



IMPACT Act: Drug Regimen Review Measure Overview for the Home Health Quality Reporting Call

Moderated by: Leah Nguyen
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event.

All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this Medicare Learning Network call on the IMPACT Act: Drug Regimen Review Measure for the Home Health Quality Reporting Program.

The Improving Medicare Post-Acute Care Transformation Act of 2014, or IMPACT Act, requires reporting of standardized patient assessment data by post-acute care providers, including skilled nursing facilities, home health agencies, and patient rehabilitation facilities and long-term care hospitals.

During this call, CMS and measure developers present the Home Health Drug Regimen Review Quality measure, which was adopted to fulfill the Medication Reconciliation domain requirement of the IMPACT Act. A question-and-answer session follows the presentation.

Before we get started, you received a link to the presentation and handout in your confirmation email. These materials are available at the following URL – go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

At this time, I would like to introduce our first presenter, Dr. Tara McMullen, Senior Health Analyst for the Division of Chronic and Post-Acute Care. I will now turn the call over to Tara.

Presentation

Dr. Tara McMullen: Hi, everyone. Good afternoon. This is Tara McMullen. And thank you for calling in and being with us today as we talk about the Drug Regimen Review Quality measure that was developed under the IMPACT Act.

And if you have your slides open, you'll see here on slide 2 today's presentation objectives. So, we'll be walking through the measure, talking about the reporting of the measure, and some key takeaways for data accuracy for the measure. And as a reminder, today's focus is on the Home Health measure for the Home Health Quality Reporting Program. However, this is a standardized measure. So the key components of the measure and the discussion about those components are standardized to the IRF, LTCH, and SNF settings.

IMPACT Act and Domain of the Medication Reconciliation

So if you can join me on slide 4. The Improving Medicare Post-Acute Care Transformation Act of 2014, or what we like to call the IMPACT Act, was signed into law October 6th, 2014. This law moved seamlessly through the



House and the Senate. It was a bipartisan law signed into being in 2014. And IMPACT Act requires many things.

But overall, it asks that CMS standardize data so that data is uniform to improve quality outcomes, so data is uniform to help supply information for payment modelling, so that data is interoperable and that we could do things such as back-end discharge planning, improve coordinated care, and really look at comparisons across post-acute care settings of persons who are traversing the care continuum.

If you look at slide 5, you'll see some driving forces of the IMPACT Act. And, really, the point of this slide is to say the IMPACT Act occurred because of escalating costs associated with post-acute care stays and lack of data for standards or even quality data that are interoperable and standardized across post-acute care settings. Standardization allows the senders and the receivers to send information that is usable on both ends so that data talks to one another. This will help not only for quality and clinical workflow, but it helps for payment as well.

And on slide 6, there are measures – there are many measures that are mandated under the IMPACT Act. And, of course, in this presentation we're talking about the Medication Reconciliation domain, and you'll see here that we have circled that in red.

The Medication Reconciliation domain – the IMPACT Act asked CMS to standardize data and to develop a standardized quality measure for this domain to be effective and collected in home health agencies January 1st, 2017, and in the facility settings for SNFs, IRFs, and LTCHs October 1st, 2018, or no later than October 1st, 2018.

So on slide 7 you'll see that in all four settings, we have proposed and adopted the Drug Regimen Review measure to fulfill the intent of the Medication Reconciliation domain. And currently, this measure is collected in home health agency settings, which is why we focus on this measure today. This measure will be collected in 2018 in SNF, IRF and LTCH settings.

On slide 8, you'll see that this measure was adopted because of the IMPACT Act and the intent of the IMPACT Act. CMS contracted with Abt Associates and RTI International, who join us on the call today, to develop a measure – and it was dubbed the Drug Regimen Review measure – for all PAC providers to fulfill the requirements as mandated. The measure itself originated – the items that calculate the measure originated from the OASIS assessment instrument.

For those of you – probably everyone on this call – who are familiar with the OASIS, the original items that we assessed and used and modified to basically develop the Drug Regimen Review measure were M2000, M2002, and M2004. So these three items were the foundation of the measure that CMS adopted, finalized, and now is using for collection in the Home Health Quality Reporting Program.

So, over the course of the collaboration between Abt Associates, RTI International, and CMS when we were developing the Drug Regimen Review measure, you will see that when we modified items M2000, M2002, and M2004, we renumbered the items that you currently collect M2001, M2003, and M2005. And those are in the OASIS.



And next year, for anyone who is familiar with the SNF, IRF, and LTCH assessment instruments, those items will be N2001, N2003, and N2005 – N as in Nancy.

So, that was a little background about the IMPACT Act and this measure. And at this point, I'm going to turn it over to Linda Krulish, who will take you through the rest of the presentation. So, Linda, to you.

Quality Measure: Title and Description

Linda Krulish: Thanks, Dr. McMullen.

The title of the measure is Drug Regimen Review Conducted for Follow-Up for Identified Issues. That is the measure that we'll focus on today. It's a process measure.

So, unlike outcome measures that report a change in a patient's status from one time point to another time point, process measures report the rate that your home health agency uses specific evidence-based processes of care. So when you provide the specific best practice, you report that you've provided it by accurately completing select OASIS items that are then used to calculate and report the process measure.

The Drug Regimen Review, or DRR, process measure reports the percentage of care episodes where a drug regimen review was conducted at the start of care or resumption of care and timely follow-up with the physician occurred each time a potential clinically significant medication issue was identified throughout the entire care episode. And a care episode begins each time we conduct either a start of care or a resumption of care assessment. And the care episode ends with the next transfer, death at home, or discharge assessment.

So moving on to slide 10. To achieve a favorable result for this DRR process measure, three specific best practices or conditions must be met. First, there needs to be a drug regimen review completed at the beginning of the care episode. That's at the start of care – at each start of care and resumption of care assessment. And when you complete a drug review at the start of care or resumption of care, you will report that you've done so using OASIS item M2001.

Second, if any potential clinically significant medication issues are identified at the start or resumption of care, then the physician or physician designee must be contacted and follow-up actions must occur by midnight of the next calendar day. And when you take these actions, you'll report that you've done so using OASIS item M2003.

And then, third, after the start of care or resumption of care assessment, as anyone in your agency identifies potential clinically significant medication issues throughout the entire episode of care, then the physician should be contacted, and follow-up action should occur by midnight of the next calendar day from the time each new issue was identified. At the end of care – at the end of the episode, you're going to report completion of these actions using OASIS item M2005.

And when all three of these conditions are met, that patient's care episode has a favorable impact on your agency's DRR process measure rate. If any of these required conditions are not met, then the patient care episode will have an unfavorable impact on your agency's DRR measure rate. And we'll talk more about the



measure criteria later. But for now, let's move to slide 11 and briefly look at the OASIS data items that gather this information that's used to determine if your agency met the three required conditions.

And the first item is M2001, Drug Regimen Review. And it asks, "Did a complete drug regimen review identify potential clinically significant medication issues?" The second item, M2003, Medicare Follow-up, asks, "Did the agency contact a physician or physician designee by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?"

