

Long-Term Care Hospital Quality Reporting Program Provider Training

Section N: Medications

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LTCH

LONG-TERM CARE HOSPITAL

QUALITY REPORTING
PROGRAM

Acronyms in This Presentation

- Centers for Medicare & Medicaid Services (CMS)
- Drug Regimen Review (DRR)
- Improving Medicare Post-Acute Care Transformation Act (IMPACT Act)
- International Normalized Ratio (INR)
- Long-Term Care Hospital (LTCH)
- LTCH Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set)
- Medication Administration Record (MAR)
- Post-Acute Care (PAC)
- Quality Measure (QM)
- Registered Nurse (RN)



Overview

- Define the new Section N: Medications.
- Explain the intent of Section N.
- Explain new items in Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set v4.00.
- Discuss coding instructions and needed information for items.
- Provide practice coding scenarios.

Objectives

- State the intent of Section N.
- Describe the new Drug Regimen Review (DRR) Quality Measure (QM).
- Articulate the purpose of the new items and coding options.
- Apply coding instructions to accurately code practice scenarios.

Drug Regimen Review Conducted With Follow-Up for Identified Issues

Drug Regimen Review Conducted With Follow-Up for Identified Issues

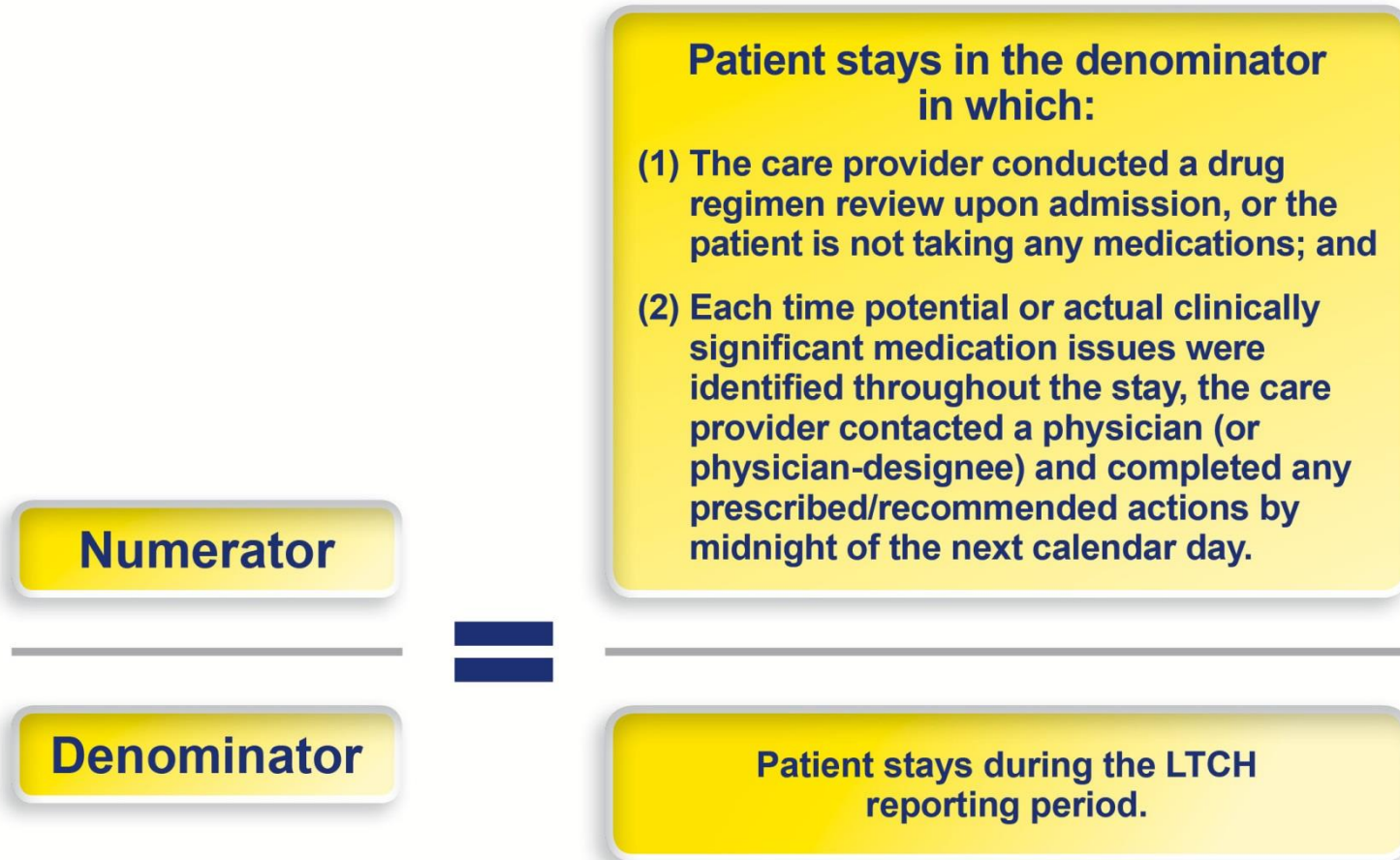
- Assessment-based, cross-setting quality measure adopted to meet the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act domain of medication reconciliation, with data collection for LTCHs beginning July 1, 2018.
- This measure assesses whether LTCH providers conducted a drug regimen review upon admission and were responsive to potential or actual clinically significant medication issues when such issues were identified upon admission and throughout the patient stay.

