Pharmacy Health Information Technology Collaborative

Via Electronic Submission to: TOHPublicComments@rti.org

May 3, 2018

RTI International
3040 E. Cornwallis Road
Research Triangle Park, NC 27709

Re: RTI Project Number 02014077.001 – Draft Specifications for the Medication Profile Transferred Measures for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies

Project Title: Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions-Medication Profile Transferred to Provider/Medication Profile Transferred to Patient

Dear Sir/Madam:

On behalf of the membership of the Pharmacy Health Information Technology Collaborative (Collaborative), we are pleased to submit comments for the *Draft Specifications for the Medication Profile Transferred Measures for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies.*

Pharmacists are users of health IT and are supportive of interoperability standards, especially those utilizing certified EHR technology (CEHRT). The Collaborative supports the use of particular standards which are important to pharmacists for working with other health care providers, transitions of care, allergy reactions, immunization (historical and administered), immunization registry reporting, medications, medication allergies, patient problems, smoking status, reporting to public health agencies, clinical decision support services/knowledge artifacts, drug formulary checking, and electronic prescribing.

The Collaborative has been involved with the federal agencies, including the Office of the National Coordinator (ONC) and the Centers for Medicaid and Medicare Services (CMS), developing the national health information technology (HIT) framework since 2010.

Although the Collaborative supports goals for enhancing HIT to improve patient outcomes, particularly with regard to interoperability, we have concerns with some of

the elements in the draft specifications. The following are our comments regarding the *Draft Specifications for the Medication Profile Transferred Measures.*

4.1 Medication Profile

This section appears to be solely documenting a medication profile to a patient; it's not tied to medication reconciliation. The Collaborative recommends that it also be connected to medication reconciliation. To be effective, it should be connected to both and be included as a data element.

4.1.1 Patient Information and
4.1.2 Medication Information

The Collaborative believes the proposed data elements need to be reconciled and aligned with ONC's draft U.S. Core Data for Interoperability (USCDI) and medication reconciliation. The USDCI are based on the adopted 2015 Edition Common Clinical Data Set (CCDS) definition that also includes Clinical Notes and Provenance.[1] CCDS is part of ONC's 2015 EHR certification requirements. The purpose of the USCDI is to achieve the goals established by the 2016 enactment of the 21st Century Cures Act. The Collaborative also believes it is vitally important that RTI's draft specifications should align with the Cures Act, even though the IMPACT Act is different.

On April 27, CMS published five proposed rules concerning the FY 2019 prospective payment system and quality reporting programs for segments of Medicare. The most significant and comprehensive of these proposals are *the Hospital Inpatient Prospective Systems for Acute Care Hospitals and Long Term Care Hospital Perspective Payment System Proposed Policy Changes* (1,883 pages) and the *Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule FY 2019, SNF Value-Based Purchasing Program and SNF Quality Reporting Program*. In these proposed rules, CMS states the proposed changes are to implement certain statutory provisions of the 21st Century Cures Act. These proposed rules adopt USCDI. Additionally and importantly, the Medicare and Medicaid EHR Incentive Programs will become the Promoting Interoperability Programs (no longer called EHR Incentive Programs). The intent of these proposed changes is to make the transfer of health information more streamlined and interoperable.

The draft USCDI Version 1 Data Classes proposes 21 data elements. RTI's proposal lists 11 and omits several data elements that are critical for health care providers, especially, pharmacists (e.g., laboratory values/results, problems, care team members, immunizations, provenance, health concerns, assessment and plan of treatment, preferred language, clinical notes).[2]

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[1] *Draft U.S. Core Data for Interoperability (USCDI) and Proposed Expansion Process,* the Office of the National Coordinator, Health Information Technology, January 5, 2018, page 5. https://www.healthit.gov/sites/default/files/draft-uscdi.pdf

[2] Ibid, page 6.

Each data element should have a definition or description so that health care providers know and understand what is being collected. For example, what does #24, "Patient adherence with medication therapy," mean? Is this a yes/no answer? Does it require a written explanation about adherence or non-adherence? We recommend that RTI work with the Collaborative on defining these data elements.

For #10, "Patient adherence strategies," we recommend adding digital health to the list, as there are now apps for that.

A key component to the medication profile is medication reconciliation, which is missing from the proposal. The Collaborative strongly recommends that medication reconciliation be included as a data element and connected to the medication profile.

