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*National Provider Call*

# **IMPACT Act: Connecting Post-Acute Care Across the Care Continuum**

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# Agenda

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- IMPACT Act: Requirements to Standardize and Make Interoperable Post Acute Care Assessment Data Elements
- Using and Exchanging Clinically Relevant Assessment Data for Multiple Purposes
- Health Information Technology Standards- A Primer
- CMS Data Element Library

# **IMPACT Act Requirements to Standardize and Make Interoperable CMS Post-Acute Care Data Elements**

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# IMPACT Act of 2014

- Bi-partisan bill introduced in March, U.S. House & Senate, passed on September 18, 2014, and signed into law by President Obama October 6, 2014
- **The Act requires the submission of standardized assessment data by:**
  - Long-Term Care Hospitals (LTCHs): LCDS
  - Skilled Nursing Facilities (SNFs): MDS
  - Home Health Agencies (HHAs): OASIS
  - Inpatient Rehabilitation Facilities (IRFs): IRF-PAI
- **The Act requires that CMS make interoperable standardized patient assessment and quality measures data, and data on resource use and other measures** to allow for the exchange of data among PAC and other providers to facilitate coordinated care and improved outcomes

[Improving Medicare Post-Acute Care Transformation \(IMPACT\) Act of 2014](#)

# Why IMPACT? Why Now?

- The lack of comparable information across PAC settings undermines the ability to evaluate and differentiate between appropriate care settings for and by individuals and their caregivers
- Standardized PAC assessment data will allow for continued beneficiary access to the most appropriate setting of care
- Standardized PAC assessment data allows CMS to compare quality across PAC settings (longitudinal data)
- Standardized and interoperable PAC assessment data allows improvements in hospital and PAC discharge planning and the transfer of health information across the care continuum
- Standardized PAC assessment data will allow for PAC payment reform (site neutral or bundled payments)
- Standardized and interoperable PAC assessment data supports service delivery reform

# CMS Quality Strategy



## Foundational Principles

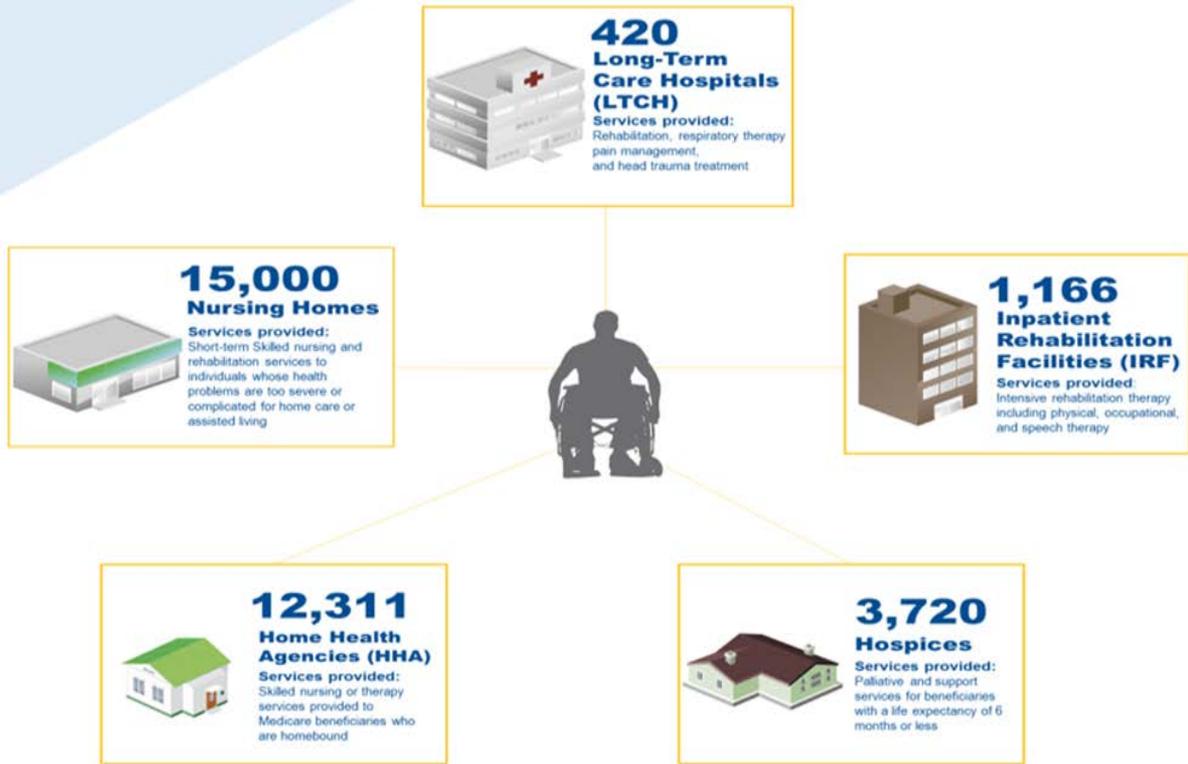
- Enable Innovation
- Foster learning organizations
- Eliminate disparities
- Strengthen infrastructure and data systems

## Goals

- Make care safer
- Strengthen person and family centered care
- Promote effective communications and care coordination
- Promote effective prevention and treatment
- Promote best practices for healthy living
- Make care affordable

# Achieving Better Care, Healthier People, & Smarter Spending

## Why Post-Acute Care Matters



# Standardized PAC Patient Assessment Data for Quality Measures

IMPACT Act requires PAC providers to report standardized assessment data for the following Quality Measure Domains by the following dates:

	LTCH	I	SNF	HH
<b>Quality Measure Domains</b>				
Functional status/ cognitive function	10/1/18	10/1/16	10/1/16	1/1/19
Skin integrity	10/1/16	10/1/16	10/1/16	1/1/17
Medication reconciliation	10/1/18	10/1/18	10/1/18	1/1/17
Incidence of major falls	10/1/16	10/1/16	10/1/16	1/1/19
Communicating the existence of and providing for the transfer of health information and care preferences	10/1/18	10/1/18	10/1/18	1/1/19

The measure domains provided in the Act are not exhaustive.