Drug Regimen Review Conducted With Follow-Up for Identified Issues (cont. 1)

Quality Measure Description

- Reports the percentage of patient stays in which:
 - A drug regimen review was conducted upon admission; and
 - Clinicians complete actions recommended by a physician (or physician designee) during a timely follow-up which were completed each time potential or actual clinically significant medication issues were identified throughout the stay.

Drug Regimen Review Conducted With Follow-Up for Identified Issues (cont. 2)



Drug Regimen Review Conducted With Follow-Up for Identified Issues (cont. 3)

- **Denominator Exclusions**
 - This measure has no denominator exclusions.
- **Risk Adjustment**
 - This measure is not risk-adjusted or stratified.

Drug Regimen Review Conducted With Follow-Up for Identified Issues (cont. 4)

- **LTCH CARE Data Set v4.00 Items Included in the QM:**
 - N2001. Drug Regimen Review.
 - N2003. Medication Follow-up.
 - N2005. Medication Intervention.
- If a dash is entered for any of these three items:
 - The patient stay will not be included in the numerator count.
 - The patient stay will be included in the denominator count.

Section N: Medications

New Section in
LTCH CARE Data Set v4.00

New Items

New:

- N2001. Drug Regimen Review and N2003. Medication Follow-up have been added to the **Admission Assessment**, effective July 1, 2018.

N2001. Drug Regimen Review

Enter Code

Did a complete drug regimen review identify potential clinically significant medication issues?

0. **No - No issues found during review** → *Skip to 00100, Special Treatments, Procedures, and Programs*
1. **Yes - Issues found during review** → *Continue to N2003, Medication Follow-up*
9. **NA - Patient is not taking any medications** → *Skip to 00100, Special Treatments, Procedures, and Programs*

N2003. Medication Follow-up

Enter Code

Did the facility 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?

0. **No**
1. **Yes**

New Items (cont.)

New:

- N2005. Medication Intervention has been added to the **Planned Discharge, Unplanned Discharge, and Expired Assessments**, effective July 1, 2018.

N2005. Medication Intervention	
Enter Code <input type="text"/>	<p>Did the facility 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 admission?</p> <p>0. No 1. Yes 9. NA - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications</p>

Section N: Medications

Definitions

Drug Regimen Review (DRR)

- The drug regimen review in post-acute care is generally considered to include medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.
- Note: The drug regimen review includes all medications, prescribed and over the counter (including nutritional supplements, vitamins and herbals); administered by any route (for example, oral, topical, inhalant, injection, sublingual, parenteral, and by infusion). The drug regimen review also includes total parenteral nutrition (TPN); and, oxygen.