And the third item, M2005, Medication Intervention, asks, "Did the agency contact and complete physician or physician designee prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the start of care or resumption of care?"

Then moving to slide 12, just as these three cross-setting standardized data collection items have been embedded into the OASIS, as Tara mentioned, three similar standardized items will be embedded into the setting-specific assessment instruments for the other PAC settings that are affected by this IMPACT Act requirement. And, again, specifically, that's in-patient rehab facilities, skilled nursing facilities, and long-term care hospitals.

In each of these four PAC settings, the first two standardized items will be collected at the beginning of the care episode or stay, and the last item will be collected at the end of each care episode or stay. In home health, these three new items began being collected with implementation of OASIS V2 this January 1st, 2017.

LTCH providers will begin collecting data on the DRR items using the LTCH care data set starting on July 1st, 2018. And IRF and SNF providers will begin collecting the DRR items using the IRF-PAI and the MDS, respectively, starting on October 1st, 2018. In all the settings, the collected data will be used to calculate and report the Drug Regimen Review Conducted with Follow-up for Identified Issues process measure for facilities and agencies in each PAC setting.

So now that we've had a brief overview of the measure and data collection items, let's define some key terms that we're going to see in these OASIS items.

Definitions

So starting on slide 14, our first key term is "drug regimen review" or, again, DRR. The definition encompasses a full review that goes well beyond just compiling a list of medications or even resolving discrepancies between two medication lists, activities that we describe as medication reconciliation.

A drug review includes not only med reconciliation activities but also a review of all the medications that a patient is currently using to identify and, if possible, to prevent potential clinically significant medication issues from occurring or from exacerbating.

When considering all medications, the drug review includes reviewing all prescribed and all over-the-counter medications that the patient's currently taking, including TPN and herbals and all medications administered by



any route – any route of administration – so including orals, topicals, patches, inhalant or mist medications, pumps, injections, IV, via enteral tube, or any other route.

So the drug regimen review is more than just comparing the patient's home medications with their med list from their recent hospital stay. It also includes assessing the patient to determine if he or she is experiencing any problems or any issues that would meet the definition of a clinically significant medication issue.

Then that takes us to our second key term or phrase. And that is “clinically significant medication issue.” And this is defined as an issue that in the care provider's clinical judgment requires physician or physician designee notification by midnight of the next calendar day at the latest. So it's important to note that in addition to identifying potential issues, the item also includes identification of any actual existing clinically significant medication issue that, again, in the care provider's clinical judgment requires physician notification by midnight of the next calendar day.

So let's talk about some examples of situations that an assessing clinician might determine would require this timely physician notification and follow-up and, therefore, would meet the definition of a clinically significant medication issue.

First could be adverse reactions. So this could be something like a rash or diarrhea. An adverse reaction is a secondary effect of a medication that's usually undesirable. It's different from the desired therapeutic effect. Similar to adverse reactions are side effects like bleeding relating to anticoagulant therapy.

Not every adverse reaction or every side effect should automatically be considered a potential clinically significant medication issue. It always is going to be determined by the assessing clinician based on their findings from a thorough patient assessment.

Other situations that may be considered a potentially – a potential clinically significant medication issue could be things like duplicative drug therapy where a patient might be confused by the same medication prescribed and filled once under a brand name and another time under a generic name.

The home health clinicians may identify situations where patients are not taking a medication that's been prescribed. So, this can occur for multiple reasons. The patient or family might decide not to pick up the prescription either because they can't afford it or they don't think they need it or they don't have transportation to get it or they just forget about it.

There can be dosage errors that occur either by mistake or when a patient or family knowingly alters the dose. So patients might intentionally cut back on their dose. They might split pills or take a daily med every other day to save money. Or a patient or family member might adjust the dose to minimize the side effects, like skipping a diuretic so the patient doesn't have to get up at night to use the bathroom.

So again, these are only a few examples, any of which may be considered a potential or actual clinically significant medication issue based on the assessing clinician's judgment.

So let's look at slide 16. Being able to apply the definition of a clinically significant medication issue to what you see in the home setting is critical in obtaining accurate OASIS data and validity in this resulting Drug Regimen



Review measure. So let's consider how we might operationalize this in the home as part of our comprehensive patient assessment.

So again, on slide 16 we have a scenario for you to consider. Let's say that you arrive at the home to admit your patient and you find that their medications are sitting on the table. They're still in the stapled bags from the pharmacy. You're the assessing clinician, so you will be the one that determines if a potential or actual clinically significant medication issue exists for your patient today.

By just seeing the bag sitting there on the table, would you know if there was a medication problem? What if through additional assessment and interviewing of the patient and the family, you discover that the bag contains Wellbutrin for depression? And you ask more questions and you find out that the patient is finishing up their current bottle and this is a refill to start tomorrow. Would you consider that to be a potential clinically significant medication issue?

But what if, instead, you discovered that your patient ran out of their Wellbutrin last week? And since they ran out, they've been experiencing nausea and vomiting and insomnia and severe sweating and now they don't know if they should start taking the medication again or not.

What if the bag contained Bactrim for a UTI and you learned that the family delayed getting a prescription filled for a few days and you find the patient to be feverish? They have severe flank pain. The family's reporting marked mental status changes over the last 24 hours. Would you consider that a potential clinically significant medication issue? So, meaning, would you feel like you need to be on the phone with the physician to provide notification by midnight of the next calendar day at the latest?

What if the bag contained a vitamin D supplement, which the patient is currently 2 days late in taking her weekly capsule for a vitamin D deficiency and she tells you that she often forgets to take it and at her last doctor's appointment, they instructed her that it would be really great if she could try to take it a little bit more consistently. And she wants to know if you can help her come up with a strategy to help remember to take it. Would you consider that a potential clinically significant medication issue? Again, meaning, do you feel like you need to be on the phone with the physician to provide notification by midnight of the next calendar day about the situation?

So moving to slide 17. So how does a clinician determine if these kinds of medication issues are clinically significant? This does require clinical judgement, again applies all the information that you've gathered as part of a thorough comprehensive patient assessment.

First and foremost, the medication issue must, in the clinician's opinion, reach a level of clinical significance that warrants this timely notification to the physician for orders or recommendations. Therefore, any circumstance that the clinician determines doesn't require this timely attention would not be considered a clinically significant medication issue for the purpose of scoring these OASIS items.

For instance, if the identified problem can be resolved by the home care nurse educating the patient or by showing the family how to use a weekly pill planner, and based on the medications and the dosing and administration schedule and the findings from the patient assessment the clinician determines that the situation is not clinically significant and maybe it can be reported to the physician at some later time or perhaps it



doesn't even warrant specific physician notification at all. Then the assisting clinician would not consider such a situation to be clinically significant for the purpose of this OASIS data collection.

So it is important to know that this definition of clinically significant medication issue – that a clinician or an agency should not limit the definition to only high-risk medications or only to some agency-specific list of medications. This would limit the scope and not meet the intent of the measure. So, for instance, if the issue that I identified in assessing my patient is that the patient can't swallow a pill without choking on it, then it really doesn't matter what the pill is, right?