# Quality Measure: Transfer of Health Information and Care Preferences

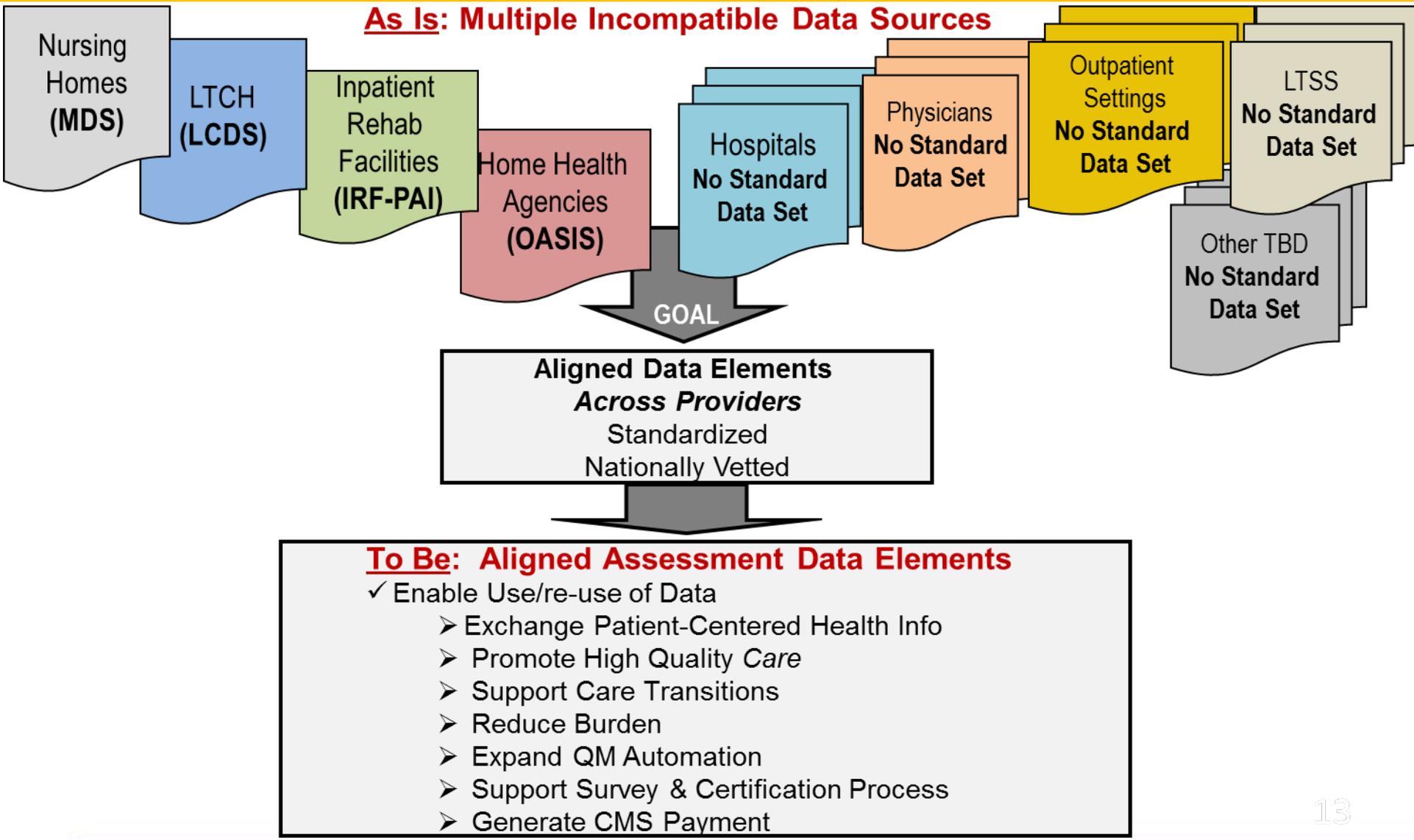
- The IMPACT Act requires a quality measure on:
  - The transfer of individual health information and care preferences of an individual to the individual, family care caregivers, and service providers when the individual transitions from:
    - Hospital or critical access hospital (CAH) to another setting including Post Acute Care (PAC) provider or home
    - PAC provider to another setting, including a different PAC provider, a hospital or CAH, or home

# Standardized Patient Assessment Data

- IMPACT Act requires PAC providers to report standardized assessment data in the following **Assessment Data Categories**:
  - Functional status
  - Cognitive function and mental status
  - Special services, treatments, and interventions
  - Medical conditions and co-morbidities
  - Impairments
  - Other categories

Standardized Assessment Data Reporting Dates	
LTCHs, IRFs, SNFs	HHAs
10/1/18	1/1/19

# Standardization: 'As Is' Transitions 'To Be'



# Data Element Standardization

- **Achieving standardization (i.e., alignment/harmonization) of clinically relevant data elements improves care and communication for individuals across the continuum:**
  - Enables shared understanding and use of clinical information
  - Enables the re-use of data elements (e.g., for transitions of care, care planning, referrals, decision support, quality measurement, payment reform, etc.)
  - Supports the exchange of patient assessment data across providers
  - Influences and supports CMS and industry efforts to advance interoperable health information exchange and care coordination
- **While data element standardization is required for certain assessment domains/categories in the IMPACT Act, unique data elements specific to PAC settings will also persist**

# IMPACT Act and Interoperability

- The IMPACT Act requires that CMS make post-acute care assessment data elements interoperable to:

**“allow for the exchange of data among PAC providers and other providers and the use by such providers of such data that has been exchanged, including by using common standards and definitions, in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes.”**

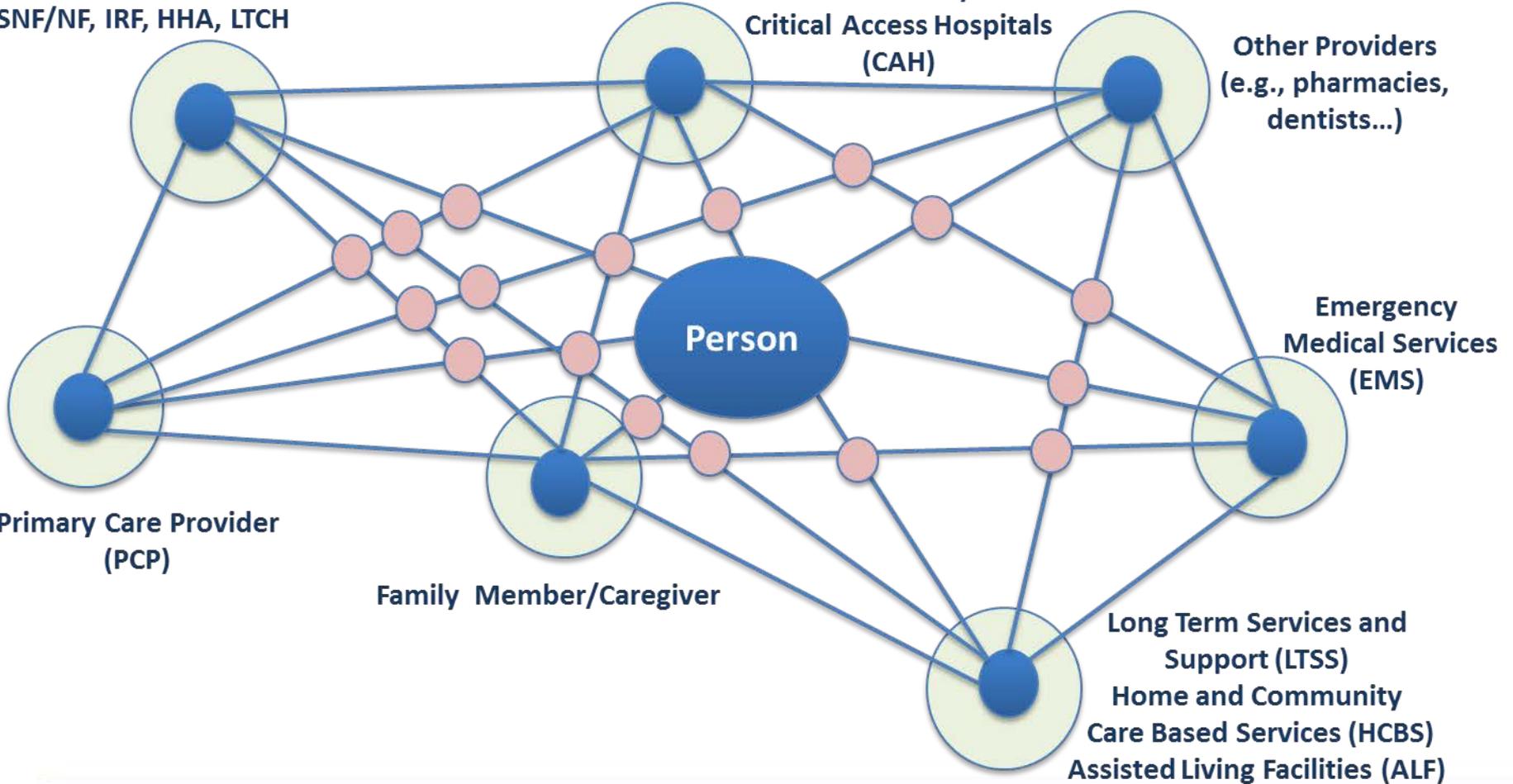
# Interoperability

## Data Follows the Person

Long Term and Post Acute Care (LTPAC):  
SNF/NF, IRF, HHA, LTCH

Acute Care/  
Critical Access Hospitals  
(CAH)

Other Providers  
(e.g., pharmacies,  
dentists...)