Potential (or Actual) Clinically Significant Medication Issues

Clinically Significant Medication Issue

- A potential or existing issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day (at the latest).

Potential (or Actual) Clinically Significant Medication Issues (cont. 1)

- Potential or actual clinically significant medication issues may include, but are not limited to:
 - Medication prescribed despite medication allergy noted in the patient's medical record.
 - Adverse reactions to medications.
 - Ineffective drug therapy.
 - Drug interactions (serious drug-drug, drug-food and drug-disease interactions).
 - Duplicate therapy (for example, generic name and brand name equivalent drugs are co-prescribed).

Potential (or Actual) Clinically Significant Medication Issues (cont. 2)

- Potential or actual clinically significant medication issues may include, but are not limited to:
 - Wrong patient, drug, dose, route, and time errors.
 - Omissions (drugs missing from a prescribed regimen).
 - Nonadherence (purposeful or accidental).

Potential (or Actual) Clinically Significant Medication Issues (cont. 3)

- Examples of potential or actual clinically significant medication issues can be found in the LTCH QRP Manual, Section N, available at:
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html>.
- Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.

Contact With Physician (or Physician-Designee)

- Communication to the physician (or physician-designee) to convey an identified potential or actual clinically significant medication issue(s); **AND**
- A response from the physician (or physician-designee) to convey prescribed/recommended actions in response to the medication issue(s).

Contact With Physician (or Physician-Designee) (cont. 1)

- Communication can be:
 - In person.
 - Telephone.
 - Voicemail.
 - Electronic means.
 - Facsimile.
 - Any other means that appropriately conveys the message of patient status.

Contact With Physician (or Physician-Designee) (cont. 2)

- Communication can be directly to/from the physician (or physician-designee) or indirectly through the physician's office staff on behalf of the physician (or physician-designee), in accordance with the legal scope of practice.

Medication Follow-Up

- The process of contacting a physician (or physician-designee) to communicate the identified medication issue and completing all physician (or physician-designee)-prescribed/recommended actions by midnight of the next calendar day (at the latest).

Section N: Medications

Coding Guidance and Practice Scenarios

Data Sources/Resources for Coding the Items

- Medical record (within the electronic health record/ electronic medical record, and/or paper medical records as transferred from the acute care hospital).
- Medication list (for example, medication administration record (MAR), home medication list).
- Clinical communication notes (including pharmacy, nursing, physician (or physician-designee), and other applicable clinical notes).

Data Sources/Resources for Coding the Items (cont.)

- Acute care hospital discharge summary and discharge instructions.
- Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, patient and patient family/significant other).

N2001, N2003, N2005. Drug Regimen Review Conducted With Follow-Up for Identified Issues

Admission Assessment

- N2001
 - Identifies if a drug regimen review was conducted upon admission, and if the clinician identified any potential or actual clinically significant medication issues.
- N2003
 - Identifies if the facility contacted a physician (or physician-designee) and completed all physician (or physician-designee) prescribed/ recommended actions by midnight of the next calendar day in response to all potential or actual clinically significant medication issues identified upon admission.

Discharge Assessment (Planned or Unplanned, Expired)

- N2005
 - Identifies if the facility contacted a physician (or physician-designee) and completed all physician (or physician-designee) prescribed/ recommended actions by midnight of the next calendar day each time potential or actual clinically significant medication issues were identified throughout the stay.

N2001: Drug Regimen Review (Admission)

- 0. No -
- 1. Yes -
- 9. NA -

Section N		Medications
N2001. Drug Regimen Review		
Enter Code <input type="checkbox"/>	Did a complete drug regimen review identify potential clinically significant medication issues? 0. No - No issues found during review → Skip to O0100, Special Treatments, Procedures, and Programs 1. Yes - Issues found during review → Continue to N2003, Medication Follow-up 9. NA - Patient is not taking any medications → Skip to O0100, Special Treatments, Procedures, and Programs	

N2001 Steps for Assessment

1. Complete a drug regimen review upon admission or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues.

N2001 Coding Instructions

Completed only if A0250 = 01 Admission.

