

**Technical Expert Panel Summary Report:
Development of two quality measures to satisfy the
Improving Medicare Post-Acute Care Transformation
Act of 2014 (IMPACT Act) Domain of Transfer of Health
Information and Care Preferences When an Individual
Transitions to Skilled Nursing Facilities (SNFs),
Inpatient Rehabilitation Facilities (IRFs), Long-Term
Care Hospitals (LTCHs), and Home Health Agencies
(HHAs)**

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TECHNICAL EXPERT PANEL SUMMARY REPORT: DEVELOPMENT OF TWO
QUALITY MEASURES TO SATISFY THE IMPROVING MEDICARE POST-ACUTE CARE
TRANSFORMATION ACT OF 2014 (IMPACT ACT) DOMAIN OF TRANSFER OF
HEALTH INFORMATION AND CARE PREFERENCES WHEN AN INDIVIDUAL
TRANSITIONS FOR SKILLED NURSING FACILITIES (SNFS), INPATIENT
REHABILITATION FACILITIES (IRFS), LONG-TERM CARE HOSPITALS (LTCHS), AND
HOME HEALTH AGENCIES (HHAS)

DELIVERABLE 14

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LIST OF ACRONYMS AND SHORT FORMS

C-CDA	Consolidated-Clinical Document Architecture
CMS	Centers for Medicare & Medicaid Services
DNH	Do Not Hospitalize
DNI	Do Not Intubate
DNR	Do Not Resuscitate Order
EMR	Electronic Medical Record
HHA	Home Health Agency
HIE	Health Information Exchange
IMPACT Act	Improving Medicare Post-Acute Care Transformation Act of 2014
IRF	Inpatient Rehabilitation Facility
IRF-PAI	Inpatient Rehabilitation Facility-Patient Assessment Instrument
LTCH	Long-Term Care Hospital
MAP	Measure Application Partnership
MDS	Minimum Data Set
NQF	National Quality Forum
OASIS	Outcome and Assessment Information Set
PAC	Post-Acute Care
PCP	Primary Care Physician
QM	Quality Measure
QRP	Quality Reporting Program
SNF	Skilled Nursing Facility
RTI	Research Triangle Institute
TEP	Technical Expert Panel
TOH	Transfer of Health Information and Care Preferences

SECTION 1

INTRODUCTION AND OVERVIEW

1.1 Introduction

On behalf of the Centers for Medicare & Medicaid Services (CMS), RTI International and Abt Associates reconvened a Technical Expert Panel (TEP) for the third time on August 3, 2017 to seek additional expert input on the development of quality measures (QMs) that would satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain, the Transfer of Health Information and Care Preferences When an Individual Transitions. The initial TEP meeting was on September 27, 2016 and the TEP was reconvened on January 27, 2017.

To satisfy this domain, CMS and their contractors developed two quality measures, Transfer of Information at Post-Acute Care Admission, Start, or Resumption of Care from Other Providers/Settings and the Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings. These cross-setting measures are developed for the Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH), and Home Health Agency (HHA) settings. The measures under development focus on the transfer of information at admission and discharge. This report summarizes the key discussion points from two TEP meetings, including recommendations and feedback on specific assessment items and the quality measure specifications that are under development.

1.2 TEP Webinars

As noted above, RTI and Abt have conducted three TEP meetings. The focus of this third TEP meeting was to obtain input on the feasibility of quality measure and item data collection and on the transfer of health information (TOH) admission and discharge measures' relationship for post-acute care (PAC) with respect to information transfer. A summary of the January 2017 meeting is provided in Appendix B.

The third TEP meeting was held on August 3, 2017 to discuss pilot test preliminary findings following the completion of the pilot test. The purpose of the pilot test was to inform transfer of health measure development through quantitative and qualitative analysis of data collection methods, item reliability, quality measure (QM) performance under varying specifications, completion time estimates, feasibility, and the overall experience of collecting and submitting data for these TOH quality measures. While the pilot test gathered data about the types of information being received and transferred by providers, it did not assess the quality of that information. TEP members were asked to provide input on the admission and discharge items, and measure specifications based on these preliminary findings.

Twelve of the 14 TEP members attended this three and a half hour TEP webinar. The webinar and discussion focused on: (a) measure development updates and revisions to the draft TOH items and measure specifications since the January 2017 TEP meeting; (b) pilot test recruitment activities and preliminary findings; (c) admission and discharge assessment item coding by pilot test staff; (d) the measures' relationship to quality of information transfer processes; and (e) measure calculation results if the exclusions and numerator criteria were

changed. The draft TOH items that were pilot tested are provided in Appendix D. The TEP was provided with slides that described how the 30 pilot test sites responded to the 8 TOH items, estimates of the time to complete each of the items, details about the QM scores under the current draft specifications and with increases to the numerator criteria, the inter-rater agreement on the items, coding issues, and the QM scores. Qualitative findings from interviews with the pilot test sites were also presented to provide context about how sites coded the items and to share their views on the draft measures they helped to test. TEP members were then asked to provide input on the draft assessment items, measure calculations, and other topics and themes described below.

