Draft Specifications for the Medication Profile Transferred Measures for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies

RTI
INTERNATIONAL

DRAFT SPECIFICATIONS FOR THE MEDICATION PROFILE TRANSFERRED MEASURES FOR SKILLED NURSING FACILITIES (SNFS), INPATIENT REHABILITATION FACILITIES (IRFS), LONG-TERM CARE HOSPITALS (LTCHS), AND HOME HEALTH AGENCIES (HHAS)

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SECTION 1
PROJECT INFORMATION

1.1   Project Titles

The Centers for Medicare & Medicaid Services (CMS) has contracted with RTI International and Abt Associates to develop a cross-setting transfer of health information and care preferences measure in order to meet the mandate of the Improving Post-Acute Care Transformation Act of 2014 (IMPACT Act). The contract names and task orders are:

1. Development and Maintenance of Symptom Management Measures (RTI International; CMS Contract no. HHSM-500-2013-13015I, Task Order HHSM-500-T0001)

2. Outcome and Assessment Information Set (OASIS) Quality Measure Development and Maintenance (Abt Associates; CMS Contract no. HHSM-500-2013-13001I, Task Order HHSM-500-T0002)

1.2   Project Overview

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. Care settings included in these measure development projects are Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs). 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. For more information on the background of measure work for this transfer of health domain, including TEP, public comment, and pilot summary documents, please see: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html.

1.3   Date

Information included is current on March 16, 2018.

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SECTION 2
MEASURE DESCRIPTIVE INFORMATION

2.1   Measure Names

The Medication Profile Transferred concept consists of two measures:

1. Medication Profile Transferred to Provider

2. Medication Profile Transferred to Patient

2.2   Measure Type

Process

2.3   Care Settings

Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs)

2.4   Brief Description

These measures address the IMPACT Act mandate to specify quality measures on which PAC providers are required to submit standardized patient assessment data with respect to the following 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.

The medication profile transferred measures ensure that a provider is accountable for transferring important medication information at transitions. For example, when a resident transitions from SNF to home with HHA services, the first measure would capture the transfer of the current medication profile from the SNF to the HHA. When the resident is discharged to home, the second measure would capture the transfer of the current medication profile from the SNF to the patient, family and/or caregiver. The measures will also capture standardized information about the route of information transfer. While these measures assess the transfer of a medication profile, there is also an item that collects information on the route(s) of transmission of the medication profile.

The data for the measures will be collected by means of the Minimum Data Set (MDS) for SNF residents, the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for IRF patients, the Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set (LCDS) for LTCH patients, and the Outcome and Assessment Information (OASIS) Information Set for HHA patients.

SECTION 3
MEASURE JUSTIFICATION

3.1 Why Two Measures

There are two measures because there are two important and distinct cohorts and recipients of the medication information: 1) the cohort of patients who are discharged/transferred to the care of a subsequent provider, who is the recipient of the medication profile; and 2) the cohort of patients who are discharged to their home or other living arrangement and are the recipients of their medication profile. Both measures are collected at the time of discharge/transfer.

3.2 Measure Priority

The communication of health information, such as that of a medication profile, is critical to ensuring safe and effective patient transitions from one health care setting to another. Medication errors, poor communication, and poor coordination between providers, along with the rising incidence of preventable adverse events and hospital readmissions, have drawn national attention to the importance of the timely transfer of health information, such as a current medication profile, at discharge or transfer. Additionally, the transfer of health information is an important topic area in the Meaningful Measures Initiative under the Promoting Effective Communication and Coordination of Care domain.

3.3 Background and Current Gaps

Care transitions across health care settings have been characterized as "common, complicated, costly and potentially hazardous for older adults." Poor patient outcomes resulting from poor communication and exchange of information have been found to contribute to hospital readmissions, ED visits (Barnsteiner, 2005; Arbaje et al., 2014; Jencks, Williams, & Coleman, 2009; Institute of Medicine, 2010; Kitson, Lau, & Showler, 2013; Mor, Intrator, Feng, & Grabowski, 2010) and mortality (Toles, 2016). Incomplete and missing information for patients who transition to and from PAC settings has been well-documented (Forster, Murff, Peterson, Gandhi, & Bates, 2003; Tupper, Gray, Pearson, & Coburn, 2015; Kind & Smith, 2008). Improved communication and timely transfer of health information can result in safer transitions by reducing adverse events (Vognar & Mujahid, 2015; King, 2013; Atkinson, 2013; Cibulskis, 2011; Lattimer, 2011; Siefferman & Fine, 2012). However, despite evidence of the importance of timely transfer of health information and the large number of care transitions, studies have found that there is little incentive for health care organizations to coordinate the transfer of health information (McGinn-Shapiro, et al, 2015).

