NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
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TO: HSAG (IPF Quality Reporting Contractor);
Centers for Medicare & Medicaid Services (CMS)

DATE: February 10, 2010

FROM: Kathleen McCann, R.N., Ph.D., Director of Quality and Regulatory Affairs
National Association of Psychiatric Health Systems

RE: NAPHS Comments on Proposed Medication Reconciliation Measure

The National Association of Psychiatric Health Systems (NAPHS) advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations, including more than 800 psychiatric hospitals, addiction treatment facilities, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care.

We agree with the concept that quality care is enhanced when there is a clear understanding of a patients' medication history at the time of admission. We acknowledge the careful work done by HSAG in developing this measure. However, we have serious concerns about how the proposed measure will actually be feasible. As specified, data collection for this measure presents an overwhelming burden for facilities and potentially detracts from the organization's ability to focus on the most important elements of mediation reconciliation. There are 21 data elements specified in the measure. While some of these only need to be collected once for the patient, at least 10 must be collected for EACH medication the patient reports. According to the pilot test data, patients reported being on an average of 4.5 medications. In addition, the measure requires verification through a "health systems source" for each medication (whether the patient is deemed to be a reliable informant or not). At the time of admission of a psychiatric patient (always an emergency--there are no scheduled psychiatric admissions) critical decisions must be made about priorities. Compliance with collection of, on average, 44 data elements may seriously interfere with critical priorities. This does not include the burden of seeking information from other health system sources.

The proposed algorithms and calculations are extremely complex. During the pilot phase, organizations received significant training and were not responsible for calculating performance rates. As this measure potentially rolls out to more than 1600 facilities (with significant turn-over of abstraction staff), it is hard to project how accurate the data will be--even with the very best efforts of clinicians and abstractors. The measure has three very distinct components with complex elements within each component, yet is reported as one measure. This is not typical of other measures used in the CMS payment system requirements.

Psychiatric hospitals have a significantly lower rate of utilization of electronic health records than general healthcare (there have not been federal funds appropriated to support EHRs in psychiatric hospitals). Electronic systems help, to some degree, with the collection of data (including health system sources).

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We strongly recommend that the measure also be e-specified to make it usable for facilities that do have electronic medical records.

Many of our members have told us that attempting to find other sources will require "random" calling of pharmacies, outpatient treatment programs, private providers, etc.. Patient consent is required for these contacts. Timely response is totally out of the control of the organization yet a retail pharmacy that is closed is the only consideration given in the measure. Health system sources can often be outdated or incomplete and lack reference to discontinued or over-the counter medications.

The measure materials reference The Joint Commission National Patient Safety Goal on Medication Reconciliation (NPSG.03.05.01). The requirements for meeting this goal (while not designed to be a measure) are much more simple than the proposed CMS measure yet seem to assist facilities in collecting and using relevant data for purpose of safe medication administration.

Failure to meet the requirements of the IPFQR program results in facilities loosing 2% of their Medicare update. Failure to report on one measure constitutes failure to meet the requirements. We cannot support the promulgation of a measure that is inherently so complex, with so many data points and internal inconsistencies, that it presents great potential for organizations to be unsuccessful. The data is publically reported and tracked by many interests. While the data, at this time, is not used for pay for performance purposes, we expect that it eventually will. Benchmarks will be used to determine reimbursement. Collection of data that is not valid and reliable because of problems with the measure, does not allow establishment of benchmarks that are accurate.

We understand the tension between developing the "ideal" measure from a theoretical perspective and the development of a measure that is feasible in the clinical setting in which it is used. We can significantly advance medication reconciliation without overwhelming the field with requirements that distract from answering the most important questions about what medication the patient is on and what they are prescribed during hospitalization.
The burden of both data collection and reporting and the burden of staff training should be evaluated. The numbers reported in the pilot data represent only data abstraction and do not capture the total requirements of the measure reporting. There is a long list of issues in the specifications that we would like to discuss with you in an effort to streamline the measure. Please do not hesitate to call upon us.

Recommendations:

The measure should undergo major simplification, focusing only on data elements that contribute to the most important aspects of medication reconciliation. This process should also result in major simplification of the algorithms and data reporting requirements.

The measure should not be used for payment purposes until it is NQF endorsed. NQF review should include careful attention to the feedback given to CMS/HSAG.

If a patient is deemed to be a reliable informant, no further data sources should be required.
The measure should be e-specified (in addition to non-e-specified) before it is required for the payment program.

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