- **Code 0, No - No issues found during review**, if a drug regimen review was conducted upon admission and no potential or actual clinically significant medication issues were identified.
- **Code 1, Yes - Issues found during review**, if a drug regimen review was conducted upon admission and potential or actual clinically significant medication issues were identified.
- **Code 9, NA - Patient is not taking any medications**, if a drug regimen review was conducted upon admission and, per data sources/resources reviewed, there were no medications prescribed for the patient and the patient was not taking any medications at the time of the assessment.

N2003: Medication Follow-up (Admission)

0. No
1. Yes

N2003. Medication Follow-up

Enter Code

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Did the facility **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?

0. No
1. Yes

N2003 Steps for Assessment

1. Determine if the following criteria were met for all potential and actual clinically significant medication issues that were identified upon admission:
 - Two-way communication between the clinician(s) and the physician (or physician-designee) was completed by midnight of the next calendar day; AND
 - All physician (or physician-designee) prescribed/recommended actions were completed by midnight of the next calendar day.

N2003 Coding Instructions

Completed only if A0250 = 01 Admission.

- Code **0, No**, if **all** identified potential or actual clinically significant medication issues were **not** completed **by midnight of the next calendar day**.
- Code **1, Yes**, if the two-way communication AND completion of the prescribed/recommended actions occurred by midnight of the next calendar day after the potential clinically significant medication issue was identified.

N2005: Medication Intervention (Discharge)

- 0. No
- 1. Yes
- 9. NA -

Section N		Medications
N2005. Medication Intervention		
Enter Code <input type="checkbox"/>	Did the facility 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 admission?	
	<ul style="list-style-type: none">0. No1. Yes9. NA - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications	

N2005 Steps for Assessment

1. Review the patient's medical record and **all** available data sources and identify **all** potential and actual clinically significant medication issues that were identified upon admission and throughout the patient's stay.
2. Determine if the following criteria were met for **all** potential and actual clinically significant medication issues that were identified upon admission or at any time throughout the patient's stay (admission through discharge):
 - Two-way communication between the clinician(s) and the physician (or physician-designee) was completed by midnight of the next calendar day; AND
 - All physician (or physician-designee) prescribed/recommended actions were completed by midnight of the next calendar day.

N2005 Coding Instructions

Completed only if A0250 = 10 Planned discharge, 11 Unplanned discharge, or 12 Expired.

- Code **0, No**, if **all** clinically significant medication issues identified upon admission or at any time throughout the patient stay (admission through discharge) were **not** completed **by midnight of the next calendar day**.
- Code **1, Yes**, if **all** clinically significant medication issues identified upon admission or at any time throughout the patient stay (admission through discharge) **were** completed **by midnight of the next calendar day**.
- Code **9, NA - Not applicable**, if there were no potential or actual clinically significant medication issues identified upon admission or throughout the patient stay, or the patient was not taking any medications at the time of admission or throughout the stay.

N2001 Practice Coding Scenario 1

- The admitting LTCH nurse reviewed and compared the acute care hospital discharge medication orders and the LTCH physician's admission medication orders for Ms. W.
- The nurse interviewed Ms. W, who confirmed the medications she was taking for her current medical conditions. Upon the nurse's request, the pharmacist reviewed and approved the medication orders as appropriate for the patient.
- As a result of this collected and communicated information, the registered nurse (RN) determined that there were no identified potential or actual clinically significant medication issues.

N2001 Practice Coding Scenario 2

- Mr. C was admitted to an LTCH after undergoing mitral valve replacement cardiac surgery. The acute care hospital discharge information indicated that Mr. C had a mechanical mitral heart valve and was to continue receiving anticoagulant medication.
- While completing a review and comparison of the patient's discharge healthcare records from the acute care hospital with the LTCH physician's admission medication orders, an RN noted that the admitting physician ordered the patient's anticoagulation medication to be held if the international normalized ratio (INR) was below 1.0.
- The RN questioned the INR level listed on the admitting physician's order, based on the LTCH's established INR therapeutic parameters of (2.0-3.0) which prompted the RN to call the physician immediately to address the issue.