1.3 Organization of the Report

The following sections of this report summarize TEP members' input during the August 3rd, 2017 TEP webinar. **Section 2** summarizes TEP discussion and feedback. Section 2.2 summarizes the discussion of TEP members' own experiences related to the quality of information transfer processes; 2.3 summarizes feedback on the measures' relationship to the quality of information transfer process; 2.4 summarizes feedback on the determination of categories for inclusion in the measure; 2.5 summarizes feedback on the transfer of patient care preferences and patient goals of care; 2.6 summarizes feedback on assessment item wording; 2.7 summarizes the feedback about the transfer of information when the subsequent provider is unknown; and 2.8 summarizes the input on the usefulness of benchmarking information related to route of transmission. **Section 3** provides an overall summary and Section 3.1 summarizes the current state of measure development and next steps.

Information in this report is current as of October 1, 2017.

SECTION 2

SUMMARY OF TEP DISCUSSION: TEP #3

2.1 Introduction

This section summarizes the TEP discussion. The sub-sections represent the themes that emerged during the discussion. In most cases, these themes were directly related to the questions that were posed to the TEP during the webinar.

2.2 TEP member experiences with information transfer

TEP members were asked to share how the information captured in the admission measure aligns with their own experiences with the transfer of information between settings. One TEP member, who is a caregiver, mentioned that his family member's preferences were not transferred to each setting and must be reestablished after each new admission. This TEP member also said that through multiple transfers he was responsible for the continuity of information between the settings because everything was proprietary and they wouldn't share that much. To keep track of all of this information, the TEP member took notes on an iPad. When his family member was transferred between settings he would then update the next care provider.

Another TEP member, who also cared for a family member, shared that they helped to transfer information between settings within a system that has a shared medical record. The TEP member pointed out that they often had to add to the shared information and that, in their viewpoint, many patients do not have anyone able to transfer information across settings on the patient's behalf.

A few TEP members stressed that further, while information may be captured in the EHR, it may not be readily available or easily accessible to providers at admission for several reasons, including how the information is inputted or a lack of awareness that the information exists within the records. One TEP member stated that the available information may not be reviewed or only quickly skimmed due to volume.

2.3 Measure Relationship to Quality of Information Transfer Processes

2.3.1 Admission QM

When asked whether the admission QM, as currently specified, would reflect and differentiate providers in terms of the quality of their admission information transfer processes, the majority of TEP members agreed that it would. Several TEP members said that the QM will differentiate those providers with poor quality transfer processes from those with good processes, but would not differentiate those providers with good quality transfer processes from those with the highest quality processes.

When further probed about whether the measure could better differentiate providers by requiring more categories be transferred, most TEP members agreed that additional categories would better differentiate providers. Several TEP members pointed out that while requiring additional categories would capture information about what is being transferred and providers

can “check-off the boxes,” it will not address the quality of the information transferred nor will this necessarily provide a good portrait of the patient. However, in response, one member suggested that while the QM is not perfect, just measuring the transfer of information will ensure that this is a focus of PAC providers. Another member agreed with this statement, but felt that adding categories to the measure may not be worth the additional provider burden. Upon voting, the majority of TEP members agreed that providers should be required to receive more than one category of information at admission to be included in the QM numerator.

2.3.2 Discharge QM

When asked if the discharge process QM, as currently specified, will reflect and differentiate providers in terms of their quality of discharge information transfer processes, most TEP members said it would. However, when probed further, like the admission process QM, a concern was raised by TEP members about whether this measure would only distinguish the poor performers from the good performers, but be unable to distinguish the good from the highest quality performers. One TEP member was again concerned that this measure will add to provider burden and take time away from providing care.

The majority of TEP member said yes when asked if the discharge measure would better differentiate providers in terms of their quality of information transfer processes if more categories were required. One TEP member stated that the quality of provider transfers would be better distinguished if more categories were required because it would be hard to see a situation where just one piece of information would tell you enough about that person. When probed further and asked if they would recommend that providers be required to transfer more than one category of information at discharge to be included in the QM numerator, most TEP members said yes. While the majority of TEP members felt that more than one category should be included because one is not enough to understand the patient’s status and needs, they also felt that it should be balanced to not burden providers. One TEP member suggested three categories based on results from the pilot testing. It was also suggested by TEP members that the appropriate number of categories may differ by setting.

2.4 Determining Categories for Inclusion in the Measure

The TEP was guided through a discussion about the importance of the categories to transfer and other criteria for determining the categories to include in the measures. The TEP was provided with feedback collected from the pilot test sites during testing that all information categories were important to transfer, with the categories rated as most important generally matching the frequency with which they were transferred. The pilot test sites also reported that the time spent for data collection related to some categories of information such as patient goals of care was higher than for other categories.

2.4.1 Admission QM

Admission measure pilot test results indicated that some categories of information such as patient goals of care, patient care preferences, and special services are less likely to be transferred at admission. Other categories, such as medication information and medical conditions, which apply to most patients/residents, are almost always transferred. Cognitive functional and mental status was the third most frequently transferred category.