So the assessing clinician could determine that the physician needs to be notified to consider alternative options for the patient even if the pill that they're choking on is not a medication that would be considered clinically as a high-risk med.

Moving to slide 18, another key term in these items relates to physician contact. So contact with a physician includes communicating with the physician or the physician designee. It can be made by telephone, by voicemail, fax, or any other means that appropriately conveys the message of the patient's status and the assessing clinician's concern.

So communication can be directly to and from the physician or physician designee or indirectly through someone at the physician's office who can speak on behalf of the physician in accordance with the legal scope of practice. The communication needs to be bidirectional, meaning I can't call and leave a message or send a fax without getting that two-way acknowledgment that my communication was received by the physician or their designee.

And physician designee is defined as physician office staff that can communicate, including receiving and providing information, on behalf of the physician in accordance with the legal scope of practice. You may need to consult with your agency policies, with State regulations, and, possibly, other entities to determine exactly who can be considered the physician designee for the purpose of this communication that's described.

Slide 19 is another phrase in the item – asks if the agency completed, prescribed, or recommended actions. And prescribed or recommended actions mean just that – anything that the physician tells you to do in response to you notifying them of the clinically significant medication problem that your patient is experiencing.

So your patient might tell you that since they started a new medication that they have not been able to get a good night's sleep, and this fatigue is causing them to have low pain tolerance. It's affecting their function. Their mobility is unsteady. It's affecting their willingness to participate in therapy. So let's say that due to the impact on the patient, you consider this a clinically significant medication issue. So you call the physician to address this.

An example of a prescribed or recommended action could include the physician telling you to have the patient take the medication in the morning instead of at night. So in that case you would be considered as having completed the prescribed or recommended action once you have communicated to the patient or the caregiver that the physician wants them to take the particular medication in the morning instead of at night.



Sometimes the prescribed or recommended action that the doctor gives you might be something that cannot be completed by midnight of the next calendar day. For instance, in the situation that I just described, what if the physician said to have the patient take the medication in the morning instead of the evening for the next 3 days, and then, if the patient's sleep doesn't improve, to completely discontinue the medication?

So in a situation like that, the prescribed or recommended action can be considered as having been completed for the purpose of responding to these OASIS items if within the allotted timeframe, which is by midnight of the next calendar day, the agency has taken whatever actions are possible to complete with the actions recommended by the physician.

So in this case, if by midnight of the next calendar day, you've communicated to the patient something like, "Hey, I spoke with your physician and starting tomorrow, the doctor wants you to take your pill in the morning instead of at night, and then on Monday we're going to see if your sleep is any better or if we need to stop the medication altogether."

So since you did as much of the recommended action as you possibly could in the allowed timeframe, you would report, "Yes," you completed the prescribed or recommended actions.

And then the last term that we will discuss is this allowed timeframe of by midnight of the next calendar day. This is not a 24-hour timeframe. The time period is whatever time the problem's identified until midnight of the next calendar day. So if you identified a clinically significant medication issue right now, you have all of the rest of today and all of tomorrow until midnight tomorrow night for the two-way communication and completion of the recommended actions to occur.

So with the foundation of those key terms and definitions, let's look at the items in more detail. And I'm going to highlight some item-specific guidance that will support standardized data collection.

Item-Specific Guidance with Patient Scenarios

So I'm on slide 22. And the first OASIS item that we'll discuss is M2001, Drug Regimen Review. And this item is collected, again, at the start of care or resumption of care. And the intent of the item is to identify if a review of the patient's medications indicated any potential clinically significant medication issues. So this is where you're going to need to rely on those definitions that we just discussed.

And probably the most important definition for this measure is remembering that a potential or existing clinically significant medication issue is an issue that in your clinical judgment as the care provider requires physician or physician designee notification by midnight of the next calendar day at the latest.

And it may include things like those adverse reactions or ineffective drug therapy or side effects or nonadherence – all of the issues that we previously discussed. But it always will be based on clinical judgment of the assessing clinician and be patient-specific.

So on slide 23. If a drug regimen review is completed and the assessing clinician finds things like the med list from the hospital exactly matches the meds that the patient has in the home and the patient's symptoms that they're taking medications for are effectively controlled and the patient seems to be taking the right medication



in the right dose at the right time and there seems to be no indication of adverse drug reactions or significant side effects – so in those situations where, after completing this review, the clinician determines that no potential clinically significant medication issues exist, response “0 – No issues found during review” would be selected for M2001.

And based on data from the first quarter of our OASIS data collection, we see that this item is reported as “0 – No issues found” on 76 percent of the start of care and resumption of care assessments. So that does that necessarily mean that 76 percent of our patients don’t have any medication-related problems or questions or education needs when we start home care – because, actually, most of them do.

But what it does mean is that 76 percent of the time, the patient either doesn’t have any medication issues or those issues that are found are able to be addressed and remedied either without specific physician involvement or with physician involvement that didn’t rise to the level of urgency that necessitated contact by midnight of the next calendar day.

So moving on to slide 24. If the assessing clinician completes the drug regimen review and finds a situation that they consider significant enough to warrant this physician notification by midnight of the next calendar day, then response “1 – Yes, issues found during review” is selected.

And some situations in which the assessing clinician may determine that a clinically significant medication issue exists might include discovering that the list of meds from the hospital discharge paperwork doesn’t match the medications that the has patient in the home or assessing the patient and determining that the diagnosis or the symptoms that the patient is taking a medication for is not adequately controlled.

Or maybe we learned through our patient assessment that the patient’s medications are with the daughter at work or, for some reason, the patient has decided not to take them, or we discovered that our patient is exhibiting symptoms that could be problematic adverse reactions to a medication.

So this is all patient-focused and patient-specific. Depending on the medication and the patient-specific findings, any of these situations might be considered by the clinician as a potential clinically significant medication issue, in which case we would report response, “1, Yes – Issues found during the review” for M2001. And again, just to provide some national clinical context for this, based on the quarter one data, M2001 was reported as “1 – Issues found” on 23 percent of the start of care and resumption of care assessments.

Slide 25 outlines the situations where response “9, NA – Patient is not taking any medications” would be reported. If at the beginning of our care episode the patient is not taking any medications – this means your patient’s taking no medications by any route – no prescribed meds, no over-the-counter meds, nothing – then we would report response “9.”

So, as you would expect, we don’t have a lot of home health patients who are not taking any medications. Based on quarter one data, M2001 was reported as “9” on .22 percent of the start of care and resumption of care assessments.

And on slide 26, starting this past January when we transitioned to using OASIS V2, home health providers have the introduction of a new response option for a few of the OASIS items, including these three DRR items



that we're discussion today and that the dash. A dash can be entered for M2001 when a drug review was not completed.

We should note that the home health conditions of participation require that a drug regimen review be completed as a mandatory part of every comprehensive assessment at every mandatory time point. So, as we would expect, the frequency of the use of the dash for M2001 is low. Based on this quarter one data, M2001 was reported with a dash on .15 percent of the start of care or resumption of care assessments.

