Pharmacy Health Information Technology Collaborative

Via Electronic Submission to: http://www.regulations.gov

January 4, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS- 3311-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-3311-P – Medicare and Medicaid Program; Revisions to Requirements for Discharge Planning Hospitals, Critical Access Hospitals, and Home Health Agencies

Dear Sir/Madam:

On behalf of the membership of the Pharmacy Health Information Technology Collaborative (Collaborative), we are pleased to submit comments on the proposed rule – *CMS-3311-P – Medicare and Medicaid Program; Revisions to Requirements for Discharge Planning Hospitals, Critical Access Hospitals, and Home Health Agencies.*

The Collaborative is supportive of the proposed modifications for the discharge planning process from acute care hospitals and post-acute care (PAC) settings for transitioning care to a patient's home (with or without PAC services), skilled nursing facility, nursing home, long term care hospital, rehabilitation hospital or unit, assisted living center, or other health care settings. Pharmacists are already providing a critical role in discharge planning. Therefore the Collaborative recommends that the proposed rule explicitly indicate that pharmacists be included in the discharge planning process.

Pharmacists play important roles at points of transition of care, especially, in post-acute and long-term care; by assuring orders created by eligible professionals (EPs) are correct, and reconciling medications. These roles require pharmacists to 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 following are our comments for *CMS-3311-P: Medicare and Medicaid Program; Revisions to Requirements for Discharge Planning Hospitals, Critical Access Hospitals, and Home Health Agencies.*

Discharge Planning for Hospitals (pages 18-28)

The Collaborative agrees with CMS that providing hospital patients discharged back home with literature to read about medication usage and required therapies; prescriptions for post-hospital medications and supplies do not adequately reinforce the necessary skills that patients, their caregivers, and support persons need to meet post-hospital clinical needs. We also agree that inadequate patient education may lead to poor outcomes, including medication errors and omissions and possibly re-hospitalizations. A more detailed, easy to understand discharge plan by hospitals, as proposed, would help by providing additional education regarding patients' medications.

The Collaborative supports requiring that all patients be evaluated for their discharge needs and have a written discharge plan developed for those patients identified for whom a discharge plan is necessary. We note that CMS proposes to combine and revise two existing requirements (§482.43(b)(2) and §482.43(c)(1)) into a single requirement §482.43(c)(1). This proposal states that the "resulting provision would require a registered nurse, social worker, or other personnel qualified in accordance with the hospital's discharge planning policy, coordinate the discharge needs evaluation and the development of the discharge plan." It is not clear if this would include the pharmacist. The collaborative recommends that pharmacist be explicitly included in the discharge planning process.

We recommend that the discharge plan should include the hospital pharmacist in the discharge planning. This could include the pharmacist meeting with the patient, to discuss use of prescribed and non-prescription medications, as well as the proper storage and disposal of such medications, especially controlled substances. As CMS notes in its discussion, lack of education concerning these areas may also be a factor in overdoses, substance use disorders, and diversion of controlled substances.

Prescription Drug Monitoring Program for Evaluation of a Patient's Relevant Co-morbidities and Past Medical and Surgical History (pages 28-29)

The Collaborative supports the use of states' Prescription Drug Monitoring Programs (PDMP) in conjunction with clinical decision support (CDS) tools. As stated in the Office of the National Coordinator's proposed *Shared Nationwide Interoperability Roadmap*, "CDS based on availability of pharmacist prescribing and fill data will enable patient education, prevention of adverse drug events, tracking and improvement of medication adherence and, through linkages to Prescription Drug Monitoring Program (PDMP) systems, enable interventions to prevent abuse of controlled substances."

PDMP systems are used for medication reconciliation of controlled substances; identifying or preventing drug abuse and diversion; facilitating the identification of

prescription drug-addicted individuals and appropriate intervention and treatment; and educating individuals about prescription drug use, abuse, and diversion.[1] PDMPs support access to controlled substances for legitimate medical use.

The majority of states allow pharmacists and practitioners to access PDMP information related to their patients.

New Requirement §482.43(c)(7): Patient's Goals of Care and Treatment Preferences (page 30)

The Collaborative recommends that during the discharge planning process that the pharmacist be included with the medical staff and patient for discussing the patient's post-acute care goals and treatment preferences. The Collaborative supports the adoption of health IT standards for the sharing of electronic care plans. The Collaborative is leading efforts within the standards development organizations (National Council for Prescription Drug Programs (NCPDP) and HL7) in developing a Pharmacist eCare Plan to identify and electronically share pharmacist/patient agreed medication-related goal of care.

New Requirements §482.43(d)(2)(ii) and §482.43(d)(2)(iii): Discharge Instructions Include Written Information on Warning Signs and Symptoms (pages 35-36)

The Collaborative supports this new requirement for written information about warning signs and symptoms for all prescribed and non-prescription medications selected for use after the patient's discharge from the hospital.