In discussing if certain categories are more or less important to transfer between settings at admission, one TEP member suggested that it may depend on the audience. For example, as a provider, they felt it may be less vital to patient safety to know information related to care preferences and goals of care than other categories of information (e.g. medication information). However, patients and caregivers may place more importance on transferring patient goals of care and care preferences and less on other categories of information. A few TEP members stated that patient goals would be a lower priority category to transfer than care preferences because as one TEP member pointed out, the information related to patient goals may be dependent on the setting to which the patient is being transferred. For example, if a goal of care within a PAC setting is to return to the community, once the patient has returned home, this goal of care is no longer relevant. One TEP member suggested a core list of categories that are important to transfer across all settings and then additional categories that are dependent on the setting.

TEP members were asked if other criteria should be considered when determining if and what categories should be included in the admission measure. One TEP member suggested that one way to prioritize the categories would be to include only those categories that providers are not transferring as frequently. For example, while medication information is an important category, it may be one that can be considered lower priority because there are other requirements and regulations in place related to the transfer of medication information. Further, pilot test results suggest that this information is already almost always transferred. However, there was disagreement among TEP members about dropping medication information because it is so important and often inaccurate and incomplete. This discussion concluded with TEP members agreeing that the QM currently captures important types of information being transferred, but not the quality of the information being transferred.

2.4.2 Discharge QM

When asked which categories of information were more important to transfer, TEP members suggested categories of information they thought could be removed from the discharge measure based on the pilot test results. TEP members suggested only retaining the categories which are not being transferred as frequently, such as care preferences, goals of care, special services and impairments. It was suggested that only including categories less frequently transferred could reduce data collection burden while encouraging providers to transfer the categories of information they are currently less likely to transfer, such as goals of care. However, it was noted that decreasing the number of categories while increasing the number required to meet the numerator criteria may make it more difficult to meet the minimum threshold of categories because providers would have fewer opportunities to achieve the higher threshold.

2.5 Patient Care Preferences and Patient Goals of Care

TEP members were asked if they interpret that the transferring of patient care preferences and goals of care measures would increase and improve the information transfer. An overall concern raised by a few TEP members was that collecting additional data related to the goals of care and care preferences would not speak to the quality of the information being transferred. It was explained to the TEP that a measure of this type would not be expected to measure the quality of the information transferred and can only measure the type of information transferred. Despite this, one TEP member stated that the quality of the information needs to extend beyond a

few notes in a file after completing a lengthy discussion with a patient. Some stated that more detailed information related to the goals of care and care preferences was important to a high-quality transfer and that a key element is that this information be transferred as part of a “warm hand-off” via verbal communication between the two providers. Two TEP members mentioned that efforts have been underway in their organizations to improve warm hand-offs between clinical staff, such as during shift changes. Much of the information related to goals of care and care preferences is not available or standardized in medical records, and the verbal transfer of this information can provide a more personal approach to the transfers. It was also noted that this verbal, warm hand-off may be more challenging to document (for measurement purposes), but could be accomplished by indicating some details in the patient’s records, such as between whom and when the verbal communication took place. Another TEP member raised the possibility of requiring that clinical notes related to discussions of goals of care and care preferences be included in transfer materials because that information is often not passed along at transition.

2.5.1 Patient Care Preferences

In relation to both the TOH admission and discharge measures, TEP members were asked specifically about care preferences, and if they thought that including patient care preferences as a category of information transferred for the measures will increase the transfer of care preferences at admission and/or discharge. As noted earlier, one TEP member who is a caregiver mentioned that a family member’s preferences were not transferred to each setting and their preferences had to be reestablished after each admission.

2.5.2 Admission QM

When discussing the admission measure, one TEP member stated that while it appeared to be time consuming to collect care preferences information during the pilot test, the patient’s voice is so critical it’s worth the time. Further, if the measure is implemented and clearly defined the burden would decrease over time as health care providers became used to collecting and documenting care preference information. Several members agreed that it was worthwhile to include care preferences for this reason and one said that if more time were spent collecting care preferences at admission it would save time in care planning later. Another TEP member suggested revising the question to ask if care preferences were documented. A TEP member said that the categories should include only those that can be quantified, such as a cognitive test score or medications. If this concrete type of information is transferred, it allows the staff more time to have conversations about patient care preferences. The TEP member felt that transferring patient care preferences could have unintended consequences if the providers who receive the care preferences don’t feel that they need to gather this information from the patient. This TEP member stated that each setting should be talking with the patient and family about the patient’s care preferences and goals of care. It can be noted that most conditions of participation also require these conversations.

2.5.3 Discharge QM

When discussing the discharge measure, TEP members stated that it is important to transfer care preferences at discharge because patients’ voices are important in discharges and admissions. Another TEP member agreed that this was important information to transfer and

should be included as a category, but was concerned that there is no uniformity in documenting patient care preferences and felt that it should not be a requirement until data collection is standardized. An argument made for including patient care preferences as a category is the potential influence this could have, such as encouraging standardization and transfer of this information.