So let's work through a couple of patient scenarios and practice applying this guidance that we've discussed related to M2001.

So Scenario A's on slide 27. During the comprehensive assessment visit, the nurse reviews all of the patient's medications and identifies that medications have been ordered by several different physicians. These include eye drops and topical ointments. The patient also says that she takes several herbal supplements, but she's not sure if her doctor's aware that she takes them.

The nurse discusses with the patient, of course, the importance of consulting with her physician prior to taking any over-the-counter supplements or medications. And the nurse is concerned enough that she contacts the physician from the patient's home for instruction.

So what response would we select for M2001? So we would report response "1, Yes – Issues found during the review." So the nurse, who is the assessing clinician, considers the patient findings to warrant timely physician contact.

Let's do one more scenario, Scenario B, slide 29. During the comprehensive assessment visit, the PT reviews all of the patient's meds and identifies no problem except that the patient's newly prescribed pain medication is not in the home. The daughter states that they were only going to pick it up from the pharmacy if the pain got bad enough.

The PT emphasizes the need to comply with the physician's instructions for the new medication. And prior to the PT leaving the home, the daughter has gone to the drug store and returned with the medication. So what would we select for M2001 in this case? And in the case, the answer is going to be "0 – No issues found during the review."

So remember our definitions. Because the issue did not require physician contact by midnight of the next calendar day to address, this situation doesn't meet the definition of a potential clinically significant medication issue. So this is one of those examples where, based on the clinician's intervention or the patient education or caregiver engagement, the problem was able to be resolved without physician involvement.

And if you're concerned that this isn't going to give you credit for action that you've taken, just be patient. We'll talk about how this impacts the measure shortly and you'll see that this is still appropriate and part of the best practices.

So let's move to slide 31 and our next OASIS slide. And this is M2003, which is collected at the start of care and resumption of care. And before we kind of delve into M2003, I want to point out that based on the skip



patterns that are embedded in OASIS, M2003 is only answered if an issue had been identified in the previous OASIS item that we just discussed – so in M2001.

If an issue had been found during the drug review, the clinician will use M2003 to report whether or not the physician or physician designee were contacted, and if prescribed or recommended actions were completed by midnight of the next calendar day for that issue. And we're going to need to, again, rely on those definitions, remembering that contact with the physician has to be two-way and it has to be completed by midnight of the next calendar day. All of those definitions are listed again for you here on slide 31.

Moving to slide 32, if the assessing clinician determined that a potential clinically significant medication issue exists but then did not complete the two-way communication with the physician or they didn't complete the prescribed or recommended actions by midnight of the calendar day, then response "0, No" would be reported.

And note that this would include situations where the home care nurse identifies the medication issue and makes every effort to call the physician but does not get a return call from the physician until after midnight of the next calendar day. It would also include situations where the timely communication occurred but where the agency didn't complete all the prescribed or recommended actions that could have been completed by midnight of the next calendar day.

So in all of those situations, response "0, No" would be reported. And based on quarter one home health data, 15 percent of the patient care episodes where the assessing clinician had identified a potential clinically significant medication issue at the start or resumption of care were reported as "0, No" on M2003, indicating that either the timely physician communication was missed, or the prescribed or recommended actions were missed, or possibly both.

So moving to slide 33. If the assessing clinician determines that a clinically significant medication issue exists and then did complete the two-way communication with the physician and the recommended actions by midnight of the next calendar day, then response "1, Yes" would be reported.

A few things to talk about here. Sometimes, even when the clinician identifies an issue and reports it to the physician timely, the physician might not provide any new orders or instructions to the agency in response to the issue. So they really don't give the agency anything to do. So in that case, then response "1, Yes" would still be reported because no prescribed or recommended actions were offered by the physician.

Do remember that if the action that the physician gives us is going to take longer than the allowed timeframe, then we would still mark "1, Yes" as long as by midnight of the next calendar day, the agency has taken whatever action is possible to comply with the physician's recommended action.

And if the drug review that is conducted at the start of care reveals multiple – more than one – potential clinically significant medication issue, then all such issues would be expected to be communicated to the physician with all prescribed or recommended actions taken by midnight of the next calendar day in order to report response "1, Yes" for M2003.

And based on quarter one data for those patient care episodes where the assessing clinician identified a potential clinically significant medication issue at the start or resumption of care, 85 percent were reported as



“1, Yes” on M2003, indicating that the timely physician communication and the actions were both completed in the allowed timeframe.

So let’s work through a couple of scenarios to apply this guidance. I’m on slide 34. It’s late Friday afternoon. During a resumption of care visit, you identify a potential clinically significant medication issue that you believe needs timely attention. You leave a message with the physician’s answering service before you leave the home that Friday, and you leave a second message on Saturday. And the physician returns your call on Monday morning and tells you to have the patient discontinue the medication.

You relay the information to your patient by phone and you confirm that he understood the direction during your home visit on Monday afternoon. So what would we do for both M2001 and 2003? And that’s covered on slide 35.

Because the assessing clinician identified an issue that they believed warranted this timely physician contact, it meets the criteria for response “1 – Issues found during review” on M2001. And since the issue was not met with the required two-way physician communication by midnight of the next calendar day, the criteria for M2003 was not met. So M2003 would be “0, No.”

And let’s do another scenario, Scenario D, slide 36. During the comprehensive assessment visit, the nurse completes the drug review, identifying that the patient is taking two anti-hypertensives: one which was newly prescribed during her recent hospital stay and another that she was taking prior to her hospitalization. During the home visit, the nurse contacts the physician’s office and leaves a message with the office staff providing notification of the potential duplicative drug therapy and a request for clarification.

The nurse returns to the home the next day to complete the comprehensive assessment and again contacts the physician from the patient’s home. And the physician’s office nurse reports to the agency and the patient that the physician would like the patient to continue with only the newly prescribed anti-hypertensive and to discontinue the previous medication.

So we have the answer on slide 37. Because the issues identified by the clinician to meet the definition of this potential clinically significant medication issue, M2001 would be “1, Yes – Issued found during the review.”

And because the medication issue was resolved by a physician notification and completion of prescribed or recommended actions occurred by midnight of the next calendar day, then M2003 would be “Yes.”

The third item that we want to talk about is M2005, Medication Intervention. And M2005 is similar to M2003, the item we just discussed, in that it also reports if the agency contacted the physician by midnight of the next calendar day. But instead of being collected at the beginning of the care episode and just including significant issues that were identified at the beginning of care, M2005 is collected at the end of the care episode.

And it reports if the agency contacted and completed physician-prescribed or recommended actions by midnight of the next calendar day each and every time that a potential clinically significant medication issue was identified by the home health agency at any time throughout the entire care episode.



So slide 39 depicts this important distinction between M2003 and M2005. And again, that is this time period under consideration. For M2003, we were just reporting on medication issues that were identified at the start or resumption of care.