Primary Care Provider  
(PCP)

Family Member/Caregiver

Long Term Services and  
Support (LTSS)  
Home and Community  
Care Based Services (HCBS)  
Assisted Living Facilities (ALF)

Emergency  
Medical Services  
(EMS)

# Opportunities to Re-Use Standardized and Interoperable Assessment Data Elements

- **Leveraging and mapping PAC assessment data elements to nationally accepted Health IT standards supports:**
  - Information exchange and re-use with and by:
    - Acute care hospitals and primary care providers
    - Long-term and post-acute care providers
    - Home and community based providers (HCBS)
    - Other providers
    - Health Information Exchange Organizations
  - Use and re-use of assessment data in a variety of document types including:
    - Transfer documents
    - Referral documents
    - Care plans
    - LTPAC Assessment Summary Documents
- **CMS will make available public reports of PAC Assessment Data Elements mapped to health IT standards**

# Summary

- **The IMPACT Act requires that:**
  - PAC providers report to CMS (by certain dates) standardized assessment data elements in certain quality measure domains and assessment categories; and
  - CMS make assessment data elements interoperable.
- **CMS will:**
  - Standardize (aka align/harmonize) data elements,
  - Make data elements interoperable by linking to health IT standards, and
  - Make available to the public reports mapping assessment data elements to health IT standards (more on this to follow).
- **Use of standardized and interoperable PAC assessment data elements are key enablers to achieving service delivery and payment reform envisioned in the CMS Quality Strategy.**

# The Exchange and Re-use of Clinically Relevant Data Elements

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Terrence A. O'Malley, MD, Physician, Massachusetts General  
Hospital

# What Will IMPACT Give Us?

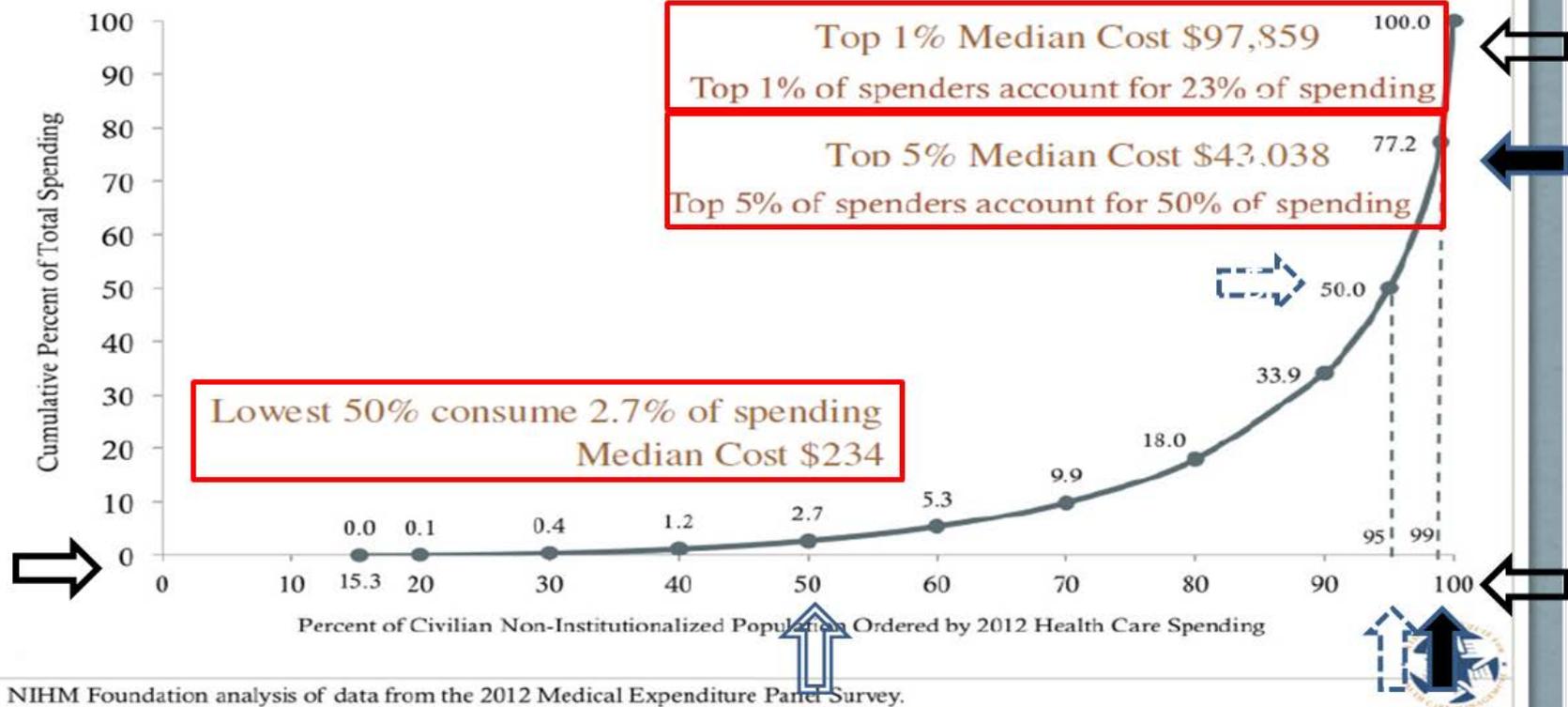
- Standardized and interoperable data elements
- Exchangeable information across the care continuum including hospitals, post acute care facilities, home health agencies, and other providers (e.g., home and community based service providers and pharmacists)
- So what? Why do we need Standardized and Interoperable data elements?
  - Currently, these providers and other actors don't really need to work well together
  - They are only working well enough to be successful with FFS

# Value Based Payments Replaces Fee For Service

- Value Based Payments (VBP) pays for outcomes and not for the volume of services
- Total cost of care for a population
- Must focus on the most complex individuals who:
  - Drive most of the costs; and
  - Get care in multiple sites from multiple providers