Capturing Data

It appears there is no standardized template or mechanism proposed or recommended in the draft specifications for capturing data. How will data be collected? The Collaborative recommends that RTI review standardized templates that are currently used in HIT for the collection of health information. For example, one of the standards that the ONC included in its 2014 EHR Certification for Meaningful Use Stage 2 was the Health Level Seven (HL7) Consolidated Clinical Document Architecture (C-CDA). C-CDA defines the structure of certain medical records, such as discharge summaries and progress notes, as a better way to exchange this information between providers and patients.

The draft specifications also need to ensure that standardized vocabularies are incorporated to collect clinical and drug information, including observations. As an example, how will drug allergies/intolerance be captured in a way to create a medication profile for sharing and exchanging? Based on the draft patient information list (#8 "Known drug sensitivities and reactions), it's not clear how that will be done. There has to be a method to drive the collection of these data elements. Using standardized vocabularies and notes (e.g., HL7 C-CDA) would help in that.

Vocabularies that are widely used by federal agencies and health care providers are: Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT), RxNorm, and Logical Observation Identifier Names and Codes (LOINC). These standardized vocabularies facilitate the exchange of a patient's health information and enable interoperability and clear communication between systems, regardless of software and hardware compatibility.

The Collaborative recommends that RTI work with standard setting organizations in this regard.

Sharing Information at Transition of Care

Critical to meeting the IMPACT Act's goal of "accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions…" is ensuring that the information shared is understandable.

Hospitals may be able to capture electronically, but others may not be able to understand what is being received (see previous comments regarding capturing data). Additionally, a patient's medication profile that is sent to the patient or family caregiver needs to be sent in the patient's preferred language. This is not included in RTI's proposed data elements nor is how the information will be sent (e.g., paper, electronically). The Collaborative recommends that the patient's preferred language and method of sending information be included in the patient information data elements (see also comment regarding USCDI data elements).

Another aspect that appears to be missing from the proposal are pharmacists, particularly, community pharmacists. The proposal focuses exclusively on skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, and home health agencies. It is vitally important that pharmacists are included as recipients of and contributors to the medication profile transferred measures.

Pharmacists provide more patient care today than before, and interoperable solutions are more important now than ever. This is especially critical for transitions of care, which community pharmacists are also a part. Pharmacists play an important role at points of transition of care in assuring orders created by providers are correct, especially, in post acute and long-term care settings. Pharmacists are involved in the transition of care and medication reconciliation for patients, making it vitally important that pharmacists have access to current problem lists at the points of transition to match medications for patients to use. This is particularly important for medication therapy management (MTM) services pharmacists provide under Medicare Part D. The Collaborative recommends that proposed medication profile transferred measures be aligned with MTM, and as mentioned previously, be included as recipients of and contributors to the medication profile.

As with post acute care (PAC) providers, pharmacists were not eligible to participate in the Medicare and Medicaid Electronic Health Records (EHR) Incentive program. Although pharmacists were not eligible for the incentive program, they have adopted and are meaningful users of health IT and EHRs.

Timeframe for Completing Implementation Process

The Collaborative recommends establishing an action plan to use EHRs and exchanging information and a timeframe for finalizing and implementing the draft specifications. It is not clear what the implementation plan is or how long this process will take. Although the IMPACT Act sets October 1 as the effective date, we do not believe that date is doable at this time and may necessitate asking CMS to delay that date.

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The Pharmacy HIT Collaborative comprises the major national pharmacy associations, representing 250,000 members, including those in pharmacy education and accreditation. The Collaborative's membership is composed of the key national pharmacy associations involved in health information technology (HIT), the National Council of Prescription Drug Programs, and nine associate member encompassing e-prescribing, health information networks, transaction processing networks, pharmacy companies, system vendors, pharmaceutical manufacturers, and other organizations that support pharmacists' services.

As the leading authority in pharmacy health information technology, the Pharmacy HIT Collaborative's vision and mission are to ensure the U.S. health IT infrastructure better enables pharmacists to optimize person-center care. Supporting and advancing the use, usability, and interoperability of health IT by pharmacists for person-centered care, the Collaborative identifies and voices the health IT needs of pharmacists; promotes awareness of functionality and pharmacists' use of health IT; provides resources, guidance, and support for the adoption and implementation of standards driven health IT; and guides health IT standards development to address pharmacists' needs. For additional information, visit www.pharmacyhit.org.

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On behalf of the Pharmacy HIT Collaborative, thank you again for the opportunity to comment on the *Draft Specifications for the Medication Profile Transferred Measures.*

For more information, contact Shelly Spiro, executive director, Pharmacy HIT Collaborative, at shelly@pharmacyhit.org.

Respectfully submitted,

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