But for M2005 we're reporting based on every potential clinically significant medication issue that has been identified at any time throughout the entire care episode, including those issues that were identified at the start or resumption of care. So a clinically significant medication issue that's identified at the start of care is considered again at the end of the care episode, which is triggered by the next transfer or discharge or death at home time point.

Moving to slide 40. When a clinically significant medication issue was identified at any time during the episode, and it was not both communicated to the physician and addressed through completion of any recommended actions by midnight of the next calendar day, then response "0, No" would be reported for M2005.

And to demonstrate how the lookback period might look, let's consider a situation where a clinically significant medication issue's identified at the start of care and the agency doesn't reach out to the physician for 2 days.

Then that issue and the lack of timely communication would be reported at both the start of care on M2001 and M2003 and again at the transfer, death, or discharge on M2005. Based on quarter one data, 6 percent of the transfer, discharge, or death assessments were reported as "0, No," indicating that these targeted best practices of timely communication and completion of recommended actions were not completed by midnight of the next calendar day each time a medication issue was identified throughout the episode of care.

Slide 41. We're going to enter response "1, Yes" on M2005 when the two-way communication and completion of the actions occurred timely each and every time such issues were identified throughout the episode – again, including those issues that were identified at the start or resumption of care. And based on quarter one data, response "1, Yes" was reported on M2005 at transfer, discharge, and death for 27 percent of the care episodes.

On slide 42. If at the end of our care episode it's determined that there have been no potential clinically significant medication issues identified at any time during the episode or if the patient isn't taking any medications, then response "9, NA" would be reported. For 66 percent of the care episodes, M2005 reported that no potential clinically significant medication issues had been identified at any time during the episode of care or that the patient was not taking any medications.

So, based on this preliminary data, we're finding that agencies are reporting that in only about 4 percent of episodes, potential clinically significant medication issues were identified at some point in the care episode after the start or resumption of care.

So agencies really need to make sure that their field staff are identifying these medication issues on an ongoing basis whenever they are happening throughout the care episode and that they take timely action related to physician communication and completion of any recommended actions and that they document these activities within the clinical record for easy reference at discharge to ensure that all identified medication issues and agency actions are considered for the reporting on these items in this measure.



So let's work through one last scenario, Scenario E, slide 43.

During the start of care comprehensive assessment, the nurse completes the drug regimen review and identifies a potential clinically significant medication issue. On that day of admission, the nurse calls and leaves a message with the physician's office related to the medication issue. The physician does not return her call until after midnight of the next calendar day. No other medication issues arise during the episode, and the patient's discharged from home health.

So let's talk through how we would report this on all three of the DRR items. Because the issue's identified by the clinician to be clinically significant, then M2001's going to be "Yes – Issues were found during the review."

And then, while the clinician initiated that communication with the physician, the required two-way communication did not occur until after midnight of the next calendar day. And that would result in a "0, No" for both M2003 and for 2005. Because remember, 2005 includes issues that occurred at the start of care.

And moving to slide 45, as a reminder for each of these three items, a dash value is a valid response. Reporting a dash indicates that there's no information available or that an item could not be assessed.

These scenarios most often occur when a patient is unexpectedly transferred or discharged or dies before the assessment could be completed. Even in these situations of unexpected transfers or discharges or deaths, providers should still complete their assessments – in this case, their chart review – as completely as possible.

And based on preliminary quarter one data, providers reported the dash on these DRR items roughly between .2 and .4 percent of the time. These numbers are somewhat consistent with CMS's expectations that the dash use should be rare.

Calculating the DRR Process Measure

Let's move to slide 46. And now that we've covered the guidance directing us how to selected responses for each of the three OASIS items used to calculate the measure, let's revisit the measure to see how the various OASIS responses impact the measure rate. This graphic on slide 46 is a depiction of a process measure, a generic process measure calculation.

We take the number of patient episodes where the desired care process was provided. That's the numerator. And we divide it by the number of patient episodes where the care process could have been provided. That's the denominator. And that results in the percentage of successful patient episodes. And in a positive process measure like the Drug Regimen Review, a higher rate is better.

So moving to slide 37. To calculate the DRR measure, first we calculate the denominator. And then, when calculating the DRR measure, all care episodes that have an ending in the reporting period are going to be included. That is, all episodes that end with a reason for assessment or RFA 6 or 7, which is "transfers to an inpatient facility either with or without an agency discharge"; episodes that end in an RFA 8, that's a death at home; or episodes that end with an RFA 9, "discharge from the agency not to an inpatient facility."



So the Drug Review measure has no denominator exclusions because the best practices related to a drug review and resolution of identified medication issues are appropriate for every type of patient. So the denominator count is all care episodes that end in the reporting period.

Next, slide 48, we'll calculate the numerator. And the numerator, which is the number of care episodes where the desired care processes were provided – that's going to include all episodes where M2001 was reported as either a zero, a one, or a nine – so in other words, anything other than a dash, M2003 was either skipped because M2001 was zero or nine, or M2003 was a response "1, Yes" and M2005 was a response "1, Yes" or "9, NA."

So, as you spend some time looking through these response combinations, you'll see the number of ways that you can achieve a favorable result on the Drug Regimen Review process measure.

I want to specifically point out that identifying a clinically significant medication issue in M2001 does not automatically cause an agency to "fail" the measure. It is best practice to identify medication issues that some patients will surely have. And then, the key is that once we identify it, it's also best practice to provide appropriate and timely physician communication and to carry out physician-prescribed or recommended actions, which are the required conditions for this measure.

And then the last step of the calculation is to divide the numerator by the denominator, which gives us the percentage of care episodes which meet our three criteria required for the measure.

Applying the Measure Specifications

So now let's put that all together and apply the measure specifications to the OASIS responses and demonstrate a favorable and an unfavorable DRR measure rate.

Slide 51 displays the three DRR OASIS items. The graphic on the left of the slide shows the responses that contribute to the numerator, meaning the responses that are consistent with achieving the measure or having a favorable rate. And the graphic on the right side of the slide shows the responses that do not contribute to the numerator, the responses like a dash on any of the three items or a response of "0, No" on M2003 or M2005.

They demonstrate that the desired care practices were not performed and the measure has not been achieved, or, in other words, will result in an unfavorable effect on your agency's overall Drug Regimen Review measure rate.

On slide 52, we've applied the OASIS responses that we came up with previously for Scenario E. That was where the nurse contacted the physician about the clinically significant medication issue that she identified but the physician did not respond back timely. To show here that the resulting "No's" on M2003 and on 2005 would result in the measure not being achieved or contributing unfavorably to your agency's Drug Regimen Review measure rate.

And on slide 53, to again point out that agencies can achieve success in the measure even when a medication issue is identified. So slide 53 we have Scenario F where the drug review's conducted at the start of care, a



potential clinically significant medication issue's identified and, in fact, during the episode of care, three more clinically significant medication issues are identified.