# Focus on the Top 1-5%

## Health Spending Is Very Highly Concentrated Among the Highest Spenders

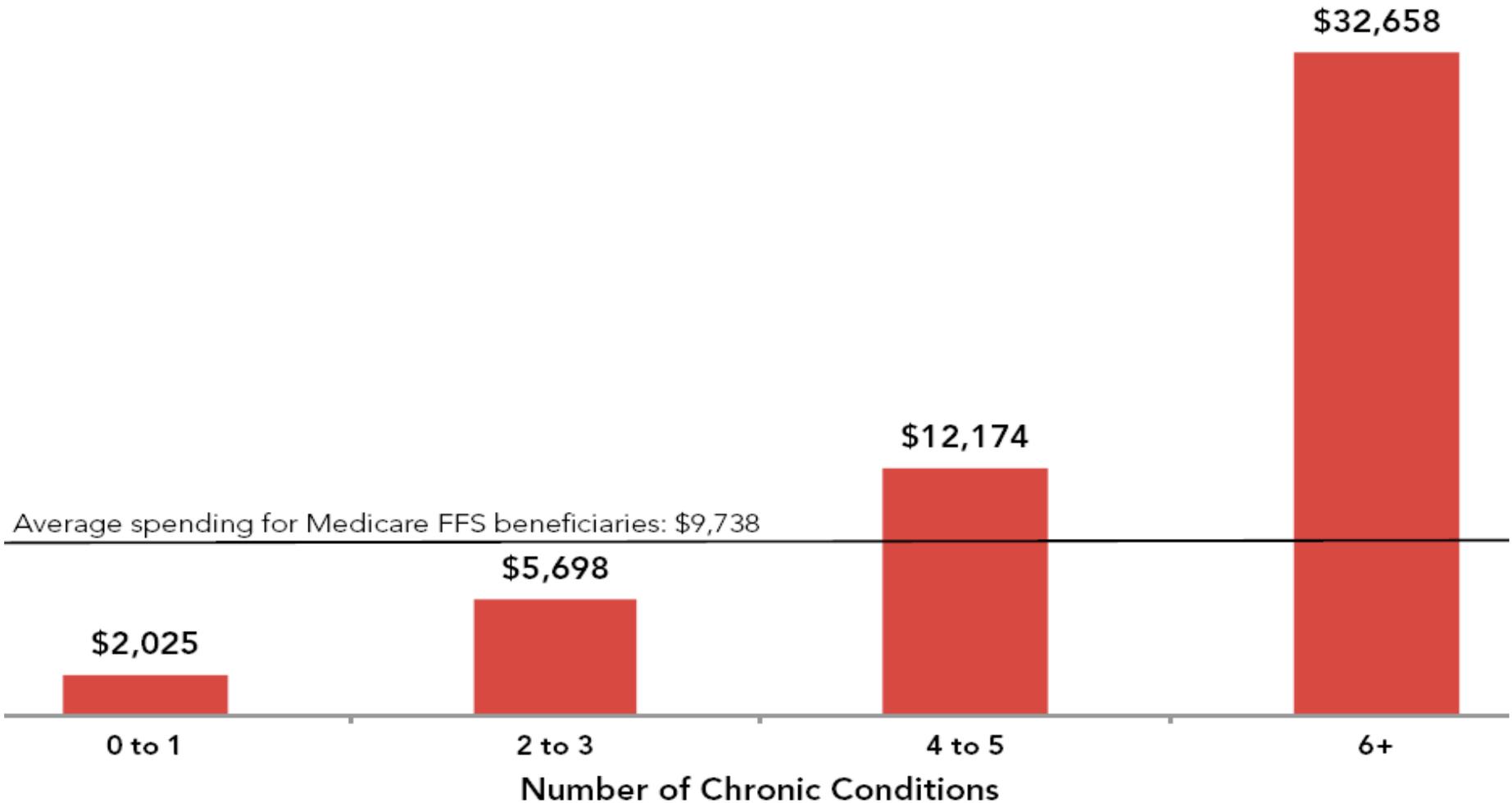


<http://www.nihcm.org/concentration-of-health-care-spending-chart-story>

# Similarities at the Top of the Cost Curve

- Complex medical, behavioral (chronic Severe Mental Illness), functional and environmental issues including social determinants
- Care from multiple providers
- Care paid by multiple payers
- Care in multiple sites
- High utilization of emergency responders, emergency departments, hospitals, nursing facilities, home nursing and home based services
- Experience multiple transitions and need an overall care plan
- Current service delivery and payment systems are in disarray
- Standardized and interoperable information is necessary (but not sufficient) to organize care

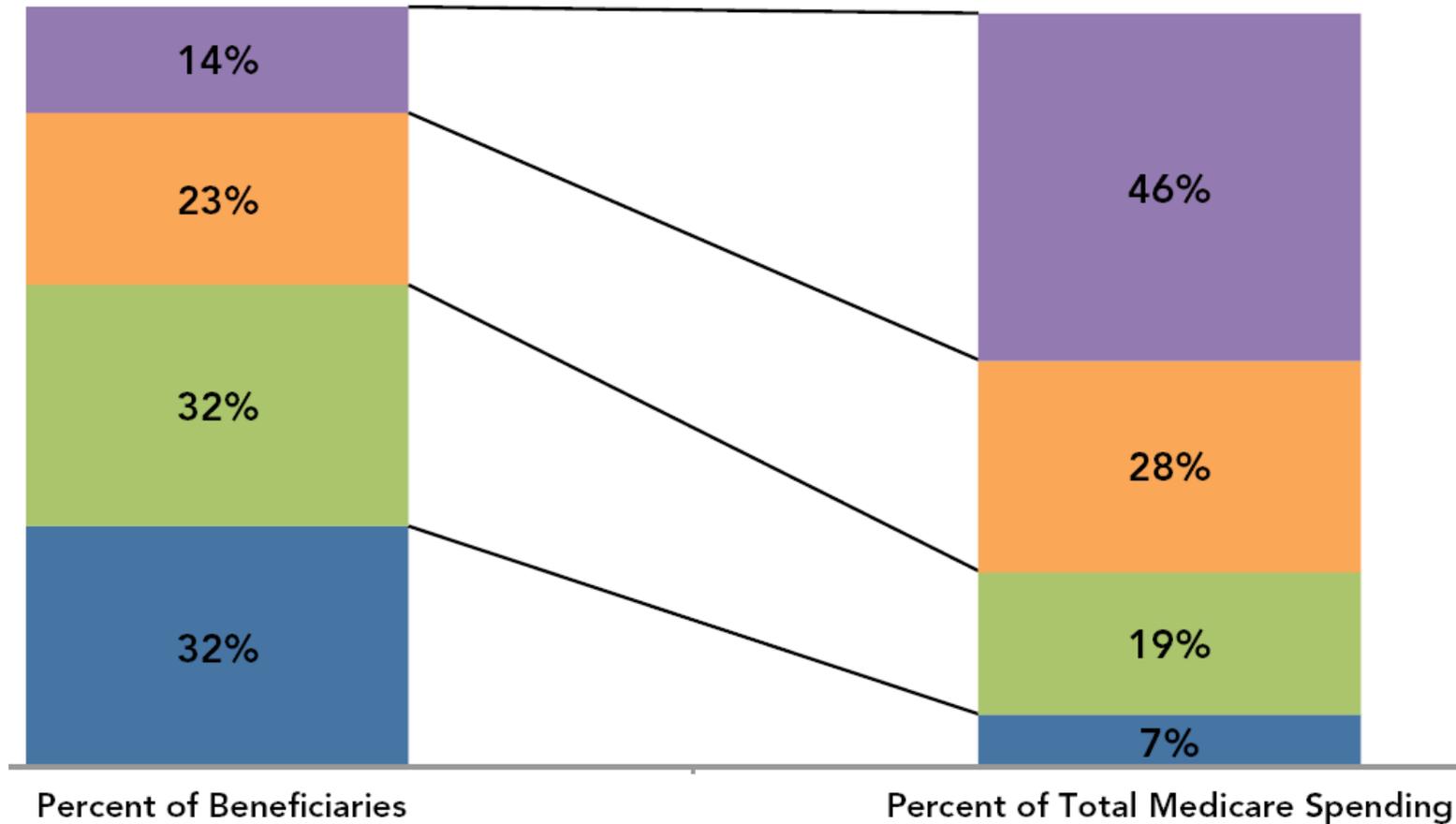
# Per Beneficiary Medicare Spending



Source: 2012 Medicare Chart Book: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/2012ChartBook.html>

