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The Physician Consortium for Performance Improvement  
American Medical Association  
515 N. State Street  
Chicago, IL 60654

Re: Public Comments on *Care Transitions Performance Measure Set*

On behalf of the American Society of Health-System Pharmacists (ASHP), thank you for the opportunity to review and comment on the draft document “*Care Transitions Performance Measure Set*.” For more than 60 years, ASHP has helped pharmacists who practice in hospitals and health systems improve medication use and enhance patient safety. The Society’s 35,000 members include pharmacists and pharmacy technicians who practice in inpatient, outpatient, home-care, and long-term-care settings.

ASHP commends PCPI’s initiative in the development of this performance measurement set. The Society believes that care transition measures can vastly improve the quality of care and we applaud PCPI’s approach of providing transition information to both the patient and the next care provider. This dual approach will maximize efforts to improve continuity of care.

The Society is pleased to have nominated Mary Ann Kliethermes, B.S., Pharm.D., Vice-Chair of Ambulatory Care and Associate Professor, Department of Pharmacy Practice at Midwestern University, to participate as a member of this workgroup. Dr. Kliethermes has been an ASHP member for more than 30 years and is an outstanding clinician with expertise in quality improvement and national measure development efforts. On behalf of ASHP, thank you for the opportunity to nominate members to this workgroup. [ASHP Policy](#) recognizes the value and importance of pharmacists in care transitions to ensure the safe and effective use of medications as patients move from one setting to another. The Society advocates for the development of strategies to address the gaps in continuity of pharmaceutical care.

ASHP encourages PCPI to consider the following comments:

**MEASURE 1: RECONCILED MEDICATION LIST RECEIVED BY DISCHARGED PATIENTS**

The Society applauds this measure’s emphasis on the importance of reconciling and communicating the medication list upon discharge. However, ASHP believes that this list should be differentiated from the medication list contained in the transition record in Measures 2 and 3. According to the Joint Commission National Patient Safety Goal 8, a discharge list of medications “should include all of the medications (prescription, OTC, herbal, etc) that the

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patient/client/resident should be taking following discharge. It should not include medications that were given only during that episode of care if those medications are not to be continued after discharge.” ASHP believes that this medication list should be a patient-friendly format that can be kept and carried by the patient. We suggest that the Numerator Statement asterisk should also include the route, frequency, and reason for use as required elements. A comprehensive medication reconciliation tool developed through multidisciplinary efforts that includes additional elements of a well-designed patient-friendly reconciled medication list is ASHP’s [My Medicine List](#). This patient education tool was designed to help stimulate discussions between patients and health care professionals. It was developed through an ASHP-convened multidisciplinary Continuity of Care in Medication Use Summit (see [Executive Summary](#)).

ASHP encourages revising the categories “discontinued,” “continued,” and “new” as currently defined to prevent confusion. As described above and in comments on Measures 2 and 3, NPSG 8 states medications given only during the admission that should not be continued after discharge should not be included on this list. Therefore, the Society recommends that these medications should be listed as an exclusion from the “discontinued” category. In addition, medications started during the inpatient stay that the patient should continue to take after discharge should be categorized as “new” because a medication identified as “continued” from admission would, in fact, be new to the patient.

ASHP would encourage revisions to the language of Measure 1 that would ensure the quality of the patient education provided with the medication list as follows: “Percentage of patients...who received a reconciled medication list AND INSTRUCTIONS PROVIDED AT THE CULTURALLY-APPROPRIATE READING AND HEALTH-LITERACY LEVEL...” As currently written, the measure can be met simply by the provision of the written list. Provision of a list without explanation misses a significant opportunity to improve patient safety. [ASHP policy](#) states that medication reconciliation should be a patient-centered process, taking into account the patient’s level of health literacy, cognitive and physical ability, and willingness to engage in his or her personal health care. The goal is improvement in patient well-being through education, empowerment, and active involvement in the accurate transfer of medication information throughout transitions along the healthcare continuum. By promoting communication among patients and healthcare providers, medication reconciliation can resolve discrepancies in medication regimens and improve patient safety. NQF’s Medication Reconciliation Safe Practice 17 specifications state, “When the patient leaves the organization’s care, the current list of reconciled medications is provided to the patient, and family, as needed, and is explained to the patient and/or family, and the interaction is documented.” The list and instructions should be provided at a reading and health literacy level that is appropriate for the individual patient.