And each time an issue's identified, physician communication and recommended actions were completed as required by the measure conditions by midnight of the next calendar day. So this would result in a reporting of "1, Yes – Issues found" for M2001 and "Yes's" for M2003 and M2005. And that combination of responses will result in the care episode contributing to the numerator or, in other words, resulting in a favorable impact on your agency's Drug Regimen Review measure rate.

Quality Reporting

So, while data collection in home health started in January 2017, agencies are going to need to wait a few more months to start to receive regular reporting of their performance on this Drug Review Quality measure. The quality reporting timelines for the Drug Review measure in all PAC settings is outlined on slide 55.

For home health, no later than January 2018 your agency will see the Drug Review measure appearing on your Confidential Feedback Report or your CASPER process measures reports. And no later than January 2019, home health agencies will see their measure rates publicly reported on Home Health Compare.

The institutional PAC settings will follow a similar timeline for Confidential Feedback Reporting no later than 1 year after initiation of data collection and public reporting on the various Compare websites no later than 2 years after data collection begins for each setting.

So, hopefully, this presentation has provided a helpful overview of the Drug Regimen Review measure and all the guidance related to accurately collecting the data on the three relevant OASIS items so that the process measure rates will be a valid representation of the great care that you are providing to your patients as it relates to their medications.

The key takeaways that we hope you will share and reinforce with the data collectors in your organization are to understand and apply the accurate definition of potential clinically significant medication issues, to remember that identifying a potential clinically significant medication issue can still result in a favorable measure if timely physician notification and recommended actions are completed. Remember that when potential clinically significant medication issues are identified at the start of resumption of care, don't forget to consider them again at discharge, transfer, or death.

Make sure that all the field staff are looking for medication issues on an ongoing basis throughout care and documenting the issue and the actions taken so that M2005 can be easily and accurately answered at the end of the care episode by whoever the assessing clinician is at that time. Only select the response "Patient not taking any medications" if the patient is really taking no medications of any kind by any route. And remember that while a dash is a valid response for the three items, CMS expects its use to be a rare occurrence.

Well, thanks for your attention. I'll now turn it back over to Dr. McMullen to facilitate our Q&A session.



Question & Answer Session

Dr. Tara McMullen: Thank you, Linda. That was wonderful. Thank you so much.

And now we're going to have a Q&A session. But prior to having the phone lines opened, we have received a few questions from you all in our PAC QI – the Quality Initiative's inbox. And so we're going to read some of the questions and the answer that we prepared and, hopefully, this will help with some of the questions that you may have.

The first question is, "When will the DRR measure be first publicly reported with a full year of data and when will we receive the first Provider Preview Report?" And so, Linda just touched on this. But this will be a nice refresher.

The Drug Regimen Review measure will first show up on the Home Health Compare website with the October 2018 refresh and will reflect episodes of care that began with a start of care, resumption of care, and ended with a transfer, death, or discharge from October 1, 2017, through December 31st, 2017. So you will receive the Provider Preview Report in July 2018 reflecting the October 2018 Home Health Compare refresh.

The second question we received is, "When will the Drug Regimen Review measure first show up on our CASPER reports and what will be the date range of that reporting period? What episodes will it include?" The Drug Regimen Review measure rates will first be available in CASPER reports starting in January 2018 and initially will reflect 6 months of data – so that's episodes which begin with a start or resumption of care and end with a transfer, death, or discharge from January 1 through June 30th, 2017.

And the last prepared question and response group – this is a longer question we received, but we've received this question a lot. And so I'm going to read portions of the question and you'll get the gist of it. So the question says, "A hospital and home health care agency share the same software, so the patient has one shared medical record. If that patient is discharged from that hospital to home care, what documentation is necessary by the admitting home care clinician to show that medication reconciliation has been performed?"

The question goes on to say, "If the patient were asked" – pardon me – "If the patient came home from a SNF or rehab and the clinician admitting the patient to home care entered the medications into our software, is it necessary to contact the primary care physician to verbally or otherwise go over medications since the medications will be entered into the same system?"

So the question to that – the response to that question set is the Drug Regimen Review measure is not prescriptive on how the drug regimen review, including the medication reconciliation, is carried out or documented.

While you may have agency policies or accreditation expectations related to the contact – related to contacting the physician and completing medication reconciliation tasks, for the Drug Regimen Review measure, only physician contact that occurs in conjunction with an identified potentially clinically – potential clinically significant medication issue is considered.



For the purpose of the Drug Regimen Review measure, it does not matter if the source for identifying the issue involved a shared medication or a medical record or another source. Physician or physician designee contact would be expected by midnight of the next calendar day from the date the issue was identified.

So I know that was a lot of information, so I'm hoping that we can make this information available to you in a public way so that you guys have these questions and responses.

At this time, I'm going to turn it over to Leah.

Leah Nguyen: Thank you, Tara.

We will now take your questions. As a reminder, this event is being recorded and transcribed.

All right, Dorothy. We are ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. If you have more than one question, press star, one to get back into the queue, and we will address additional questions as time permits.

Please hold while we compile the Q&A roster.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Jessica Parra.

Ms. Parra, your line is open.

Jessica Parra: Okay. My question is if same interactions from a previous start of care or resumption of care has been noted, do we still need to fax the MD even though no changes were ordered to be made by the doctor?

Dr. Tara McMullen: Linda?

Linda Krulish: Sure. So, Jessica, let me clarify your question. So you've identified the problem at the start of care and you want to know if at the – then the patient's admitted to an inpatient facility and you want to know if you need to consider that again at the resumption of care? Is that your question?

Jessica Parra: Okay. So, say that we have a patient that we've seen and they're back on service with us and I ran a DDR, and the same potential major drug interactions are noted from the previous...

Linda Krulish: Yes.



Jessica Parra: ...start of care episode, and the doctor has already signed off saying no changes to be made...

Linda Krulish: Okay.

Jessica Parra: ...do I still need to fax the doctor again for this new start of care...

Linda Krulish: Okay. So...

Jessica Parra: ... although the same interactions are noted?

Linda Krulish: Great question. So, a lot of agencies do use software that helps to identify medication issues, interactions, potential problems related to the medication profile. And how you in your organization interpret that is going to be using this definition of “clinically significant medication issue.”

So you should not be just using that software to identify whether it’s a clinically significant medication issue or not. You should also be applying what you know from your patient-specific findings.

Jessica Parra: Yes.

Linda Krulish: And your example is a great one because while you might have considered that a potential clinically significant medication issue the first time it showed up, the fact that you’ve communicated that to the physician, gotten additional insight, and identified that they’re aware and they don’t want any actions taken might now cause you to clinically not think that this meets that definition. Right? So, it’s really all up to your clinical judgment and applying all of the information that you have access to through your patient assessment.

Jessica Parra: I see. Okay. Thank you.

Linda Krulish: Sure.

Operator: Your next question comes from the line of Jennifer Kohler.

Jennifer Kohler: Hello. This is Jennifer. My question is, Is CMS going to – it sounds like the home health agency is responsible again for what the physician does. At what point does it become incumbent upon the physician to respond to us?