# Proportion of Medicare Spending

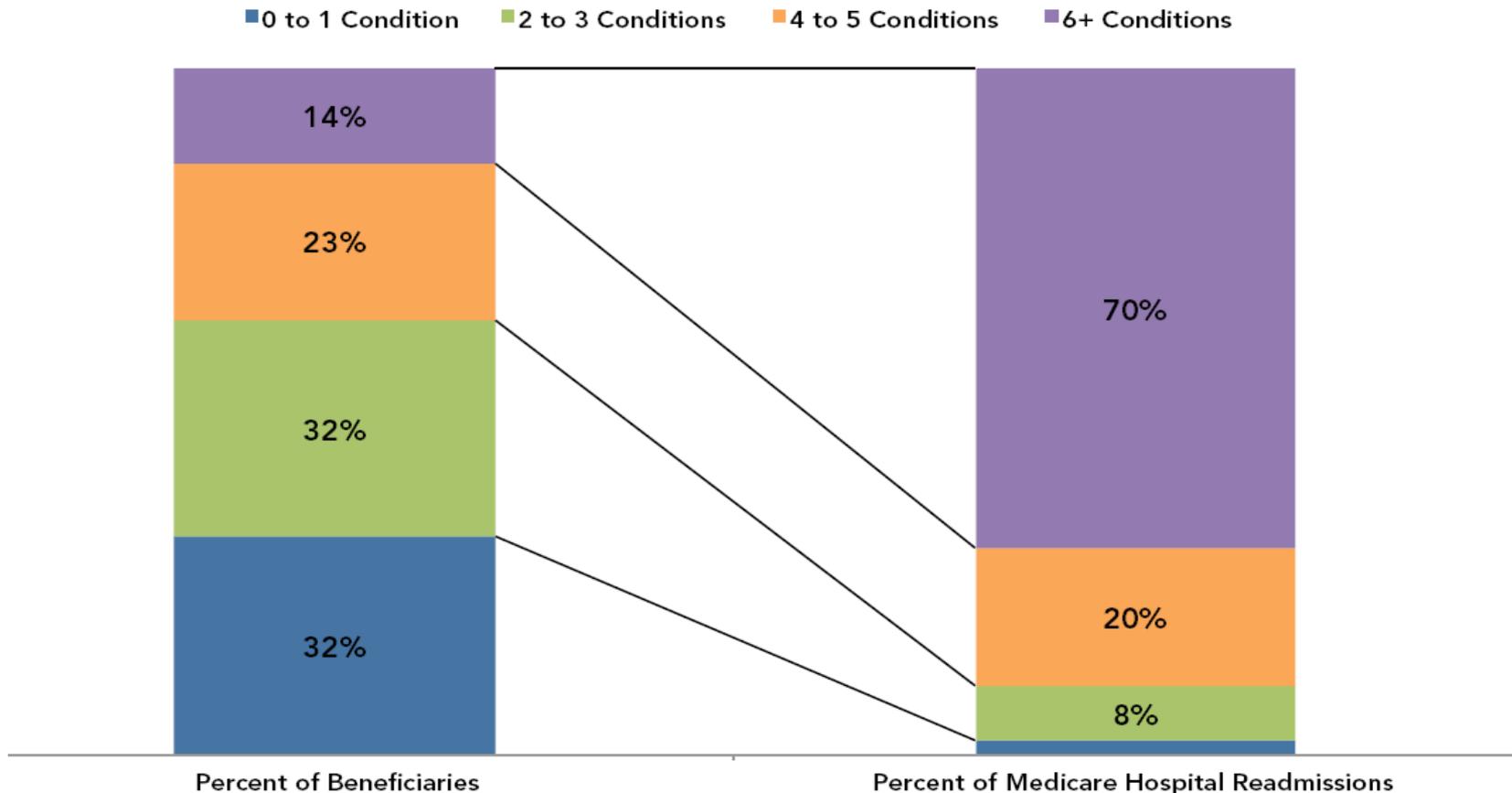
■ 0 to 1 Condition   ■ 2 to 3 Conditions   ■ 4 to 5 Conditions   ■ 6+ Conditions



Source: 2012 Medicare Chart Book: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/2012ChartBook.html>

# Medicare Readmissions by Number of Chronic Conditions

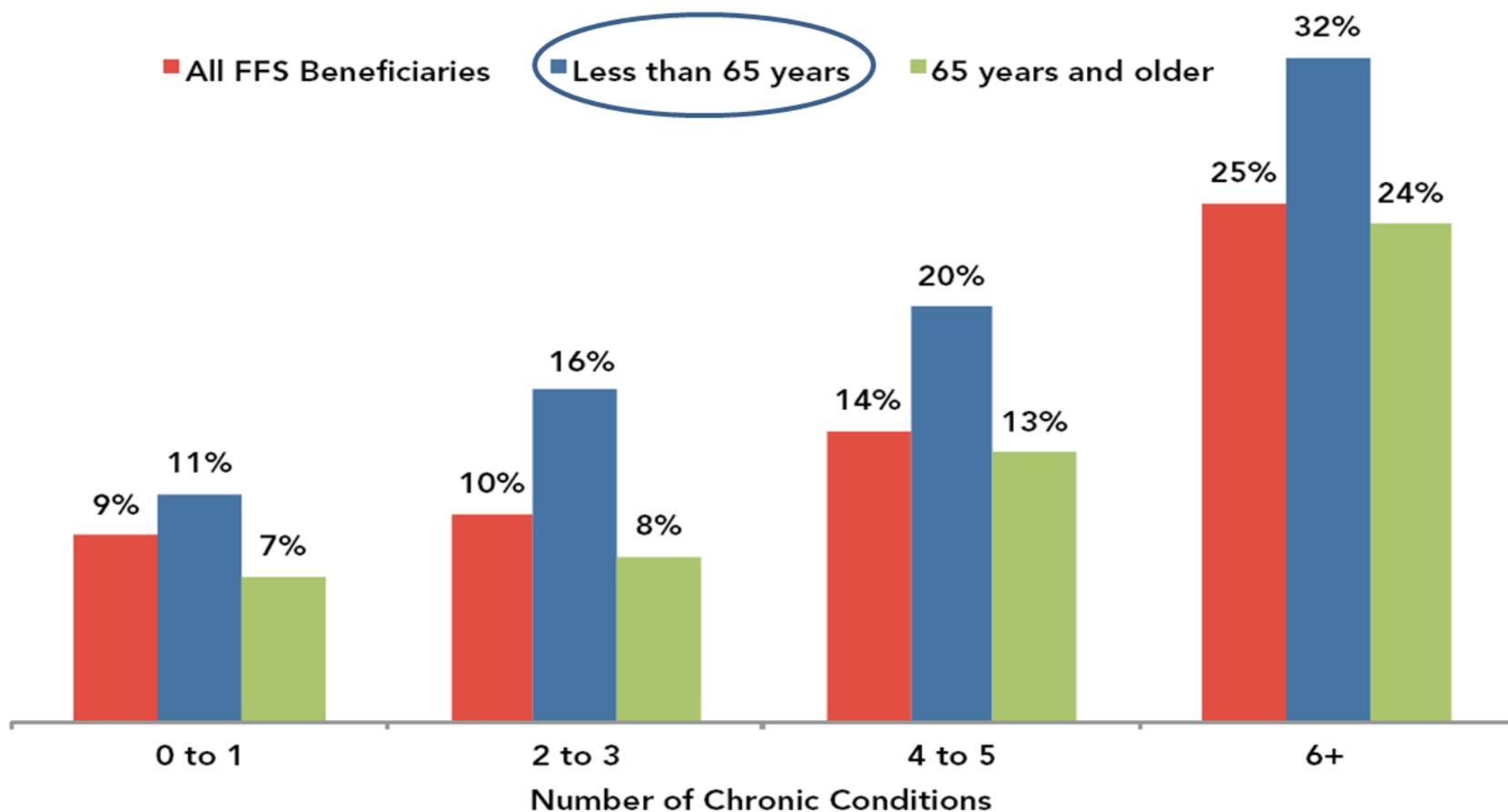
**Figure 2.7** *Distribution of Medicare FFS Beneficiaries by Number of Chronic Conditions and Total Medicare Hospital Readmissions: 2010*



Source: 2012 Medicare Chart Book: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/2012ChartBook.html>