2.5.4 Patient Goals of Care

Admission QM

TEP members were also asked if they thought including goals of care as a category of information that was possibly transferred will increase transfer of this information at admission. One TEP member said it would need to be very quantifiable, such as asking about having a Do Not Hospitalize (DNH), Do No Intubate (DNI) or Do Not Resuscitate (DNR) orders, or advance care directives, and not be subjective. Some TEP members were more in favor of “hard” and quantifiable categories than “soft” categories that are open to interpretation.

Discharge QM

When asked the same question about discharges, one TEP member said that goals of care may be more frequently documented than care preferences. Another member stated that goals are less important to document. Specifically, some TEP members were concerned that the transfer of patient goals of care could deter the next setting from working with the patient/resident to establish new goals of care.

2.6 Assessment Item Wording on Whether Information Received on Admission

When pilot sites were asked if they had received the information that “was needed to plan and provide care” they reported coding based on whether any information was received, and not based on a determination of whether the information met care planning needs (Appendix D). When discussing the admission measure, TEP members were asked if the wording of this item should be removed from the gateway question to include only “information was received at admission.” Several agreed that the wording should be retained because without the current language it would be useless information. One TEP member agreed, but asked about how information needed to plan and provide care would be determined. To address this challenge, one TEP member suggested revising the word “needed” to “useful” or “helpful.”

2.7 Transfer of Information when Subsequent Provider is Unknown

For the pilot test, sites were instructed that when a patient is discharged to the community and not another PAC setting, the subsequent provider is the patient’s primary care provider (PCP) or other community provider. The sites that did not interpret that the subsequent provider is the PCP when a patient is discharged to the community were found to code that no information was transferred at discharge. During pilot testing, pilot sites reported this was sometimes because the patient’s healthcare provider was not known.

The TEP was not in full agreement about whether the PAC provider should fail to meet the numerator if a patient’s subsequent provider is not known. While some TEP members said it was important to identify who the patient’s community provider is and transfer information to

that provider at discharge, others said the PAC provider should not be penalized in instances in which the PCP/community provider is unknown, changes, or the PCP refuses to supervise that patient (e.g., in cases where a patient has not seen the PCP in years). It was suggested by one TEP member that while it is important to ensure there is a connection between PAC provider and PCP/community provider, it may not be realistic to expect the transfer of information to PCPs within the current system due to inconsistencies in patient interaction with their named PCP (e.g., the PCP may not have seen the patient for years). One TEP member shared his own experience providing care to a family member and said that he took it upon himself to ensure information was transferred to his family member's PCP during each discharge.

2.8 Usefulness of Route of Transmission Data

TEP members were asked their overall impressions about whether the route of transfer of information item (see Appendix D, TOH3 and TOH6) would be valuable to collect as part of the QM. Specifically, the TEP was asked if the route of transmission information would be helpful to policymakers and consumers in understanding and monitoring how information is being transferred at admission and discharge. Three TEP members felt that this information would be helpful and/or useful to both policymakers and consumers. Another TEP member noted that in the pilot test findings, some sites noted difficulty in gathering and correctly coding the different types of electronic transfer such as health information exchange or other third party. Some TEP members felt that the potential limitations in gathering and coding the different types of electronic transfer information could be overcome by further education and training of the coding staff. This same TEP member also explained that information comes in through multiple routes (e.g., electronic, fax, verbal) that are not standardized and often depends on who is sending the information. This increases the burden related to collecting this information. At the same time, on discharge, providers may be transferring information via more standardized routes such as a Consolidated-Clinical Document Architecture (C-CDA). Thus, providers will be coding the same response for each discharge. This TEP member questioned how submitting the same route of transmission information at each discharge supports the QM. Another TEP member agreed and suggested that it would be better to collect this information through periodic surveys.

SECTION 3 SUMMARY

In summary, the TEP was still generally favorable of the concept and development of the draft transfer of health information and care preferences measure(s) after learning more about the pilot test findings. TEP members supported the idea that these measures have the potential to improve communication and information transfer between providers, and could reflect the quality of information transfer processes. However, most TEP members felt that the measures, as currently developed, could only differentiate good from poor transfers of information, but not good from highest quality transfers of information. Almost all TEP members felt that the TOH measures at admission and discharge could be improved by increasing the number of information categories to be transferred to meet the numerator criteria from the current specification of one category, but some cautioned against requiring too many categories.

The TEP discussed the importance of the categories to transfer and other criteria for determining the categories to include in any potential measure(s). The TEP members agreed that the quality measures that are under development capture important types of information being transferred. Further, there was valuable discussion about, but no agreement on, whether some categories of information should be retained or were more important for the measure because they are less frequently transferred such as patient care preferences. There was also discussion of whether others should be removed or were lower priority for the measures because they are almost always transferred, such as medication information and medical conditions. TEP members also noted that the measure(s) do not capture the quality of the information being transferred.

There was mixed agreement as to the usefulness of collecting data on the route of transmission of information (e.g. electronically). A few TEP members felt these data would be useful information for consumers and policymakers, while others were uncertain, referencing the pilot test findings. Two TEP members felt that this type of information would be better captured using survey methods rather than on each assessment.