Dr. Tara McMullen: Hi, Jennifer. It’s Tara McMullen. So, this is a process measure that is simply evaluating a process that occurs within your agency. This is not a measure that is dictating workflow or is placing responsibility on a physician for anything. We’re simply collecting data and doing surveillance on the process that’s occurring within your facility or agency – I’m sorry.

Jennifer Kohler: Well, if it’s going to be reported on Home Health Compare and other measure – other things, we’re being held to the standard of coercing our physicians. I mean, we’re doing our part. But if they don’t do their part, then it sounds like we’re the ones that are paying for it.



Dr. Tara McMullen: Yes. We understand that there are – I mean, through this measure and many measures that there are a lot of issues and things that go on in terms of interactions within an agency or even a facility setting. The stance of the Quality Reporting Program is that under our National Quality Strategy and really the priorities of CMS that we collect data and we report data to illuminate what is going on in a facility.

And, hopefully, that data will help with that business practice and workflow and things like that. So, again, this is just a process measure that is evaluating the rate of the home health agency use of the specific evidence-based process. So we hope at this time that this helps. But we sincerely – and I've written it down – we've heard you and I appreciate your comment and your thoughts.

Leah Nguyen: Thank you.

Jennifer Kohler: Thank you.

Operator: Your next question comes from the line of Carmen Letcher.

Carmen Letcher: Hi. We have a question regarding the M2005 because it says that you're identifying that these problems have occurred since the start of care or resumption of care, as opposed to – so, if it happened at start of care and you already have identified that and it's been resolved, then upon transfer, discharge, or death, why would you count that again if the question reads "since start of care"?

Linda Krulish: That's a great question, Carmen. So in the item itself, it says, "since the start of care or resumption of care." But the guidance that you'll find in the OASIS guidance manual does clarify that that includes issues that were identified at. So it's at the time of or any time since the most recent start of care or resumption of care.

Carmen Letcher: Thank you.

Linda Krulish: It includes the entire episode. Yes.

Leah Nguyen: Thank you.

Linda Krulish: Thank you.

Operator: Your next question comes from the line of Randall Tipton.

Randall Tipton: Yes. Am I here? Hello?

Leah Nguyen: Yes, we can...

Randall Tipton: Hello. Okay. I'm touching – I guess I'm piggybacking on what Jennifer was talking about in the accuracy or what this DDR score is actually telling us. If I'm doing the math correct – correctly, the way that it comes out here is that it's not giving you what you're asking it to do, is to reflect what's going on internally in the agency. That score doesn't tell you that.



It tells you whether or not the physician played along with you. Two thousand, or 2003 and 2005 are both questions, half of which are contingent upon the actions of the physician. So, we could actually get negative scores based on this methodology and, in fact, be doing nothing incorrect whatsoever. Am I correct in saying that?

Dr. Tara McMullen: Well – hi. This is Tara McMullen. And I also ask Lynn, Linda, Carol, and the team to chime in as well. I think we need to think differently about the outcome of the measure. This measure – and I appreciate these comments. So, thank you, Randall, and thank you to Jennifer as well.

Randall Tipton: Right.

Dr. Tara McMullen: So the outcome of the measure is not to apply a ding to the agency or the facilities. And I say facilities because this is a standardized measure. But it's not to apply a ding. It's not to reflect poorly on what's going on. It's basically to discuss a process. And the way that this is going to be reported on Home Health Compare and really any other Compare site – we're still in discussions on what that looks like because those things change.

Again, I think the intention of the writers of the IMPACT Act was that they know that medication issues which – there are a ton of issues under that main domain and a ton of things that we can develop in terms of quality measurement. They wanted us to begin looking at the process of medication reconciliation. And as we were digging in, we said, "Oh, well, drug regimen review – this is a robust measure. This looks – this will give us a starting point for collection of data so that we can see what's going on in these processes so that at a later time, with the maintenance of a measure, we can perfect this measure and really focus in on areas that might be troubling."

Randall Tipton: Right. Yes.

Dr. Tara McMullen: So, again, I just want to say that this is not to – this measure was never to make an agency look bad or to cause a ding or to cause any workflow issues if there were...

Randall Tipton: So it only touches on the process. It does not give you an opinion of whether or not the agency is acting in good faith or not.

Dr. Tara McMullen: Yes. I mean – exactly.

Randall Tipton: And, then, you have to wonder, why are we doing it then?

Dr. Tara McMullen: Well, we're doing this for – beyond the statutory mandate, we're doing this because this is an important area to assess.

Randall Tipton: But, your methodology is not giving – it's not giving you the answers that you want.

Dr. Tara McMullen: Yes.



Randall Tipton: This method doesn't give you the answers that you want. It doesn't tell you where the breakdown's occurring. It doesn't.

Dr. Tara McMullen: Yes.

Randall Tipton: So why would we do it?

Dr. Tara McMullen: Yes. Well, Randall, we thank you for that comment. And as we collect data, we go through monitoring and evaluation efforts. And we hope to...

Randall Tipton: But if you can't answer that question to me, if you can't answer that question, why do I care about this then? If you can't even tell me what the purpose of it is and what it actually tells, why do I care about it.

Leah Nguyen: Thank you for your comment. Can we take the next question?

Operator: Your next question comes from the line of Audrey Moore.

Audrey Moore: Okay. I actually am "thirding" the issue of the question. What my concern is is in our agency, we do everything right to make sure we communicate medication issues to our physicians. But we do have a problem with them returning any type of communication with us.

So I'm along the lines with the other two that we're getting – if it is going up on Home Health Compare, that we are going to look bad to the public that we had no follow-up. So why doesn't CMS come up with another question that says, "Did you have a problem with the doctor following up?"

And then, what about the doctors? Do they get scored on something? I mean, because we're doing everything we can to try to solve problems. But it seems like all the blame gets put on us, and none on them to do their job. So, I think....

Dr. Tara McMullen: Thank you so much.

Leah Nguyen: Thank you for that.

Operator: Your next question comes from the line of Linda Raymer.

(Crosstalk on participant's line.)

Operator: Ms. Raymer, your line is open.

Linda Raymer: Okay. Thank you. So, we're part of a single entity where we share medical record with the physician and pharmacy. And currently we have pharmacy preloading medications for patients. And as part of their standard work, they do check for adverse reactions and duplicative medications and side effects.



I'm wondering if this fulfills – if it's okay to say that the pharmacist has checked that. And any duplicative or adverse reactions that they find, they do address with the physician as a separate process as part of their standard work.

Linda Krulish: So, Linda, let me address that. That's similar to Jessica's previous question in that you're having a – in this case, a pharmacist who is contributing and participating in the completion of the drug review, the identification of problems and assisting, it sounds like, in actually resolving some of those problems.

So, again, your role as the home health agency is that you're required to complete a drug regimen review. You can certainly have collaboration with the pharmacist. But you would need to identify – assess and identify if there's any medication issues that your assessing clinician determines to be a potential clinically significant medication issue.

And then, if you do identify that, have you communicated it to the physician by midnight of the next calendar day and completed whatever actions are required? So you can use that collaboration. But it's still incumbent on the agency to make sure that they've completed that.