ASHP recommends making Measures 1, 2, and 4 consistent in regards to the level of measurement (practitioner and/or system). Our preference is for system-level because different practitioners might complete the measure (case managers, physicians, pharmacists) and the types of clinicians completing these functions may vary by practice site.

In the Measure Importance section, ASHP suggests that the ‘Relationship to desired outcome’ should include the following statement to provide consistency with this section in Measure 2: “PROVIDING DETAILED DISCHARGE INFORMATION ENHANCES PATIENTS’ PREPARATION TO SELF-MANAGE POST-DISCHARGE CARE AND COMPLY WITH TREATMENT PLANS.”

In the Supporting Guidelines section, ASHP suggests reviewing the source document for the description of required elements for transition records which includes a medication list with “drug interactions.” ASHP believes this terminology may be incorrect. Drug interactions are unlikely to be listed on the medicine record. Drug allergies may have been intended by the authors of the source document. In addition, the medication reconciliation statement on page 14 uses the nursing medication administration record as the sole source of information for the medication reconciliation process. ASHP suggests including references that reflects the valuable information available from pharmacy records. Pharmacy systems are the best source of medication order history information.

### **MEASURE 2: TRANSITION RECORD WITH SPECIFIED ELEMENTS RECEIVED BY DISCHARGED PATIENTS -- INPATIENT DISCHARGES**

ASHP strongly supports the medication list as a critical element of the transition record. However, ASHP believes that the transition record’s medication list should be differentiated from the medication list described in Measure 1 and should contain the pre-admission medication list and complete information about all medications given during the admission, including those that should not be continued after discharge. In the Numerator Statement, the Society suggests changing the verbiage “current medication list” to read “Pre-admission medication list, all medications given during the inpatient stay, and reconciled medication list.\*” The asterisked numerator element definition should include the same verbiage to described the reconciled medication list as used in Measure 1 to provide consistency as well as other medication information that might be available from the Medication Administration Record and from the pharmacy system.

ASHP would encourage revisions to the language of Measure 2 that would ensure the quality of the patient education provided with the transition record as follows: “Percentage of patients...who received a written transition record AND INSTRUCTIONS PROVIDED AT THE CULTURALLY-APPROPRIATE READING AND HEALTH-LITERACY LEVEL...” As currently written, the measure can be met simply by the provision of the transition record. Provision of the record without explanation misses a significant opportunity to improve patient safety. This is recognized in the definition of a transition record in Measure 3 (“...care plan that is discussed with and provided to patient...” page 23).

ASHP recommends making Measures 1, 2, and 4 consistent in regards to the level of measurement (practitioner and/or system). Our preference is for system-level because different practitioners might complete the measure (case managers, physicians, pharmacists) and the types of clinicians completing these functions may vary by practice site.

### **MEASURE 3: TIMELY TRANSMISSION OF TRANSITION RECORD**

ASHP supports the medication list as a critical element of the transition record as described in Measure 2 and strongly recommends that all elements of the transition record, including the medication list, be consistent between Measures 2 and 3. The transition record’s medication list should be differentiated from the medication list described in Measure 1 and should contain the pre-admission medication list and complete information about all medications given during the admission, including those that should not be continued after discharge. In the Numerator Statement, the Society suggests changing the verbiage “current medication list” to read “Pre-admission medication list, all medications given during the inpatient stay, and reconciled medication list.\*” The asterisked numerator element definition should include the same verbiage

to described the reconciled medication list as used in Measure 1 to provide consistency as well as other medication information that might be available from the Medication Administration Record and from the pharmacy system.

As a future enhancement to this measure, the patient's outpatient pharmacy should also have access to the transition record to provide continued care in medication management when the IT infrastructure is available.

**MEASURE 4: TRANSITION RECORD WITH SPECIFIED ELEMENTS RECEIVED BY DISCHARGED PATIENTS -- EMERGENCY DEPARTMENT DISCHARGES**

In the denominator exclusions, patients discharged from the E.D. to be admitted to the hospital should be excluded from this measure.

ASHP suggests being consistent with the approach used for the inpatient setting by adding a separate measure to assess the percentage of patients who receive a reconciled medication list at the time of discharge from the E.D. If no medication changes are made during the E.D. visit, patients should be excluded from the denominator per Joint Commission NPSG 8. Although the challenging environment of the E.D. may result in a lower compliance rate compared to the inpatient setting, the provision of a reconciled medication list if any changes are made in the E.D. offers critical potential to improve care.