There was extensive discussion around the importance and ability to collect patient care preferences and patient care goals. TEP members agreed that the patient's voice was important as patients moved from setting to setting. However potential limitations pertaining to the standardizing, coding, and collecting care preferences and care goals were acknowledged. There was less support for transferring patient care goals than for the other categories of information, as patient goals of care are expected to change between settings and are important to discuss with the patient and family in each setting. There was discussion about an alternative approach to document and collect information on whether care preferences and goals were discussed with the patient.

3.1 Current State and Next Steps

Feedback from this TEP will be used to continue to develop and further refine the specifications for these measures. Based on input from the TEP meeting in August 2017 and other stakeholder input, significant refinements have been made to the measure under development and implementation of the measure has been delayed. The measure now being developed and refined will focus on the transfer of a medication profile at PAC discharge or

transfer. Development of this transfer of medication profile measure will include consensus vetting of the measure and pilot testing. A public comment period will be scheduled in early 2018.

APPENDIX A:
TRANSFER OF HEALTH INFORMATION AND CARE PREFERENCES TECHNICAL
EXPERT PANEL MEMBERS

Name, Credentials	Professional Role Organizational Affiliation City, State
Maria Brenny-Fitzpatrick DNP, RN, FNP-C, GNP-BC	Director of Transitional Care University of Wisconsin Hospitals and Clinics <i>Madison, Wisconsin</i>
Bruce Hanson, BA, MS (patient/caregiver perspective)	Rural Parish Pastor Evangelical Lutheran Church Patient Advocate National Patient Advocacy Foundation <i>Garnavillo, IA</i>
Robert Latz, PT, DPT, CHCIO	Chief Information Officer (CIO) Trinity Rehabilitation Services <i>St. Clairsville, OH</i>
Cheryl Meyer, MS, RN, PHCNS-BC	Director of Clinical Excellence Advocate at Home <i>Oak Brook, IL</i>
Cheryl Miller, DrOT	National Director of Therapy Operations HealthSouth <i>Sunrise, FL</i>
Grace Wummer, RN (caregiver perspective)	Clinical Director of Senior Services Main Line Health <i>Bryn Mawr, PA</i>
Susan Tracy Moore, MPH, RN, CCM	Senior Director of Case Management Spaulding Rehabilitation Network <i>Cambridge, MA</i>
Angela Orsky, DNP, LNHA, RN	Senior Administrator, Post-Acute Care Greenville Health System <i>Greenville, SC</i>
Marjory Palladino, RN, BS, MSN, CRRN, CSPHSP	Director of Nursing Southington Care Center, Hartford Healthcare Senior Services <i>Chicago, IL</i>
Jane Pederson, MD, MS	Chief Medical Quality Officer Stratis Health <i>Bloomington, MN</i>
Robert Rosati, PhD	Chair, Connected Health Institute VNA Health Group <i>Red Bank, NJ</i>
Wayne Saltsman, MD, PhD, CMD, FACP	Chief, Geriatrics/Transitional Care Lahey Health <i>Burlington, MA</i>
Mary Van de Kamp, MS, CCC-SLP	Senior Vice President of Quality Kindred Healthcare <i>Louisville, KY</i>
Victoria Zombek, RN, BSN, ACM	Director of Post Acute Liaisons University of Pittsburgh Medical Center <i>Pittsburgh, PA</i>

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APPENDIX B: SUMMARY OF TEP MEETING HELD JANUARY 27, 2017: TEP 2

B.1 Introduction

On behalf of the Centers for Medicare & Medicaid Services (CMS), RTI International and Abt Associates reconvened a Technical Expert Panel (TEP) to seek expert input on the development of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain Transfer of Health Information and Care Preferences When an Individual Transitions. These cross-setting measures were developed for Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH), and Home Health Agency (HHA) settings.

The TEP was reconvened to provide additional input on the draft measure specifications, including issues addressed in public comments. Of particular interest was TEP input on the measures' relationship to post-acute care (PAC) with respect to information transfer and the burden of data collection.

B.2 TEP Webinar

The two-hour TEP webinar was held on January 27, 2017. Thirteen of fourteen possible TEP members attended the meeting. Discussion was moderated and facilitated by Marian Essey, Abt Associates, with support from various members of the RTI and Abt measure development team. Representatives from CMS were also in attendance. The following key topics were discussed: (i) revisions made to the draft admission and discharge assessment item sets since the TEP was first convened; (ii) measure feasibility, reliability, and validity in preparation for upcoming rulemaking; (iii) facilities' data collection processes, sources, and documentation for completion of the assessment items. The meeting was audio recorded and transcribed by a professional transcriptionist for the purpose of summarizing the TEP proceedings.

B.3 Summary of Discussion

B.3.1 TEP Discussion

Prior to the webinar, TEP members received a series of questions in order to prepare for the discussion. TEP members were asked to provide input on the draft assessment items and measure calculations for the TOH Admission and Discharge Measures. After the TEP was updated on refinements made to the measures since the September 2016 TEP webinar, discussion focused on the topics and themes described below.

