

ASCP Position Statement: Admission Medication [Drug] Regimen Review in Nursing Facilities

ASCP Position:

As the median age of the older adult population increases, the acuity of residents living in nursing facilities continues to advance. This trend is demanding more post-acute care for residents coming to nursing facilities from acute care facilities. To satisfy this demand, the Centers for Medicare and Medicaid Services (CMS) have regulated that medication regimen reviews (MRR)* now include the Admission MRR (aMRR), the change of condition MRR, and the monthly MRR; which is reflected in the CMS State Operations Manual (SOM) as a result of new regulations in the Mega Rule and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 that went into effect in October 2018. As the experts in medication management for older adults, ASCP believes that senior care pharmacists are the best positioned health care practitioners to perform all medication regimen reviews, including aMRRs.

*Please note: In this document, “medication regimen review” will be used synonymously with “drug regimen review.”

Background and Support:

Types of MRRs

MRR is the thorough evaluation of the medication regimen of the patient with the goal of promoting positive health outcomes and minimizing adverse consequences related to medications. The review should include preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and promote collaboration with other members of the interdisciplinary team.¹ Given the increased complexity of the MRR process, guidelines and standards for pharmacists performing MRR continue to advance as the nursing facility industry is shifting from long-term care to post-acute care.² In addition to the traditional monthly MRR, the CMS SOM clearly defines the potential need for more frequent MRR based on the resident’s condition. It has been recognized by CMS that the pharmacist has the specialized training and clinical expertise to perform these reviews to help reduce medication-related problems.³

Medication-Related Problems

Medication-related problems are a major cause of morbidity and mortality in the healthcare system. They are estimated to be the largest cause of hospital readmissions (40%), and many are considered preventable. It is also estimated that 22% of Medicare beneficiaries experience adverse events during a nursing facility stay, of which 37% are medication-related.⁴ Transitions of care-related medication errors are increased in post-acute care transitions due to shorter lengths of stay and greater health acuity of the patient.⁵ Pharmacists are highly trained medication management experts that are uniquely qualified to reduce medication-related problems, improve patient outcomes, reduce readmissions to acute care, and reduce unnecessary costs.⁶ The IMPACT Act now defines the need for an Drug Regimen Review (DRR) upon the admission of a resident to a nursing facility.

IMPACT Act DRR:

¹ American Society of Consultant Pharmacists. Consultant Pharmacist Handbook: A Guide for Consulting to Nursing Facilities. Fifth Edition. 2018;4:33-57.

² Improving Care Transitions in Nursing Homes. J Am Society Aging. Available at <https://www.asaging.org/blog/improving-care-transitions-nursing-homes>.

³ OBRA 1987. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/lewingroup.pdf>

⁴ Levinson D. Adverse Events in Skilled Nursing Facilities: National Incidence among Medicare Beneficiaries. Department of Health and Human Services: Office of the Inspector General. February 2014

⁵ Improving Care Transitions in Nursing Homes. J Am Society Aging. Available at <https://www.asaging.org/blog/improving-care-transitions-nursing-homes>.

⁶ American Society of Consultant Pharmacists. Position Statement: Pharmacist Role in Transitions of Care. Consult Pharm 2017 Oct;32:645-91 | Page

Creation of Medication Reconciliation Quality Domain & DRR Quality Measure

The IMPACT Act of 2014 requires the reporting of standardized patient assessment data in regards to quality measures and standardized patient assessment data elements across all post-acute care settings.⁷ In the nursing facility setting, these requirements are defined in the MDS 3.0 Resident Assessment Instrument manual, which define the medication reconciliation domain as a DRR quality measure.⁸ The intent is to have a DRR conducted upon the resident's admission to the nursing facility as well as throughout the stay, and to address any clinically significant medication issues in a timely manner. This definition of DRR conflicts with the existing SOM requirements for MRR on two accounts. First, the discipline that performs the DRR is not specified by the IMPACT Act, whereas the SOM points to the pharmacist as the health care practitioner most prepared to perform this function and provides MRR guidelines and standards. Secondly, the definition of DRR now includes medication reconciliation.

Medication Reconciliation:

According to the Joint Commission of Pharmacy Practitioners, medication reconciliation is the process of comparing a patient's medication orders to all of the medications the patient has been taking or should be taking.⁹ This reconciliation is done to avoid unintended medication errors such as omissions, transcription, or duplication errors. The act of MRR may or may not include medication reconciliation since these are two different and distinct processes. It may also depend on the availability of the medication lists and the facility policy for medication reconciliation. Some nursing facilities may choose to have medication reconciliation performed by another member of the interdisciplinary team while having MRR performed by a pharmacist.

Interdisciplinary Team Roles in the aMRR Process:

While ASCP takes the position that the pharmacist is the lead discipline that can perform aMRR most effectively, we firmly support the need to work in conjunction with the interdisciplinary team, who are also essential in achieving optimal outcomes for the residents in their care. As outlined in our 2019 Guidelines for Admission Medication Regimen Review (aMRR) in the Nursing Facility Setting, under CMS SOM regulations, pharmacists work together with a team of facility administrators, nurses, medical directors, and medical providers to ensure proper medication reconciliation and MRR.¹⁰ ASCP's stance on MRR pertains only to the roles and responsibilities of the pharmacist in performing aMRR while continuing to emphasize the important role of the interdisciplinary team in ensuring appropriate medication use.

Position Summary

ASCP believes that pharmacists should clearly be defined as the discipline responsible for performing aMRR. This document aims to inform of inconsistencies in aMRR guidance between the CMS SOM and the IMPACT Act that may endanger patient safety. ASCP also believes that regulations must clearly define medication reconciliation as a separate process from MRR as stated in the SOM.

APPROVED BY THE ASCP BOARD OF DIRECTORS July 23, 2019

⁷ SNF Quality Reporting Program Training. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html>.

⁸ IMPACT Act of 2014 Data Standardization & Cross Setting Measures. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures.html>

⁹ The Joint Commission. Medication reconciliation. Sentinel Event Alert 2006. http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_35.htm.

¹⁰ Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.16. <https://downloads.cms.gov/files/1-MDS-30-RAI-Manual-v1-16-October-1-2018.pdf>.