New Requirement §482.43(d)(2)(v): Patient Medication Reconciliation (pages 36-40) and Revised §482.43(e) Transfer of Patients to Another Health Care Facility (page 42)

The Collaborative supports patient medication reconciliation prior to hospital discharge or transfer of the patient. We also recommend that the medication list also be provided to all providers, including pharmacists, at the point of transition of care, and not just provided to the patient. The Collaborative recommends that for a patient being discharged to their home, the hospital should obtain the name of the patient's preferred pharmacy for transmitting the medication list and prescribed post-discharge medication order directly to the patient's pharmacy, as part of its discharge plan process.

[1] Congressional Research Service*, Prescription Drug Monitoring Programs*, March 24, 2104 (The Prescription Monitoring Program Center of Excellence, *Prescription Drug Monitoring Programs: An Assessment of the Evidence for the Best Practices*, September 20, 2012; National Alliance for Model State Drug Laws, *Prescription Drug Monitoring Programs: A Brief Overview,* August 17, 2010.)

The Collaborative supports the definition outlined in the American Society of Health-System Pharmacists (ASHP) and American Pharmacists Association (APhA) *Improving Care Transitions: Optimizing Medication Reconciliation*[2] as appropriate guidance for pharmacists during transitions of care.

Patients are vulnerable at transitions of care and these transitions may involve multiple health care providers, as well as the patient, family members, and other caregivers. Comprehensive medication review (CMR) that includes medication reconciliation at transitions of care should be provided by a pharmacist and be part of all providers' EHR documentation in all practice settings.

Additionally, the following information should be included and provided electronically to pharmacists at transitions of care: medication lists, directions for use, indication for each medication related to the patient's problems and a list of allergies. Some of these appear to be included in the listing of information to be provided for §482.43(e) though not at §482.43(d)(page 44). For optimal MTM services at transitions of care, the full content of a continuity of care document (CCD), including prescriber information and medication history should also be provided electronically to pharmacists.

The Collaborative is supportive of hospitals accessing the patient's prescription formulary and benefit information and any formulary restrictions during the discharge prescribing process. This can reduce lack of patient adherence related to the prescribed medication not being on the formulary or the cost of the drug being too costly for the patient to purchase. The patient should be allowed to choose where to purchase the medication.

Certified Health IT (pages 46-47)

The Collaborative supports using certified health IT to enable real time electronic exchange and bidirectional communication. For the purposes of this rule, we recommend that CMS require facilities that are electronically capturing information, to do so using certified health IT rather than stating that CMS strongly believes facilities should be using such. This statement by CMS for the proposed rule appears to run counter to the Meaningful Use EHR Incentive Program and ONC's *Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap*.

If the goals of CMS and the ONC are to implement secure interoperability within health IT, use of certified health IT must be a requirement.

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[2] Improving Care Transitions: Optimizing Medication Reconciliation, https://www.pharmacist.com/sites/default/files/files/2012_improving_care_transitions.pdf, accessed December 15, 2015.

Critical Access Hospital Discharge Planning (page 56)

The Collaborative supports requiring critical access hospitals (CAHs) to implement a discharge planning process, including five of the six standards proposed for hospitals and the new proposed standard for discharge to home.

New Requirement: Discharge to Home §485.642(d)(1) through (3) for CAHs (page 65)

The Collaborative supports the new standard for discharge to home as proposed. As part of the medication reconciliation and patient care process, the Collaborative is supportive of practitioners consulting with state PDMP, even if the practitioner is not prescribing a controlled substance, to prevent medication adverse events and opioid/controlled substance abuse.

Transfer of Patients to Another Health Care Facility from a CAH (pages 67-69)

The Collaborative supports the proposed requirement that the CAH send necessary medical information to the receiving facility at the time of transfer. As part of integrated health care teams, pharmacists, including those in long-term care facilities and nursing homes, are involved in the transition of care. It is vitally important in these transition of care practice settings that pharmacists are sent necessary medical information, including diagnoses; course of illness/treatment; reconciliation of discharge medications (prescribed and non-prescription); all known allergies, including adverse reactions and intolerances; medication indication related to the problem list; pertinent laboratory tests and results; and immunizations.

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The Pharmacy HIT Collaborative's vision and mission are to assure the nation's health care system is supported by meaningful use of HIT, the integration of pharmacists for the provision of quality patient care, and to advocate and educate key stakeholders regarding the meaningful use of HIT and the inclusion of pharmacists within a technology-enabled integrated health care system. The Collaborative was formed in the fall of 2010 by nine pharmacy professional associations, representing 250,000 members, and also includes associate members from other pharmacy-related organizations. The Pharmacy HIT Collaborative's founding organizations represent pharmacists in all patient care settings and other facets of pharmacy, including pharmacy education and pharmacy education accreditation. The Collaborative's Associate Members represent e-prescribing and health information networks, a standards development organization, transaction processing networks, pharmacy companies, system vendors and other organizations that support pharmacists' services. For additional information, visit www.pharmacyhit.org

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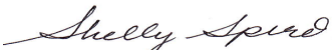
On behalf of the Pharmacy HIT Collaborative, thank you again for the opportunity to comment on *CMS-3311-P – Medicare and Medicaid Program; Revisions to Requirements for Discharge Planning Hospitals, Critical Access Hospitals, and Home Health Agencies.*

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

Respectfully submitted,



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