1. Measure Relationship to Quality

1.1 Admission Measure

The first topic of discussion focused on whether the admission measure accurately reflected provider quality of care. More specifically, TEP members were asked whether a measure reflecting the percent of patients for whom information was received for any of the 11 categories of health information and care preferences would be able to distinguish between high

and low-quality providers. Four of the TEP members voted yes, six voted no and three were undecided.

Of those who voted no, multiple TEP members expressed that this measure was not an indicator of PAC provider quality. One TEP member stated that, for the admission measure, PAC providers can do a better-quality job if they have the information, but it doesn't necessarily reflect their quality. Another commenter agreed, saying that with the admission information, we are assessing the quality of the transfer itself, which will improve the care provided to patients, but doesn't indicate the quality of the provider. While it may allow for the opportunity for better quality, we don't know for sure that is happening just because the receiving provider has the information. Another TEP member stated that it's not about having the information, it is how PACs use that information. It's also about whether it is the right information for that person.

Three of the TEP members agreed that this measure is solely a reflection of the sending provider's quality and does not reflect the quality of the receiving provider. One TEP member believed that it is imperative that the information received at admission is correct and accurately reflects the patient's needs and preferences, stating this measure doesn't do that. She further stated that this measure may create unintended consequences for providers because it could shift the focus to sending information that meets one of the assessment item categories, rather than ensuring that the information that is sent is accurate and relevant.

Multiple TEP members felt that the relationship of the measure to quality of care depended on whether more than one item would be required to be transferred to meet the numerator criteria. Many felt that requiring only one of the 11 items to be transferred was a low bar and didn't convey the overall intent of the measure. See section 2.4 for subsequent discussion of the numerator inclusion criteria for measure calculation.

1.2 Discharge Measure

TEP members were also asked whether the discharge measure distinguished between high-quality providers and low-quality providers. Only four of the thirteen TEP members agreed that it would. The first TEP member to speak on his yes vote explained that the discharge measure says more about the data that has been collected and shared by the provider than the admission measure. Many members agreed, stating that the discharge measure was the only meaningful measure and predictor of provider quality, as it holds PAC providers accountable to ensure a timely and accurate transfer of information.

Multiple TEP members agreed and restated their argument that only requiring one of the 11 items was unacceptable, with one of the TEP members affirming that we need to remain consistent with the admission measure and look for effective ways to standardize the process and prioritize the eleven items. One TEP member's main concern was that much like the admission measure, this measure becomes merely a checkbox of information. She noted that these items may not be reflective of or relevant to the patient's care needs at the time of transition to the next level of care. See section 2.4 for subsequent discussion of the numerator inclusion criteria for measure calculation.

2. Data Collection Processes and Burden

2.1 Data Collection for Admission Items

TEP members were next asked to weigh in on how PAC providers obtain the necessary admission information, what processes are in place as well as new systems or processes that might be needed. TEP members sought clarification as to what was included in data collection. A few asked if it is the time it takes for the person to be admitted and preparing the information. Some also asked if it is the time to go through each element and record specifically what the goals of care are, for example, or if it is the time for the organization to calculate how many times they get this information for each of their residents. The moderator explained that the measure calculation would be done as it is now for other measures – on the back end. Calculation would occur through the data collection and reporting already in place for PAC providers. Therefore, burden should be based on only the time to complete the assessment items.

TEP members noted that most of the information being collected in the item sets is already being collected. The location of the information would vary and could be quite a large range especially for PACs with EHRs. For example, “care preferences and goals” may be in progress notes and “diet and nutrition” may be in orders. Main concerns centered on the added burden and financial cost this measure may have on providers. TEP members questioned how this information would then be transferred and tracked, and one asked how this measure would impact small and rural facilities that are not as advanced as larger urban health care systems.

At least one TEP member felt that there is an artificial separation between reviewing information and completing these items. If there is a standard format and it is done electronically the amount of time is probably zero. But that’s not reality - if it comes in various forms (fax, electronic) somebody must sift through that information to complete the items. Therefore, the review process is tied to the item completion.

One TEP member mentioned how changing the language from “did you receive” to “did you have” the information changes the way in which we identify if PAC providers have the information, stating that it is not reflective of whether the data was shared during the transfer—which he identified as the most critical piece. Another TEP member stated that we need to hone in on what is necessary information and fine-tune the documentation to ensure it fits the needs of both parties so that they can adequately, safely and cost-effectively care for their patients.

In terms of actual time commitment, one member estimated that it could take 20-30 minutes per patient to complete the assessments and another estimated 30 minutes. TEP members expressed more apprehension about how providers would manage the increased information received, as well as the current lack of organization. One TEP member felt that it would be a lot of work to dig though the large volume of information received to put a check mark on the list and then compile it for the facility just to create the calculation. It was also mentioned that if information is received that is not useful to the care of the patient, then that would only create additional burden. Lastly, most of the members agreed that this measure would require new processes related to discharge planning, clinical communications, data collection in general and with their vendors.

One TEP member said, “We get tons of information and I don’t think it will improve quality. It is a huge burden to collect the data. How do you track that each element is present and accounted for? Most of it will be manual and the man hours and financial impact to come up with those systems will be extremely expensive.” Another noted that many PAC EHRs are set up differently than those used in acute care and that vendors will have difficulty customizing systems, since the information transferred is more likely to be paper records and a lot of documents are scanned.