# Readmissions: Greatest Among Younger Persons with Disabilities

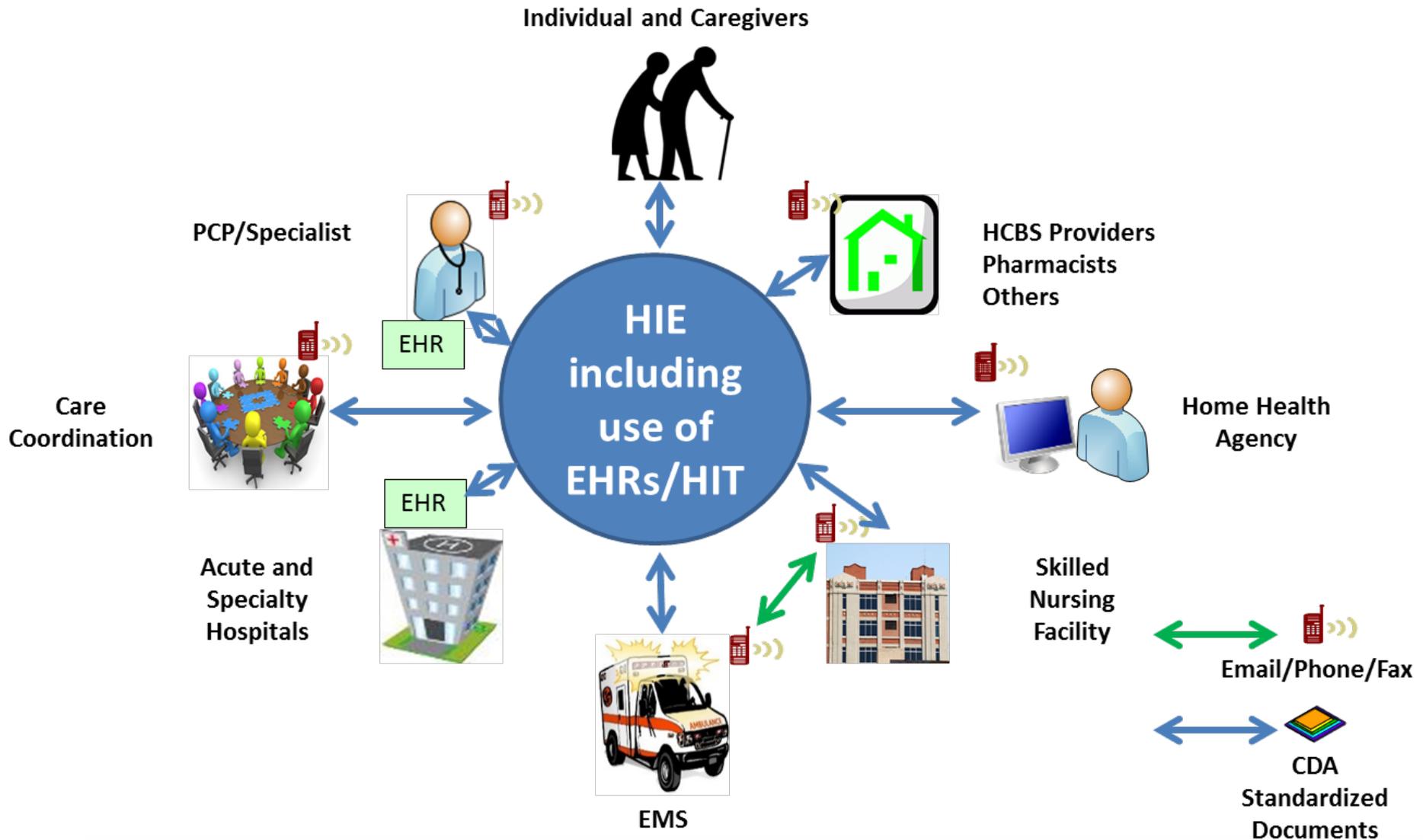
**Figure 2.6a** *Percentage of Hospital Admissions with a Readmission within 30 days by Number of Chronic Conditions and Age: 2010*



# Social Determinants

- **Social determinants drive a greater proportion of health care spending than do clinical conditions**
- **Social determinants include:**
  - Race, class, gender, education, employment, housing, community/family supports, contact with criminal justice system, chronic severe mental illness, substance abuse

# The Future Accountable Care Community



# Changing to VBP Means Changing Communications

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- Requires effective communication between sites
- To create safer transitions of care for those with the most complex issues
- To improved coordination of care across all sites with a shared care plan
- These new connections will rely on the electronic exchange of standardized and interoperable information

# Opportunities for Data Re-use in Accountable Care Communities

- **Quality Measures: How well do we exchange health information?**
  - Is the Content complete (cognition, function, etc. from standardized assessment instruments)
  - Is the Format useable?
  - Does the information arrive when needed?
- **Public health: reportable events**
- **Creation of care plan**
  - Generate all site/all team lists: problems, interventions, team members, priorities of the individual, outcomes
- **Measure ACC performance**
  - Gaps between problems and interventions
  - Effectiveness of interventions
  - Outcomes that matter

# Why This Matters

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- New Payment Demands New Systems of Care
- Many Sites Many Teams
- Standardized Exchange of Data Elements for Patient Care
  - Within, between and across sites and team (e.g., to support care coordination)
- Re-use for Quality Measurement
  - Within sites, transitions between sites, coordination across entire episodes of care
- Re-use for Public Health Reporting
- Re-use to Generate System “Intelligence” so the System can Learn

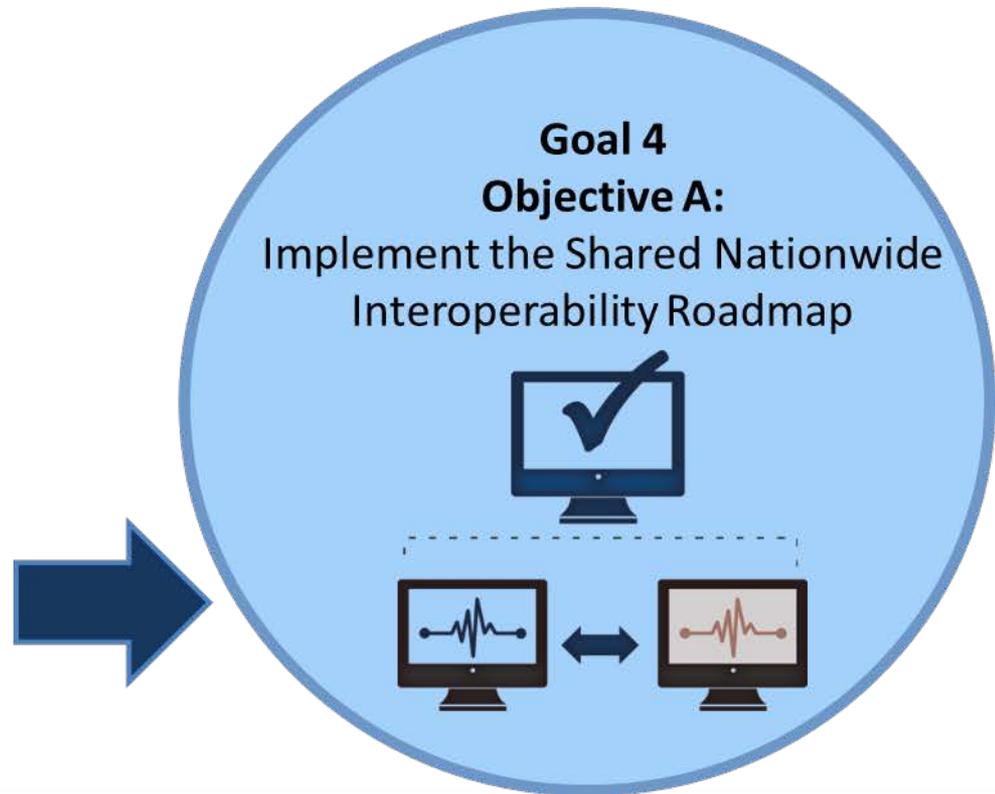
# Health IT Standards- A Primer

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Liz Palena Hall, LTPAC Coordinator  
Office of the National Coordinator for Health IT

# Interoperability Vision for the Future

## Federal Health IT Strategic Plan Goals



# What is Interoperability? What are the Benefits?

**Interoperability:** The ability of a system to exchange electronic health information with and use electronic health information from other systems without special effort on the part of the user.

- All individuals, their families and health care providers should be able to send, receive, find and use electronic health information in a manner that is appropriate, secure, timely and reliable to support the health and wellness of individuals through informed, shared decision-making.
- The electronic exchange and re-use of information means that “individuals, their families and their health care providers have appropriate access to health information that:
  - Allows individuals and caregivers to be active partners and participants in their health and care, and
  - Improves the overall health of the nation’s population.”

\*From ONC’s Connecting Health and Care for the Nation, 10 Year Vision to Achieve and Interoperable Health IT Infrastructure; A Shared Nationwide Interoperability Roadmap Final Version 1.0.