Now, because the pharmacist might remedy or, you know, resolve an issue, then you may not consider it clinically significant because it's been resolved by the time you do your assessment.

Linda Raymer: Great. Thank you very much.

Leah Nguyen: Thank you.

Linda Krulish: Thanks

Operator: Your next question comes from the line of Kim Bossaller.

Kim Bossaller: Yes. My question is, What if there are multiple issues during the episode? Let's say at the start of care there were issues, we notified the physician, he did not get back to us. But then through the episode of care, there were further issues and we did notify and we did get resolution within that specified timeframe. How would we answer the discharge?

Linda Krulish: Great question. So for M2005, the question asks, "Did the agency complete the communication and prescribed actions each and every time a medication issue was identified throughout the whole episode, including the start of care?" So, if at any time, whether it was a start of care or one of those additional times that a medication issue was identified, not all of the conditions were met, then the M2005 would be answered "No."

Kim Bossaller: Okay....

Linda Krulish: It needs to be – yes. And remember, just – something to remember here about this is your agency is the one that's identifying if this is an issue. We know we – there's a broad spectrum of degrees of medication issues that a patient could be experiencing. And as the assessing clinician, you're determining,



based on what you see and what you know about this patient and what's going on at that time of the assessment, whether or not you need to get the physician involved quickly.

So, if in fact, you're the one that's decided that and then the physician doesn't call you back, clinically it just doesn't make sense to say, "Well, you know, let's make a measure that says the patient had a really severe medication problem and we tried to contact the physician." That wouldn't really be appropriate as far as the patient-level outcome.

So we have seen in home health with – as Tara mentioned, we've had similar items on OASIS since 2010 where we are required to do a drug review, identify medication issues, and contact the physician. And, so we have seen that agencies over time have been more diligent in trying to find strategies to get that feedback, timely returned calls from the physician. So, granted, it's never going to be 100 percent, and there are things that are outside of the agency's control.

But all agencies are in the same boat. All agencies are dealing with this same – so it's not like my agency is the only that has to deal with this. We're all in the same boat as far as taking our home health patients and trying to provide the best care that we can – so, identifying medication issues and then getting physician involvement when we – ourselves – have determined that it's appropriate might mean that we are making multiple phone calls to the physician.

Or even to the point of if you have a patient that really has a medication issue that's so significant that you feel like the physician needs to be involved, and they're not calling you back, it just doesn't make sense clinically to say, "I'm just going to continue to care for this patient and just document in my chart that I made – I thought it was a really serious problem but the doc didn't call me back, so we just continued to provide care." That isn't appropriate either.

So we need to work together to find strategies to make this medication – medication issues benefit the patient in collaborating. So I would just kind of give that caveat as far as, it may not be the perfect measure at this point. But it has already shown to be changing care behavior in home health providers and helping us to be more creative and more diligent in facilitating this communication.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Kristin Drabek.

Kristin Drabek: Yes. I just had a question on M2001. I think you had said that people mark "Yes" about 23 percent of the time on start of care or resumption of care. So, I think our rate is much higher. So, I'm just trying to figure out. We often see like at start of care they don't have, like, maybe certain medications that were new in the home yet.

And, so, we're marking that, yes, there was issues found during the review. We're following up to make sure that they get those medications in, you know, making phone calls and stuff like that, that they are getting them within that 24-hour timeframe. So, are we doing that incorrectly or...?



Linda Krulish: So let me ask you this. Are you – when you identify that a medication – just you maybe you could think in your mind of a situation where you’ve marked that where a medication isn’t the home. Are you contacting the physician and saying, “Hey, this medication isn’t in the home. What do we do?” Or…?

Kristin Drabek: Sometimes ...calls to the pharmacy. You know, maybe it hasn’t been called.

Linda Krulish: Yes.

Kristin Drabek: So, if we’re not calling the physician...

Linda Krulish: I would say that all goes back to that definition of what’s a potential clinically significant medication issue. If a med isn’t in the home, and you want it in the home, then you take action. Does that action – that action could include like some of our examples, making sure the family recognizes how important it is and seeing if they can go get it, finding out why it’s not in the home.

Is it a medication issue? Are you getting social work involved? So trying to take those actions. If the only action or the appropriate action based on your clinical judgment is to call the doc and say, “Hey, this medication isn’t in the home, and it doesn’t seem like it’s going to be,” then you’d say, yes, this is a clinically significant medication issue that warrants physician contact within this timeframe.

But if you find other venues and other ways to resolve that problem that are appropriate – clinically appropriate – that do not involve physician involvement, then you would say that this isn’t a clinically significant medication issue that requires the physician involvement in this, you know, urgent timeframe.

Does that help?

Kristin Drabek: Yes. Same with duplicate meds, you know. So, at what point do you decide, you know, they’re on five bowel meds? At what point is it clinically significant versus not? So, I mean, we were under the impression that the doctor had to be notified with the duplicate drug, you know, therapy. But if they’re not having any problems, then we don’t necessarily have to contact them?

Linda Krulish: Well, so I’d just say that this is based on a thorough patient clinical assessment. And so, as far as duplicate drug therapy, again, it would be dependent on what the medications are, what you know about the patient. Let’s say a patient is on two diuretics, but this is a resumption of care and they were on two diuretics when you did the start of care.

So at the start of care, you might have thought, “I’m going to notify the physician about this potential duplicative drug therapy.” And in that two-way communication, you discover that this is intentional, okay? One’s potassium sparing, one is potassium depleting. And so, this is just the regimen that they’re on.

When I’m doing a resumption of care for that same patient, I have more information now. So this time, I might not think that this is – warrants communication with the physician because I know that this was an intentional part of the patient’s drug regimen based on the physician’s communication before. Right?



So that's why it's hard to give – that's why CMS is not going to give a complete list of things that are and are not clinically significant medication issues, because it's incumbent on the clinicians to be able to assess patients and make those determinations.

Kristin Drabek: Thank you.

Leah Nguyen: Thank you.

Dorothy, we have time for one final question.

Operator: Your final question comes from the line of Henry Rosales.

Henry Rosales: Good afternoon. This is in reference to M2001, specifically the answer number 9. Are topicals and oxygen considered medication?

Linda Krulish: Yes, they are. Yes.

Henry Rosales: Okay.

Linda Krulish: So, oxygen, topicals, medications by any route. So if they were only on – only had a. you know, a topical ointment, even if it was just an over-the-counter, then you would not mark that the patient is taking no medication.

Henry Rosales: N/A. Okay.

Linda Krulish: Yes.

Henry Rosales: Thank you.

Linda Krulish: Thank you.

Additional Information

Leah Nguyen: Thank you.

Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address listed on the call webpage and in your confirmation email. For information on evaluating today's event, see slide 60.

Again, my name is Leah Nguyen. I would like to thank our presenters, and also thank you for participating in today's Medicare Learning Network event on the IMPACT Act. Have a great day, everyone.

Operator: Thank you. This concludes today's conference call. You may now disconnect.