Incomplete medication information for medication reconciliation and management poses a particular patient/resident safety risk (Kwan, Lo, Sampson, & Shojania, 2013; Boockvar et al., 2011; Tam et al. 2005; Bell et al., 2011; Basey, Krska, Kennedy, & Mackridge, 2014; Desai, Williams, Greene, Pierson, & Hansen, 2011). Older adults are particularly vulnerable to adverse health outcomes due to insufficient medication information on the part of health care providers due to their higher likelihood for multiple comorbid chronic conditions, polypharmacy, and complicated transitions between care settings (Chhabra, et al., 2012). For example, adverse events related to medication errors in SNFs cited in a 2014 Office of Inspector General (OIG) report (Levinson & General, 2014) may be associated with multiple medications, particularly new medications, being prescribed for older patients discharged from the hospital to the PAC setting. In a recent study, hospitalized patients discharged to SNFs had an average of 13 medications on their hospital discharge list (Bell et al., 2016). Thus, SNF and other PAC providers

often are in the position of starting complex new medication regimens with little knowledge of the patient or their medication history upon admission.

Adverse events resulting from duplication of medications, unnecessary changes in medication regimens, or unexplained medication discrepancies may become life-threatening. For example, for older patients with atrial fibrillation, regimens that reduce the risk of stroke may also increase the risk of bleeding (Deitelzweig, 2012). A study examining medication discrepancies in care transitions found that discrepancies occurred in as many as three quarters of SNF admissions (Tija, et al., 2009) and 86 percent of all transitions (Sinvani, et al., 2013). Several factors were identified as contributors to medication errors during transitions, including staff communication, order transcription, medication availability, pharmacy issues, and name confusion (Desai, et al., 2011). A recent study by Manias and colleagues (2017) found that common medication classes used to treat chronic conditions in older patients - cardiovascular, respiratory, and psychotropic medications - were omitted without any clinical explanation for the discrepancy. The same study also found that older patients being discharged to settings other than their home were more likely to experience a medication discrepancy, ultimately increasing their likelihood of experiencing an adverse event.

Patients with complicated medication regimens require efficient and effective communication and coordination of care between settings, including detailed transfer of medication information to prevent potentially deadly adverse effects (Deitelzweig, 2012). Inter-institutional communication regarding medication regimens is a key factor to improving care transitions and reducing harm to patients (Oakes, et al., 2011). When care transitions are enhanced through care coordination activities, such as expedited patient information flow, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans (Mor, Intrator, Feng, & Grabowski, 2010) and prevent medical errors (Institute of Medicine Committee, 2007; Starmer et al., 2014). Many care transition models, programs, and best practices emphasize the importance of timely communication and information exchange between discharging/transferring and receiving providers (AHRQ, 2016, Murray & Laditka, 2010; LaMantia, Scheunemann, Viera, Busby-Whitehead, & Hanson, 2010).

Electronic health records (EHRs) 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 provide a standardized way to exchange critical information between PACs and other providers. While these tools and efforts are targeted at improving communications between healthcare providers at transitions, 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 (Bercovitz, Park-Lee, & Jamoom, 2013; Dougherty, Harvell, Williams, & Millenson, 2013; Wolf, Harvell, & Jha, 2012; Alvarado, 2017). Other barriers to EHR adoption by PAC providers include the initial cost of EHR adoption, user perceptions, and implementation problems (Cross, 2017).

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. A recent study using data from the 2014 American Hospital Association survey determined the proportion of hospitals that engaged in electronic health information exchange with PAC providers. Results showed that 57 percent of hospitals engaged in health information exchange with PAC providers. Just under 34 percent reported utilizing systems that are send-only, while just under 24 percent utilized systems that can send and receive information from PAC providers (Cross & Adler-Milstein, 2016). A 2016 national survey of skilled nursing facilities found that 18 percent of skilled nursing facilities used both an EHR and a health information organization (HIO); facilities that used both had higher rates of electronically sending patient health information compared to those that used an EHR alone (Alvarado, 2017).

Interoperability provisions within the 21st Century Cures Act (Pub. L. 114-255), enacted in 2016, provide new opportunities to enable the electronic sharing of health information through the development or support of a trusted exchange framework including a common agreement among health information networks and data accessibility, without special effort, through the use of application programming interfaces ((Office of the National Coordinator for Health Information Technology, 2018). These advancements are expected to improve access to electronic health information for both providers and patients.