# Standards

CATEGORIES OF STANDARDS		FUNCTIONS OF STANDARDS	EXAMPLES OF REAL WORLD USE OF THE STANDARDS
 <b>VOCABULARY &amp; CODE SETS (SEMANTICS)</b>	The information is universally understood	RxNorm Code for Ibuprofen is 5640	
 <b>FORMAT, CONTENT &amp; STRUCTURE (SYNTAX)</b>	Information is in the appropriate format	C-CDA packages up data in the appropriate format	
 <b>TRANSPORT</b>	The information moves from point A to point B	SMTP and S/MIME to send the C-CDA from one setting to another	
 <b>SECURITY</b>	The information is securely accessed and moved	X.509: to ensure it is securely transmitted to the intended recipient	
 <b>SERVICES</b>	Provides additional functionality so that information exchange can occur	DNS+LDAP: to find the recipient's X.509 certificate to encrypt a message	

\*From ONC's Connecting Health and Care for the Nation, A Shared Nationwide Interoperability Roadmap Final Version 1.0

# Interoperability and Specificity

- Six specificity questions to keep in mind when we talk about “interoperability”:
  1. For what purpose?
  2. With whom?
  3. With what data?
  4. Via what infrastructure?
  5. By when?
  6. Toward what expected benefits?

# Example Semantics

**RxNorm** - used for medications

- Metoprolol Tartrate 50 mg tablet by mouth twice daily RxNorm code: 866514

**LOINC** - used for assessment questions/answers

<b>K0300. Weight Loss</b>		54863-6
Enter Code <input type="text"/>	<b>Loss of 5% or more in the last month or loss of 10% or more in last 6 months</b>	LA11074-4
	0. No or unknown	LA11075-1
	1. Yes, on physician-prescribed weight-loss regimen	LA11076-9
	2. Yes, not on physician-prescribed weight-loss regimen	

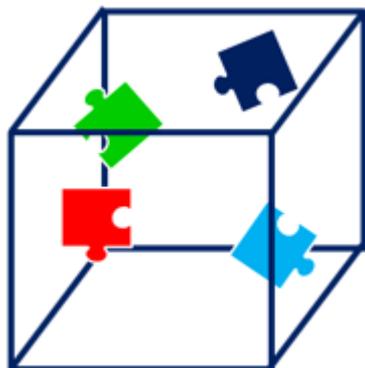
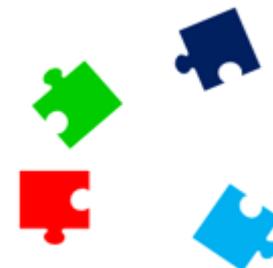
**SNOMED CT:** Used to represent clinical meaning.

For example: SNOMED codes for clinical concepts related to weight loss:

- **89362005** | Weight loss (finding) |
- **416528001** | Intentional weight loss (finding) |

# What do we mean by CDA and Consolidated-CDA?

Clinical Document Architecture (CDA) is the base standard for building electronic clinical documents



Templates provide the “building blocks” for clinical documents

To help simplify implementations, commonly used templates were harmonized from existing CDA implementation guides and “consolidated” into a single implementation guide-the C-CDA Implementation Guide (IC)



# C-CDA Release 2.1 Building Blocks

## HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, Release 2.1 - US Realm

### Document Templates: 12 (3 NEW)

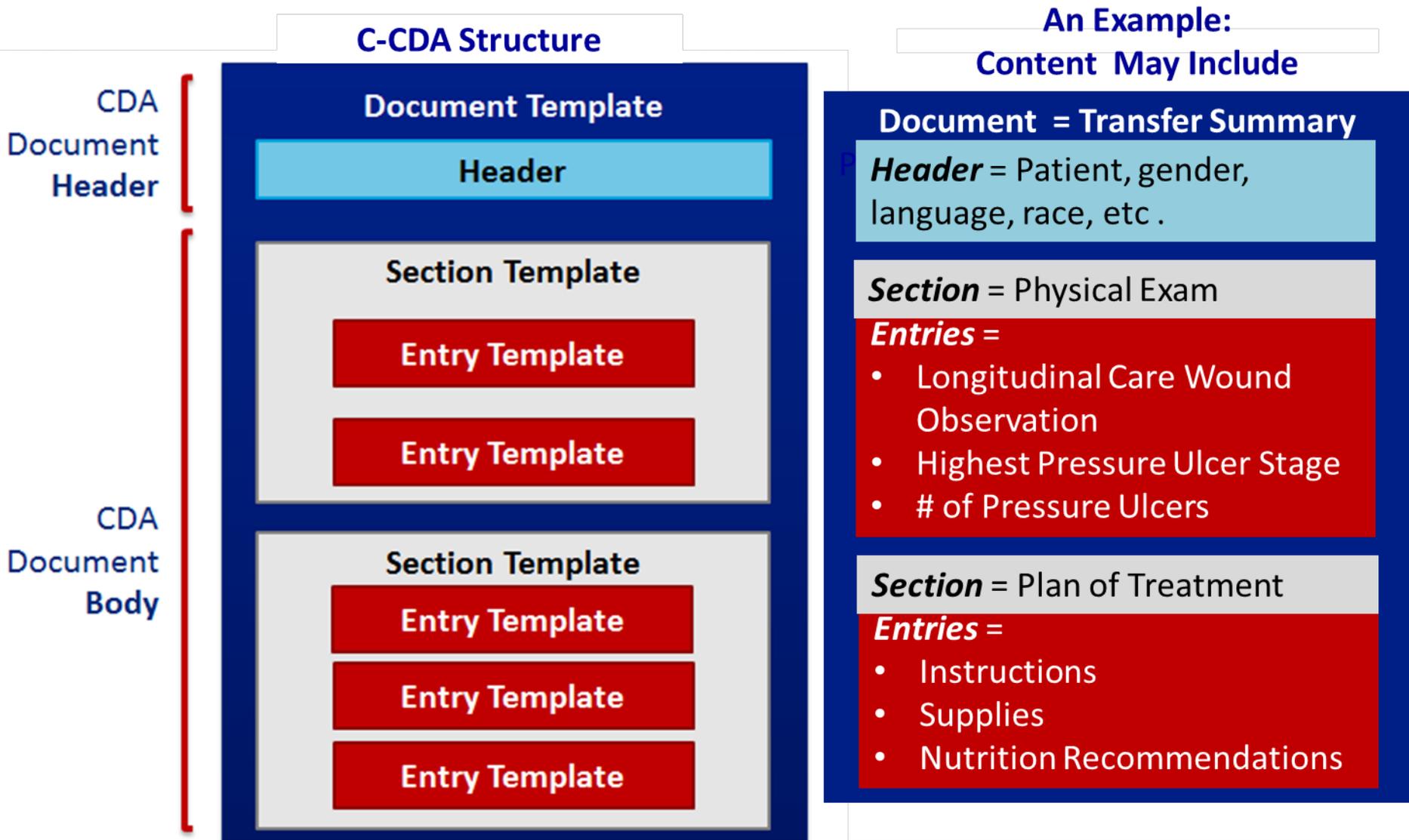
- Continuity of Care Document (CCD)
- Consultation Note
- Diagnostic Imaging Report (DIR)
- Discharge Summary
- History and Physical (H&P)
- Operative Note
- Procedure Note
- Progress Note
- Unstructured Document
- Care Plan
- Transfer Summary
- Referral Note

### Section Templates: 66 (6 NEW)

### Entry Templates: 112 (30 NEW)

Document Template	Section Template(s)		
Continuity Of Care Document (CCD)	<b>Allergies</b> <b>Medications</b> <b>Problem</b> <b>Procedures</b> <b>Results</b> Advance Directives Encounters Vital Signs	<b>Family History</b> Functional Status <b>Immunizations</b> Medical Equipment Payers <b>Plan of Treatment</b> Mental Status Nutrition Social History	Section templates in <b>YELLOW</b> demonstrate CDA's interoperability and reusability.
History and Physical (H&P)	<b>Allergies</b> <b>Medications</b> <b>Problem</b> <b>Procedures</b> <b>Results</b> <b>Family History</b> <b>Immunizations</b> Assessment	Assessment and Plan <b>Plan of Treatment</b> Social History Vital Signs History of Past Illness History of Present Illness	Chief Complaint Reason for Visit Review of Systems Physical Exam General Status Instructions U.S Realm Date/Time

