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Kate Goodrich, M.D.
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RE: Quality Measures to Satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions – Medication Profile Transferred to Provider / Medication Profile Transferred to Patient

Dear Dr. Goodrich:

On behalf of our nearly 3,300 post-acute care members, including skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs) and home health agencies (HHAs), the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) and its contractors' draft specifications for the two transfer of health information measures under development. The measures are being developed to meet CMS's statutory obligations under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. The sharing of relevant patient information with other providers and patients/caregivers is paramount to maintaining a strong and integrated continuum of care, and the AHA appreciates that CMS is thoughtfully working to meet the statutory requirements of the IMPACT Act. This letter includes feedback on the evolution of these measures as well as questions and recommendations for the developers as they continue to refine the specifications.

Evolution of Transfer of Information Measures

The AHA appreciates the marked improvement in these measures since they were first introduced to the National Quality Forum's Measure Applications Partnership (MAP) in 2016. In that iteration, the measures were titled "Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from/Discharge or End of Care to Other Providers/Settings." We and others on the MAP (as well as those in subsequent public comments) voiced significant concerns with the validity and feasibility of the measures, and the MAP recommended that the measures be refined and resubmitted for consideration. It appears that several of these concerns have been explicitly addressed in the new measures.

Primarily, the previous version of the measures placed the burden of accountability for transferring patient information on the receiving providers, when in fact these providers have little control over the information sent to them. In the specifications under consideration, the transferring/discharging provider is held accountable for providing the medication profile to the subsequent provider or the patient/caregiver. This is a preferable method of attribution, and we support the adjustment.

In addition, the previous measure counted as successful episodes of care where "at least one information type" was transferred at the relevant point of care. Not only would this specification fail to ensure that relevant information was shared (and thus likely would have little impact on patient outcomes), the low bar for success would virtually guarantee that the measure would become topped out quickly. We appreciate that the new specifications include a minimum set of vital patient information that must be transferred in order for providers to be considered successful. However, we have questions about the specific items to be included in the medication profile, which are enumerated below.

Concerns Regarding Measure Specifications
Some concerns that were raised in regard to the prior versions of these measures remain, and others have arisen in this iteration of the measures.

An overarching concern is that these measures only assess whether information was transferred. They do not evaluate the quality of the information (e.g., the items in the medication profile match patient preferences listed elsewhere) or that the receiving providers or, more importantly, patients understood that information. While we understand that CMS is only statutorily required to introduce a measure addressing the domain of "accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers," these measures as specified will not show a reliable connection between the care provided and patient outcomes.

Another concerning aspect of the newly specified measures is the inclusion of "verbal" as an acceptable route of transmission of the medication profile. Allowing providers to consider a conversation in-person or over the phone regarding the medication profile is insufficient to ensure that the information is received. Without paper or electronic records, subsequent providers and patients/caregivers might as well have no information at all.

In addition, a verbal review of the items included in the medication profile likely is already part of the discharge or transfer process, and thus transferring the information verbally would not fill an inappropriate gap in care. Because providers could continue to record their verbal interactions with patients at the point of discharge/transfer in progress notes, and thus satisfy the measures, performance likely would become topped out without any beneficial change in practice. Because of these issues, we recommend that the verbal route of transmission be removed as an acceptable route of transmission on its own, or only used as a supplement to transmission of a written or electronically transmitted medication profile.

One issue that is not addressed in the development of the measures from their previous iterations is the different measure populations by payer source. As specified, the measures would be based on different types of stays depending on the setting: for LTCHs, all patient stays regardless of payer would be counted; for SNFs, relevant stays include Medicare Part A covered stays; for inpatient rehabilitation facilities and HHAs, Medicare Part A and Medicare Advantage stays would be included. Considering that the purpose of the IMPACT Act is to require data that is "standardized and interoperable…by using common standards and definitions," the variation in the denominators seems incongruous. In addition, because Medicaid is a major source of funding for long-term care (and HHA measures include Medicaid patients), we believe that Medicaid stays also should be included.

Another concern is that there appears to be significant overlap in the items required for inclusion in the medication profile that also would be present in the discharge summary. It is our understanding of these measures that, if implemented, CMS would require providers to supply both a discharge summary *and* the medication profile upon discharge/transfer. This requirement would result in duplicative processes for providers as they would have to record information in multiple places; reconciling the multiple pieces of documentation is likely to result in confusion.

Thus, the AHA recommends that the medication profile only include information that would not otherwise be reliably documented in the discharge summary. These items comprise:

- Name and date of birth (for identification purposes);
- Primary physician name and contact information;
- Known medication allergies and sensitivities;
- Patient preferences;
- Adherence strategies;
- Name of drug that patient is accustomed to (rather than all generic and proprietary names);
- Dose, route of administration, frequency, directions/special instructions;
- When last dose was administered; and
- When final dose should be given.

Further, as CMS moves towards implementation, the AHA urges the agency to consider how it will validate measure performance. As currently written, there is no validation mechanism specified or suggested. The lack of ability to follow up and ensure information was received can compromise the validity and usefulness of these measures.

Areas for Clarification

In addition to the concerns above, we also request that the specifications include clarifications on a number of items to ensure smooth and consistent implementation of collection and reporting processes.

First, several items in the medication profile are noted "if applicable." While clinicians populating the medication profile likely will be able to intuit which items are applicable, clinicians will not necessarily be the only staff providing the profile or completing the item required for measure calculation. Additional guidance on the applicability of other items would help remove any subjectivity of determining whether the item should be included in the profile; information on where to find the information to enter it into the profile would also be helpful (especially if the items are subject to frequent change, like weight, and thus might conflict with other information being sent to subsequent settings, like the discharge summary). In short, the data collection protocol should define "if applicable" to clearly demonstrate when missing information is acceptable, and should provide additional clarification around reconciling multiple data sources.

Second, developers should consider providing more information around the inclusion of the "home under the care of a home health agency and hospice" in both measures. Conceptually, we have no concern with completing both measures (i.e., transferring the medication profile to both the patient and the provider) when the patient is transferred to these settings. However, it would be helpful if the collection protocol included assurance to providers on when they must complete both measures as opposed to one or the other.

Third, the measure developer and CMS might consider whether it could be appropriate to collect both measures regardless of the site to which the patient will be transferred/discharged. In other words, overall information sharing might be improved by evaluating providers on whether they give complete medication profiles to both the subsequent facility *and* the patient or caregiver.

Finally, several of the items required for inclusion in the profile include definitions/explanations; we suggest offering clear instructions for filling out each item, as these measures cover four care settings that serve a patient population with a wide range of characteristics. Specifically, the "primary physician name" should include instructions on whether this item indicates the patient's primary care physician (i.e., the community physician, if known) or the attending physician at the discharging/transferring site.

We thank you for the opportunity to comment on these draft measure specifications. If you have any questions concerning our comments, please contact me or have a member of your team contact Caitlin Gillooley, associate director of policy, at cgillooley@aha.org.

Sincerely,

/s/

Ashley Thompson
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Public Policy Analysis and Development