Increasing interoperable information exchange with and by PAC providers is recognized as important to improve quality and care coordination and reduce unnecessary utilization and costs. The quality measures under development will publicly report information to help CMS, consumers, policymakers, and other stakeholders better understand and monitor how patient/resident medication profile information is transferred by PAC providers to other healthcare providers and to patients/family members during transitions.

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SECTION 4
DEFINITIONS AND ACRONYMS

4.1   Medication Profile

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

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

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

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

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*
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*

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.

4.1.3   Route of Transmission Item Definitions

1. **Electronic health record (EHR):** An EHR, sometimes referred to as an electronic medical record (EMR), is an electronic version of a patient's medical history that is maintained by the provider over time. This may include key clinical data relevant to that person's care under a particular provider, including demographics, progress notes, medical conditions, diagnoses, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports (Office of the National Coordinator for Health Information Technology, 2011)

   This route would be coded if the medication profile is electronically shared through the PAC provider's EHR.

   Examples of EHR as the route of transmission include:

   • Sending the medication profile from the PAC provider's EHR directly to the receiving hospital's EHR system (e.g., via interface connection between EHR systems)
   • Providing patients with remote access to view their medication profile through the PAC provider's EHR portal (website)
   • Electronically transmitting the medication profile data from the PAC provider's EHR to a patient's personal health record or a health application
   • Providing the receiving hospital or care team member access to the PAC provider's EHR through a portal (website) or other means, such as remote or onsite access. This allows other providers (e.g., hospitals, HHAs) involved in the care of the patient to view the medication profile within the medical record

2. **Health Information Organizations (HIOs)**

   Health information Organizations (HIOs) facilitate exchange between unaffiliated organizations within a specific geographic area (national, statewide or regional) that share health care-related information according to accepted health information technology standards.

   Examples of these health information organizations include health information service providers (HISPs), EHR vendor networks, health information exchanges

(HIEs) and other health information networks. HISPs are entities that provide services to securely transport encrypted health information (e.g., Direct secure email). EHR vendors may establish networks that enable their users to exchange data with each other or affiliated EHR vendor systems. HIEs may include state-based or independent regional health information exchanges or private exchanges between aligned facilities.

This route would be coded if the medication profile is electronically exchanged using a HIO and often occurs when the PAC provider's EHR or portal is integrated with the HIO.

Examples of HIOs as the route of transmission include:

- Exchanging the medication profile between a PAC provider and the receiving hospital through a state HIO
- A PAC provider exchanges medication information through a HIO that provides a web interface so that a receiving provider and the patient can view and query the information
- A PAC provider's EHR vendor participates with other EHR vendors in a health information exchange network that allows the PAC provider to transfer medication profile information with providers participating in that network in order to coordinate care
- Sending medication profile information via secure email messaging (e.g., Direct secure messaging) to the patient or receiving provider

3. **Verbal**: PAC provider verbally provided information to the receiving provider. The information relayed verbally may be documented in a progress note, or on a form or template to support communication. This form of communication could happen over the telephone or in-person.

Examples of verbal routes of transmission include:

- Receiving provider participates in discharge rounds at the discharging PAC facility/agency
- The patient's/resident's medication profile reviewed with them in person at the time of discharge
- Telephone conversation with physician or nurse at receiving facility/agency to relay medication information at PAC provider discharge

4. **Paper-based:** PAC provider sent information to the receiving hospital through a paper-based method such as sending a paper copy/form/printout, sending information via a fax machine, or sending information in the mail.

Examples of paper-based routes of transmission include:

- Sending a paper copy of the medication profile with the resident/patient or family member/caregiver when they are discharged/transferred from a PAC setting
- PAC provider sending the subsequent provider a paper copy of a transfer form that includes the medication profile, and the form is sent with the ambulance or medical transportation company
- PAC provider sends a fax of the discharge summary, which includes the medication profile, to the patient's next healthcare provider

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SECTION 5
MEASURE #1: MEDICATION PROFILE TRANSFERRED
TO PROVIDER MEASURE SPECIFICATIONS

5.1   Measure Title

Medication Profile Transferred to Provider

5.2   Measure Type

Process

5.3   Target Population

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

5.4   Data Sources

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

5.5   Data Collection Time Point

Discharge/Transfer

5.6   Summary Description

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

5.7   Purpose/Rationale for Quality Measure

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

5.8   Items Used in Quality Measure Calculation and Reporting

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

In addition to Question 1A, one additional item, Question 1B, would be collected if the facility/agency provided a current medication profile at the time of discharge or transfer to another provider. Question 1B collects information on the route(s) of transmission of the medication profile. Question 1B would potentially be collected as a standardized patient assessment data element and would

be used for the public reporting of information for consumers, but would not be used to calculate the quality measure.