2.2 Data Collection for Discharge Items

When asked the same questions about the discharge measure, a TEP member began the discussion by noting that there were a lot of differences in the systems and processes involved in the discharge measure in comparison to the admission measure. He mentioned that as a sending provider, PACs have the control and responsibility to send that discharge packet knowing that the correct items were sent.

There were again multiple comments concerning how smaller and rural facilities that currently do not have EHRs would process, compile and track information. Another TEP member said that, “having the data is extremely critical and valuable, but the way in which we have to communicate the data to each other and within an organization or then to CMS becomes very problematic with the lack of standardization of EMR communication.” Further, “In terms of the discharge process, it really comes down to the EMR or lack thereof, as well as how information is being communicated across settings.”

2.3 Data Collection Partnerships with PAC Providers

A TEP member said that some SNF and hospital providers have developed partnerships to determine what information is needed and formatted the discharge packet to meet those needs. Those types of conversations need to happen to fine tune the transfer documentation and appropriately care for the resident.

2.4 Categories of Information, Measure Calculation and Meeting Numerator Inclusion Criteria.

The final portion of the meeting centered on TEP member input and recommendations about possible revisions to the measure calculation, categories for information transfer, and criteria for inclusion in the numerator. Discussion began with one TEP member asserting that each TEP member would have a different perspective and interpretation of how to prioritize each category of information, arguing that the weight of these items would differ depending on a multitude of factors, including the role of the clinician, the setting and the patient’s specific care needs.

Multiple TEP members stated the opinion that that the categories “goals of care” and “discharge instructions” were too ambiguous to be included in the numerator. Two members stated that importance of the discharge instructions was dependent on the quality of information provided in them. They also argued that ‘discharge instructions’ may be unclear, and could cover all of the categories of information. Information from all categories should be sent as part of the instructions, along with any specific care instructions (e.g., wound care). While multiple TEP

members agreed that “discharge instructions” shouldn’t be included in the numerator, they still felt they were imperative for safely caring for a patient when they transfer to a new setting. In terms of “goals of care,” the TEP members’ rationale for removing this category rested on the fact that this category is vague and would vary across settings (e.g., goals of care in hospital are different than goals of care for patients going home). Items that some TEP members considered as more critical included “medication list,” “cognitive function and mental status,” “patient preferences” and “treatments.” In addition, two TEP members stressed the importance of “diet/nutrition,” as this can be a crucial element of care depending on the condition for which the patient is being treated.

As noted earlier, many TEP members felt that the relationship of the measure to quality of care depended on how many items would be required to be transferred to meet the numerator criteria. When asked if providers should be required to transfer more than one type of information to be included in the numerator, two TEP members felt that at least four or five of the items needed to be transferred, along with a checklist of which items were most pertinent to the condition. Another TEP member suggested that at a minimum, half of the items should be included in the transfer and that a system of prioritizing the items be developed. Another TEP member restated that this was not about quantity, but about quality, appropriateness and accurateness of the information. One TEP member, argued that this was a process measure to begin with, reasoning that the more data elements required, the more time it will take to complete the assessment. He mentioned while one is low on the bar, it provides a starting place for providers to begin putting the process in place. Another TEP member argued against that, saying that requiring one item just to put something in place, with no definite quality outcome, is useless and just creates burden. Lastly, some TEP members believed, again, that in terms of receiving a higher number of types of information, the measure will be penalizing the provider if another provider did not send it to them.

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APPENDIX C:
AGENDA FOR TEP MEETING #3

Technical Expert Panel (TEP) Meeting
Development of quality measures to satisfy the IMPACT Act
domain of: Transfer of Health Information and Care Preferences
When an Individual Transitions: Meeting #3

1:00pm-4:30pm EST, Thursday, August 3rd 2017
Dial-in Number: 1-888-706-0584 /Access Code 3790594#
(see attachment for instructions to join the webinar)

—TEP Schedule—

Time	Agenda Items	Lead
1:00–1:10 pm	Meeting Overview RTI/Abt/CMS <ul style="list-style-type: none">• Agenda• Purpose• Ground Rules	
1:10-1:15 pm	Brief Introductions	RTI
1:15-1:25 pm	CMS Opening Remarks	CMS
1:25-1:45 pm	Post TEP (1/27/17) Update <ul style="list-style-type: none">• Summary of TEP Input from Meeting #2• Measures Application Partnership (MAP) (Refine and resubmit decision)• Pilot Test Data Collection<ul style="list-style-type: none">– Recruitment and selection– Training– 6 weeks' data collection– Debriefing Interviews	RTI
1:45-2:45 pm	Pilot Test Findings – quantitative and qualitative	RTI
2:45- 2:55 pm	Break (10 min)	
3:00–4:00 pm	TEP Discussion	RTI/Abt
4:00-4:15 pm	Summary of TEP Recommendations and Next Steps	RTI
4:15- 4:30 pm	Concluding Remarks	RTI/Abt/CMS