N2003 Practice Coding Scenario 3

- Mr. B was admitted to the LTCH with a history of pneumonia. The acute care facility medication record indicated that the patient was on a seven-day course of antibiotics and the patient had 3 remaining days of this treatment plan.
- The LTCH pharmacist reviewing the discharge records from the acute care facility and the LTCH admission medication orders noted that the patient had an order for an anticoagulant drug as well as the antibiotic. On the date of admission, the LTCH pharmacist contacted the LTCH physician caring for Mr. B and noted concern about a potential increase in the patient's INR with this combination of medications, which placed the patient at greater risk for bleeding.
- The LTCH physician provided orders for laboratory testing so that the patient's INR levels would be monitored over the next three days, starting that day. However, the clinician did not request the first INR laboratory test until after midnight of the next calendar day.

N2003 Practice

Coding Scenario 4

- Ms. S was admitted to an LTCH from an acute care hospital. During the admitting nurse's review of the patient's acute care facility discharge records it was noted that the patient had been prescribed metformin. However, admission labs indicated the patient had a serum creatinine of 2.4, consistent with renal insufficiency.
- The LTCH admitting nurse contacted the LTCH physician-designee to ask if this drug would be contraindicated with the patient's current serum creatinine level. Three hours after the patient's admission to the LTCH, the LTCH physician-designee provided orders to discontinue the metformin and start the patient on a short-acting sulfonylurea for ongoing diabetes management. These medication changes were implemented within the hour.

N2005 Practice Coding Scenario 5

- At discharge from the LTCH, the discharging licensed clinician reviewed Ms. T's medical records, which included admission through her entire stay at the LTCH, and noted that a clinically significant medication issue was documented during the admission assessment.
- At admission, Ms. T was taking two antibiotics – an antibiotic prescribed during a recent acute care hospital stay that the LTCH physician had included in her LTCH medication orders, and a second antibiotic prescribed by the LTCH physician upon admission that is toxic to the patient's kidneys due to the patient's renal disease. Ms. T's medical records further indicated that an LTCH nurse had attempted to contact the assigned LTCH physician several times about this clinically significant medication issue.
- **After** midnight of the second calendar day, the LTCH physician communicated to the nurse via a telephone order to administer a newly-prescribed antibiotic in addition to the previously-prescribed antibiotic. The nurse implemented the physician's order. Upon further review of Ms. T's medical records, the discharging nurse determined that no additional clinically significant medication issues had been recorded throughout the remainder of Ms. T's stay.

N2005 Practice Coding Scenario 6

- At discharge, the licensed clinician completing a review of Ms. K's medical records identified and noted two clinically significant medication issues during the patient's stay. The patient's record included an order to hold the medication Ms. K was receiving for deep vein thrombosis prophylaxis, and based on the patient's clinical status, the LTCH RN determined that the physician needed urgent notification.
- The day after the observed symptoms were identified and physician notification occurred, the LTCH physician provided an order to resume the medication, which was carried out by the nursing staff within the hour.
- In addition, a licensed clinician identified a clinically significant medication issue during the admission assessment period and contacted the physician on the same day. Both medication issues identified during the patient's stay were communicated and addressed by midnight of the next calendar day, and there were no additional clinically significant medication issues identified during the rest of the LTCH stay.

Summary

- Section N is **new** to the LTCH CARE Data Set v4.00 and includes the following items:
 - N2001. Drug Regimen Review.
 - N2003. Medication Follow-up.
 - N2005. Medication Intervention.
- This measure assesses whether LTCH providers conducted a drug regimen review upon admission and were responsive to potential or actual clinically significant medication issues when such issues were identified upon admission and throughout the patient stay.

Action Plan

- Review Section N intent, rationale, and steps for assessment.
- Review the steps for evaluation and coding tips for Section N.
- Practice coding a variety of scenarios with staff.