Medication Profile Transferred to Subsequent Provider: Example of Assessment Items

Q1A	At the time of discharge/transfer to another provider, did your facility/agency provide the patient's/resident's current medication profile to the subsequent provider?
Enter Code ☐	1. Yes – Current medication profile provided to the subsequent provider→ Go to Q1B. 2. No – Current medication profile not provided to the subsequent provider? 3. NA (Home Health transfer only) – The agency was not made aware of this transfer timely
Q1B	Indicate the route(s) of transmission of the current medication profile to the provider. (Check all that apply) ☐ 1. Electronic Health Record ☐ 2. Health Information Organization ☐ 3. Verbal (e.g., in-person, telephone, video conferencing) ☐ 4. Paper-based (e.g., fax, copies/printouts)

5.9   Denominator Statement

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

5.10   Denominator Details

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

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

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

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

5.11 Denominator Exclusions

None

5.12 Numerator Statement

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

5.13 Numerator Details

Number of patient/resident stays/episodes where:

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

5.14 Quality Measure Calculation

The following steps would be used to calculate the measure.

Step 1. Calculate the denominator count
Calculate the total number of patient/resident stays/episodes ending in discharge/transfer to another provider.

Step 2. Calculate the numerator count
Calculate the total number of discharges/transfers where the current medication profile was provided to the provider at the time of discharge/transfer to another provider.

Step 3: Calculate the facility/agency observed score
Divide the facility's/agency's numerator count by its denominator count to obtain the observed score; in other words, divide the results of Step 2 by the results of Step 1. Multiply by 100.

5.15 Risk Adjustment

This measure is not risk adjusted.

5.16 Score

5.16.1 Type of Score

Percent

5.16.2 Interpretation of Score

Higher = better

5.16.3 Level of Analysis

Facility/Agency

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SECTION 6
MEASURE #2: MEDICATION PROFILE TRANSFERRED
TO PATIENT MEASURE SPECIFICATIONS

6.1   Measure Title

Medication Profile Transferred to Patient

6.2   Measure Type

Process

6.3   Target Population

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

6.4   Data Sources

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

6.5   Data Collection Time Point

Discharge/Transfer

6.6   Summary Description

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

6.7   Purpose/Rationale for Quality Measure

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

6.8   Items Used in Quality Measure Calculation and Reporting

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

In addition to Question 2A, one additional item, Question 2B, would be collected if the facility/agency reports that a medication profile was provided to the patient, family and/or caregiver at

the time discharge/transfer. Question 2B collects information on the route(s) of transmission of the medication profile Question 2B would potentially be collected as a standardized patient assessment data element and would be used for the public reporting of information for consumers, but would not be used to calculate the quality measure.

Medication Profile Transferred to Patient: Example of Assessment Items

Q2A	At the time of discharge/transfer, did your facility/agency provide the patient's/resident's current medication profile to the patient, family and/or caregiver?
Enter Code ☐	1. Yes – Current medication profile provided to the patient, family and/or caregiver → Go to Q2B. 2. No – Current medication profile not provided to the patient, family and/or caregiver.
Q2B	Indicate the route(s) of transmission of the current medication profile to the patient/family/ caregiver. (Check all that apply) ☐ 1. Electronic Health Record (e.g., electronic access to patient portal) ☐ 2. Health Information Organization ☐ 3. Verbal (e.g., in-person, telephone, video conferencing) ☐ 4. Paper-based (e.g., fax, copies/printouts)

6.9   Denominator Statement

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

6.10   Denominator Details

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

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

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

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

6.11 Denominator Exclusions

None

6.12 Numerator Statement

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

6.13 Numerator Details

Number of patient/resident stays/episodes where:

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

6.14 Quality Measure Calculation

The following steps would be used to calculate the measure.

Step 1. Calculate the denominator count
Calculate the total number of patient/resident stays/episodes ending in discharge/transfer to a private home/ apartment (apt.), board/care, assisted living, group home, transitional living or home under care of organized home health service organization or hospice.

Step 2. Calculate the numerator count
Calculate the total number of discharges/transfers where the current medication profile was provided to the patient, family and/or caregiver at time of discharge/transfer.

Step 3: Calculate the facility/agency observed score
Divide the facility's/agency's numerator count by its denominator count to obtain the observed score; in other words, divide the results of Step 2 by the results of Step 1. Multiply by 100.

6.15 Risk Adjustment

This measure is not risk adjusted.

6.16 Score

6.16.1 Type of Score

Percent

6.16.2 Interpretation of Score

Higher = better

6.16.3 Level of Analysis

Facility/Agency

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