ASHP would encourage revisions to the language of Measure 4 that would ensure the quality of the patient education provided with the transition record as follows: "Percentage of patients...who received a written transition record AND INSTRUCTIONS PROVIDED AT THE CULTURALLY-APPROPRIATE READING AND HEALTH-LITERACY LEVEL..."As currently written, the measure can be met simply by the provision of the transition record. Provision of the record without explanation is incomplete. This is recognized in the definition of a transition record in Measure 3 ("...care plan that is discussed with and provided to patient..." page 23). This is also mentioned in the Measure Importance section Opportunity for Improvement, where it is stated that studies have documented gaps in "the provision or *explanation* of emergency department discharge instructions..." (page 28).

ASHP recommends making Measures 1, 2, and 4 consistent in regards to the level of measurement (practitioner and/or system). Our preference is for system-level because different practitioners might complete the measure (case managers, physicians, pharmacists) and the types of clinicians completing these functions may vary by practice site.

**MEASURE 5: TIMELINESS OF POST-DISCHARGE CARE FOR HEART FAILURE PATIENTS**

While ASHP applauds PCPI's effort to harmonize the specifications for the health care professionals with whom a follow-up visit may be scheduled with existing Joint Commission measures, the Society suggests that this measure read "Percentage of patients...scheduled by the discharging facility for a follow-up visit with a physician or advanced practice nurse or physician assistant OR AT A CARDIOLOGY CLINIC STAFFED BY SPECIALTY TRAINED PROFESSIONALS SUCH AS A PHARMACIST..." Specialty pharmacy residencies in Cardiology and Ambulatory Care provide specialized clinical pharmacists with advanced training to provide high-quality post-discharge care to HF patients.

The Society suggests considering similar timeliness of post-discharge care measures for other high impact disease states.

**MEASURE 6: PATIENT UNDERSTANDING OF POST-DISCHARGE CARE NEEDED**

ASHP is in full support of this measure's objective to assess patient's understanding of post-discharge care.

**COMMENTS ON PROPOSED BUNDLING OF MEASURES 1, 2, AND 3**

While ASHP agrees with PCPI's statement that these measures will be most useful if implemented in tandem, we suggest further discussion of the rationale for bundling of these measures in the document. The society recommends collection and assessment of data for each measure independently as well as reporting as a bundle. This will measure success for individual measures which provide benefit even if implemented alone. Since these measures have not yet undergone pilot studies, there is no data that shows, when done together, a greater improvement to patient outcomes than when each is done independently. Independent measurement will allow for assessment of the validity of each measure and whether weighting should be applied to the bundled measure.

**OTHER COMMENTS**

On pages 5, 11 and 15, it is cited that, "an estimated 60 percent of medication errors occur during times of transitions..." It is important to note that this study looked at inpatient medication errors only and to consider that this article is one organization's experience. It is also twice mentioned that, "The Institute of Medicine estimated that medication errors harm 1.5 million people each year...Many of these medication errors (approximately 60% in one study) occur during times of transition." Medication errors described by the IOM include errors in both inpatient and outpatient settings. The extrapolation that of the medication errors described by the IOM, 60% occur during transitions is inaccurate. It should be noted that by definition, the IOM medication errors include errors such as drug preparation and administration errors that are unlikely to be reduced by efforts described in this measure set.

In the Disparities section (page 12) the authors note that they are unaware of any published studies that look at disparities in care transitions. The drafter may wish to consider a recent study published last month which found that Hispanic children were less likely to receive an asthma action plan at discharge.<sup>1</sup>

Thank you for the opportunity to provide feedback on the draft Care Transitions performance measurement set. We look forward to continuing to engage in the measure development process through PCPI. If you have any questions concerning the Society's comments, please contact me by phone at (301) 664-8815 or via e-mail at mandrawis@ashp.org.

Best Regards,

Mary Andrawis, Pharm.D., M.P.H.  
Medication Use Quality Improvement Associate

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**Reference**

1. Chandra D, Clark S, Camargo CA Jr. Race/Ethnicity differences in the inpatient management of acute asthma in the United States. Chest. 2009 Feb 2. [electronic copy included]