information, health providers are not prepared to share the information of medication and data elements in a readable and concise format to consumers. If you have any questions about these comments, please contact me, at			
29	5/3/18	Medication profile transferred to patient Medication profile transferred to provider	Comments to new Medication Profile Transfer data set in the following areas: **Measure titles** Whether the measure titles clearly capture the measure concept across the PAC settings **Comments:** My concern here would be patients who may not understand the term "Medication Profile". The OASIS data set, the assessment collection tool used in home health never mentions a Medication Profile. M2001 refers to a Drug Regimen review and the DATA SOURCES / RESOURCES Manual refers to a "Medication List." The term Medication Profile would not be a term understood by consumers and professionals alike, in my view. Furthermore, based upon my experience, when the term Medication Profile is used, it is typically synonymous with patients' list of medications. Clinicians themselves would not be entirely clear, at least initially, about all that the Medication Profile encompasses as defined in the proposed Data Set. Suggestions for the measure titles: • Medication List Transferred to Provider/Medication List Transferred to Patient	Jacqueline Lindsay	Jacque.lindsay@att.net	Individual

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			• Drug Regimen Hand-off to Provider/Drug Regimen Hand-off to Patient Both the Institute for Safe Medication Practices and the Joint Commission refer to Medication Lists. **Measure and Specifications** Potential impact and any unintended consequences of the measures (either positive or negative) Potential measure exclusions Potential benefits, if any, to aligning PAC discharge destinations/locations/status/disposition across PAC assessment instruments **Comments:** The measure considers transfer/discharge to another provider from a PAC setting. Would this include the Emergency Department (ED)? Today, patients can spend a number of days in the ED for observation without ever being admitted to the short-stay hospital. Does the measure consider this inevitability? I would think the Medication Profile would be particularly useful to these ED practitioners for the following reasons: • By its very nature, the assessments of patients who present to the ED needs to occur rapidly; if presented with a current patient Medication List, patient assessments are likely to occur more rapidly. • Elderly patients can often present as poor historians more especially under emergent condition and would not necessarily remember or be able to report all current over-the-counter and prescribed medications. **Medication profile** The definition of a medication profile. **Comment(s):** Extremely expansive and some information may not necessarily be important. The term "Medication Profile" when currently used in the home health arena is generally considered to be a patient's drug list. Consumers are not likely to know the term "Medication Profile."			

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			The types of medications to be included in the medication profile No concerns here. Whether the medication profile description captures the most important sources of medication profile information **Comment(s):** It does capture some important information (see below) but seemingly too expansive in scope The feasibility of collecting the medication profile data elements Data elements to include in a medication profile. (Please provide rationale for any new data elements not included in the draft definition.) **Comments:** Patients report of specific *times* when they take certain medications; this would be important to include on the Medication Profile transferred to patient. Which data elements in the medication profile should be designated “if applicable." Differences, if any, in what information should be included in a medication profile provided to a healthcare provider as compared to a medication profile provided to the patient/family/caregiver **Comment:** See above Whether discontinued medications should be included in the medication profile. If included, provide suggestions of 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.). **Comment(s):** • Home Health providers who utilize an EMR would likely be able to access discontinued medication information readily, however, it would be much more of a challenge for those PAC (home health) providers who maintain paper-based medical records.			

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			• Including discontinued medications in the "Medication Profile" provided to other PAC providers, would seem to be much more useful (from a historical perspective) to physicians in other care settings. Providing discontinued medications on the Medication Profile provided to patients, likely has the potential to create confusion among this elderly population who are frequently forgetful. Whether it is feasible and important for the patient's primary physician contact information to be included on the medication profile **Comment(s):** Yes. However, this Medication Profile is likely to contain medications from other practitioners in addition to the primary physician. Under the revised home health CoPs, (CFR 484.60(d)(1) & (d)(2) HHAs are required to communicate with and integrate all orders (which would include medications) of physicians relevant to the plan. So, it is feasible to obtain the name(s) of the other prescribers and an argument can be made that the names of the other prescribers may be important on the "Medication Profile transferred to provider." For example, the physician in the hospital may wish to communicate with the cardiac physician when the patient is transferred a critical access hospital. However, this information is <u>less</u> important on the "Medication Profile transferred to patient" as the patient has the name(s) of these other prescribers on the medication vials. • Whether it is feasible and important to include an assessment of a patient's ability to understand/accept his or her condition and the importance of taking medications as prescribed. **Comment(s):** Yes, I think it is feasible but not entirely certain about the important of collecting this information. Patients can understand their condition, recognize the importance of taking medications as prescribed and still not have the <u>ability</u> to manage their medication regimen. In other words, there are many other barriers to patients adhering to a medication regimen besides a lack of understanding of the importance of their condition and the			

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			regimen itself. See M2020 and M2030 collected at the time of Discharge from home health. An equally important question that the Medication Profile does not appear encompass is the patient's ***ability*** to manage their medication regimen. I would think **M2020** - Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications and **M2030** - Management of Injectable Medications - Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications. Whether it is feasible and important for the prescriber of each medication to be identified in the medication profile. Comment(s): See above For transfers from HHA to a subsequent provider, are there any issues with adding the response option of "NA – The agency was not made aware of this transfer timely"? Are there specific instances when this response option should be considered an allowable response? Are there specific instances when this response option should not be considered an allowable response? • **Comment(s):** Question Q1A 3 – At the time of discharge/transfer to another provider… You describe the denominator on this measure as "*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*." By definition this does not include the primary care physician.			

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			• In home health when a patient is discharged to the community after receiving care, a complete discharge Summary (which typically includes the medications the patient is taking) is required to be sent to the primary care physician "who will be responsible for providing care and services to the patient after discharge" within 5 business days. There is likely to be some confusion for home health clinicians because of these longstanding norms of providing Summaries to the primary care practitioner or other health care professional who will be responsible for providing care and services after discharge from the home health agency. Under the new CMS home health CoPs, home health agencies are required to provide transfer summaries within 2 business days of a planned transfer to the receiving facility and within 2 business days of becoming aware of a transfer. See §484.110(a)(6). Accredited home health agencies have been required to provide these medication lists at the time of patient transfer. How then does the **Q1A** 3. "NA" response aligned (or not) with the 2-business day requirement? What would be the expectation here given **§484.110(a)(6)(iii)** which states: (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. • Measure Medication Profile Transferred to Patient **Comment(s):** Similarly, **§484.110(a)(6)(i)** requires the home health agency to sent (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; See above comment(s)			

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			The denominator statement for **Q2A** includes 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. In home health there are instance when clinicians would not have an opportunity to make a home visit (patient moved, patient refused services), and may not be able to provide the patient a current Medication Profile, however, there is no "NA" response on this measure **Route of transmission of the medication profile** • Definitions of routes of transmission of the medication profile are included on pages 10-11. We seek your comments on: • Whether consumers will find value in knowing the routes by which the information profile was transmitted (e.g., verbal communication) **Comments:** I am not persuaded that consumers would care very much about the mode by which the information is transmitted. I my experience the concern is that the information is conveyed, in its entirety. • Whether the route of transmission information would inform consumer choice of providers/facilities **Comment:** To what extent to which the information on mode of transfer of information would inform consumer choice remains uncertain to me.			