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APPENDIX D:
TOH ADMISSION AND DISCHARGE ASSESSMENT ITEMS PILOT TESTED (2017)

Admission Items – Previous Provider to PAC Transfer of Information	
Date of Patient/Resident Admission	
Admission Date _____ / _____ / _____ MM / DD / YYYY	
Receipt of Health Information on Admission/Start of Care/Resumption of Care TOH-1. On admission, did your facility/agency receive, from the previous provider, the patient's health information and/or care preferences that were needed to plan and provide care? <ol style="list-style-type: none"> 1. Yes 2. No → <i>Skip to Signature.</i> 3. NA – Patient was not under the care of another provider immediately prior to this admission/start of care/resumption of care → <i>Skip to Signature.</i> 	
Types of Health Information Received on Admission/Start of Care/Resumption of Care TOH-2. Indicate the types of health information your facility/agency received from the previous provider. Check all that apply <ul style="list-style-type: none"> A. Functional status B. Cognitive function and mental status C. Special services, treatments, and/or interventions (e.g., ventilator support, dialysis, IV fluids, blood product use) D. Medical conditions and co-morbidities (e.g., pressure ulcers/injuries and skin status, pain) E. Impairments (e.g., incontinence, sensory) F. Medication information G. Patient/resident care preferences H. Goals of care I. Diet/nutrition (e.g., parenteral nutrition, therapeutic diets) J. Discharge instructions Z. None of these types of health information were received 	
Route of Health Information Transmission on Admission/Start of Care/Resumption of Care TOH-3. Indicate the route(s) of transmission of health information received from the previous provider. Check all that apply <ul style="list-style-type: none"> A. Electronic using health information exchange organization or other third party B. Electronic means using an electronic health/medical record C. Other electronic means (e.g., secure messaging, email, e-fax, portal, video conferencing) D. Verbal (e.g., in-person, telephone) E. Paper-based (e.g., fax, copies/printouts) 	

Discharge Items - PAC to Subsequent Provider Transfer of Information

Date of Patient/Resident Discharge

Discharge Date ____ / ____ / ____ MM / DD / YYYY

Provision of Health Information at Discharge or Transfer

TOH-4. At discharge or transfer, did your facility/agency provide the patient's health information and/or care preferences to the subsequent provider?

1. Yes
2. No → Skip to TOH-7 Provision of Health Information to Patient/Family/Caregiver at Discharge or Transfer
3. NA (Home Health only) – The agency was not made aware of this transfer timely and therefore was unable to transfer health information to the subsequent provider.
4. NA – Patient was not discharged to the care of another provider at discharge or transfer → Skip to TOH-7 Provision of Health Information to Patient/Family/Caregiver at Discharge or Transfer

TOH-5. Types of Health Information Provided at Discharge or Transfer

Indicate the types of health information provided by your facility/agency to the subsequent provider.

Check all that apply

- A. Functional status
- B. Cognitive function and mental status
- C. Special services, treatments, and/or interventions (e.g., ventilator support, dialysis, IV fluids, blood product use)
- D. Medical conditions and co-morbidities (e.g., pressure ulcers/injuries and skin status, pain)
- E. Impairments (e.g., incontinence, sensory)
- F. Medication information
- G. Patient/resident care preferences
- H. Goals of care
- I. Diet/nutrition (e.g., parenteral nutrition, therapeutic diets)
- J. Discharge instructions
- Z. None of these types of health information were provided

Route of Health Information Transmission at Discharge or Transfer

TOH-6. Indicate the routes(s) of transmission of health information from your facility/agency to the subsequent provider.

Check all that apply

- A. Electronic using health information exchange organization or other third party
- B. Electronic means using an electronic health/medical record
- C. Other electronic means (e.g., secure messaging, email, e-fax, portal, video conferencing)
- D. Verbal (e.g., in-person, telephone)
- E. Paper-based (e.g., fax, copies/printouts)

Discharge Items - PAC to Patient/Family/Caregiver Transfer of Information

Provision of Health Information to Patient/Family/Caregiver at Discharge or Transfer

TOH-7. Did your facility/agency provide relevant health information to the patient/family/caregiver when the patient was discharged or transferred?

1. Yes
2. No → *Skip to Z.*
3. NA (Home Health only) – The agency was not made aware of this transfer timely and therefore was unable to transfer health information to the patient/family/caregiver. → *Skip to Signature*

Types of Health Information Provided to the Patient/Family/Caregiver at Discharge or Transfer

TOH-8. Indicate the types of health information provided to the patient/family/caregiver at the time of discharge or transfer.

Check all that apply

- A. Functional status
- B. Cognitive function and mental status
- C. Special services, treatments, and/or interventions (e.g., ventilator support, dialysis, IV fluids, blood product use)
- D. Medical conditions and co-morbidities (e.g., pressure ulcers/injuries and skin status, pain)
- E. Impairments (e.g., incontinence, sensory)
- F. Medication information
- G. Patient/resident care preferences
- H. Goals of care
- I. Diet/nutrition (e.g., parenteral nutrition, therapeutic diets)
- J. Discharge instructions
- Z. None of these types of health information were provided

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