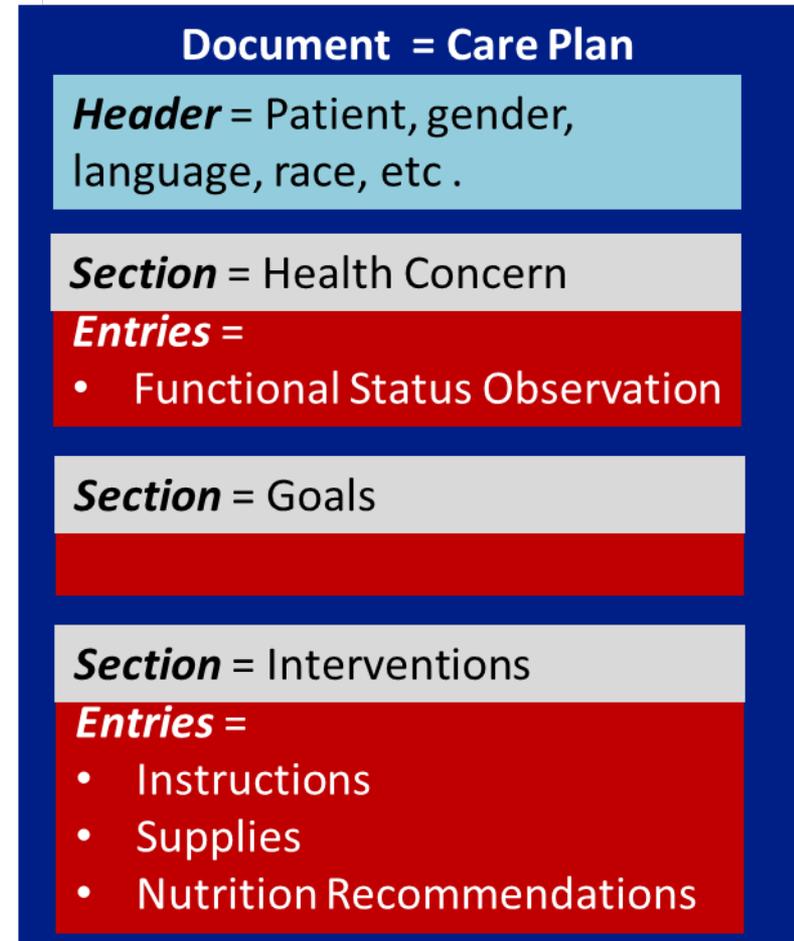
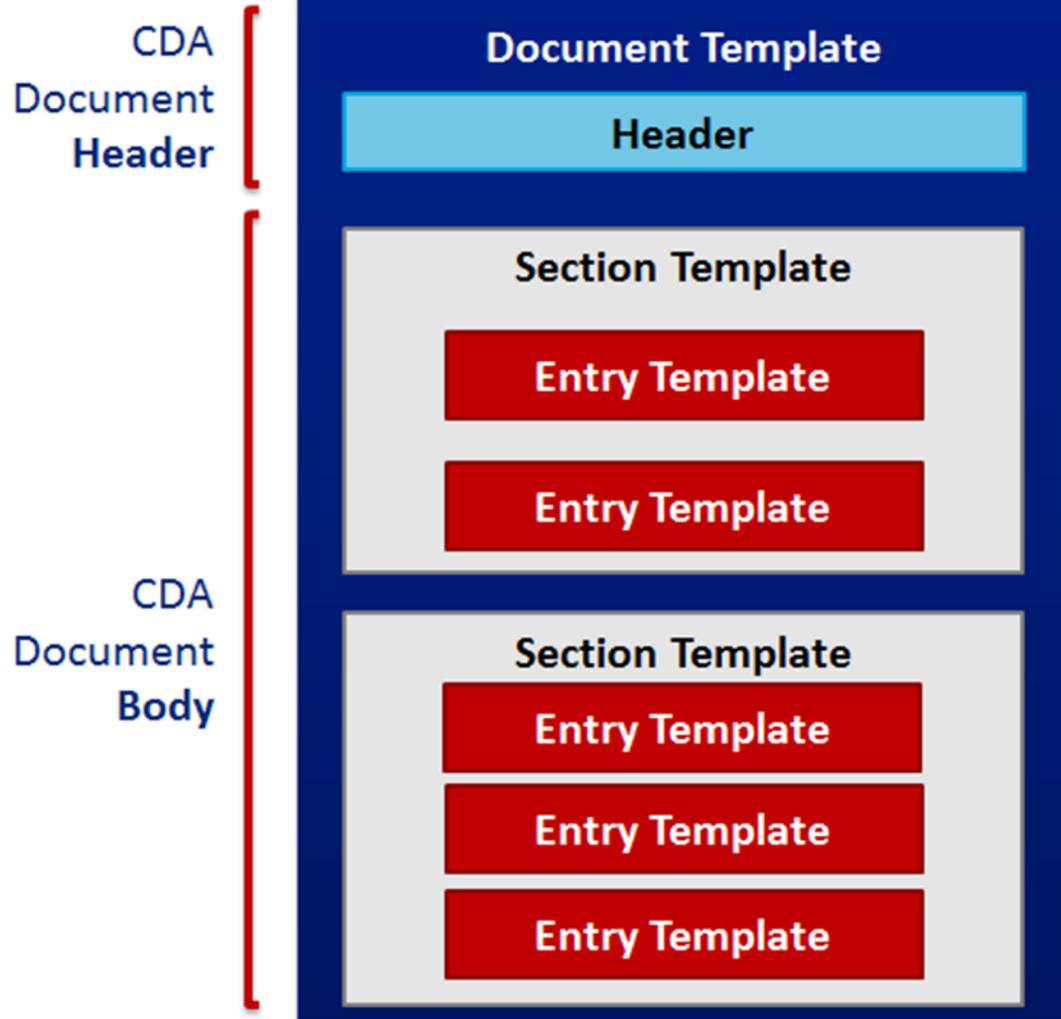
# C-CDA Built with Reusable Templates



# C-CDA Built with Reusable Templates

## C-CDA Structure

## An Example: Content May Include



# ONC 2015 Edition Health IT Certification

- Contains new and updated vocabulary, content, and transport standards for the structured recording and exchange of health information
- **The ONC Health IT Certification Program is “agnostic” to settings and programs, but can support many different use cases and needs**
- This allows the ONC Health IT Certification Program to support multiple program and setting needs, for example:
  - EHR Incentive Programs
  - **Long-term and post-acute care**
  - Chronic care management
  - Behavioral health
  - Other public and private programs

# ONC 2016 Standards Advisory

The standards advisory represents an updated list of the best available standard(s) and implementation specification(s). The list is not exhaustive but it is expected that future advisories will incrementally address a broader range of clinical health IT interoperability needs.

## Purpose:

1. To provide the industry with a **single, public list of the standards and implementation specifications** that can best be used to fulfill specific clinical health information interoperability needs.
2. To reflect the results of **ongoing dialogue, debate, and consensus among industry stakeholders** when more than one standard or implementation specification could be listed as the best available.
3. To **document known limitations, preconditions, and dependencies as well as known security patterns** among referenced standards and implementation specifications when they are used to fulfill a specific clinical health IT interoperability need.

# Summary

- **Nationwide interoperability** across the diverse health IT ecosystem **will require stakeholders to agree to and follow a common set of standards**, services, policies and practices that facilitate the appropriate exchange and use of health information nationwide and do not limit competition.
- **Standards** and methods for achieving interoperability **must be accessible nationwide** and capable of handling significant and growing volumes of electronic health information, to ensure no one is left on the wrong side of the digital divide.
- **Near-Term Success:** An increase in the proportion of individuals, office-based physicians, hospitals and behavioral health, **long-term care and post-acute care** providers that:
  - Send, receive, find and use electronic health information;
  - Have electronic health information available from outside sources and make electronic health information available to outside sources; and
  - Use electronic health information to inform decision-making.

\*From ONC's Connecting Health and Care for the Nation, A Shared Nationwide Interoperability Roadmap Final Version 1.0

# CMS Data Element Library

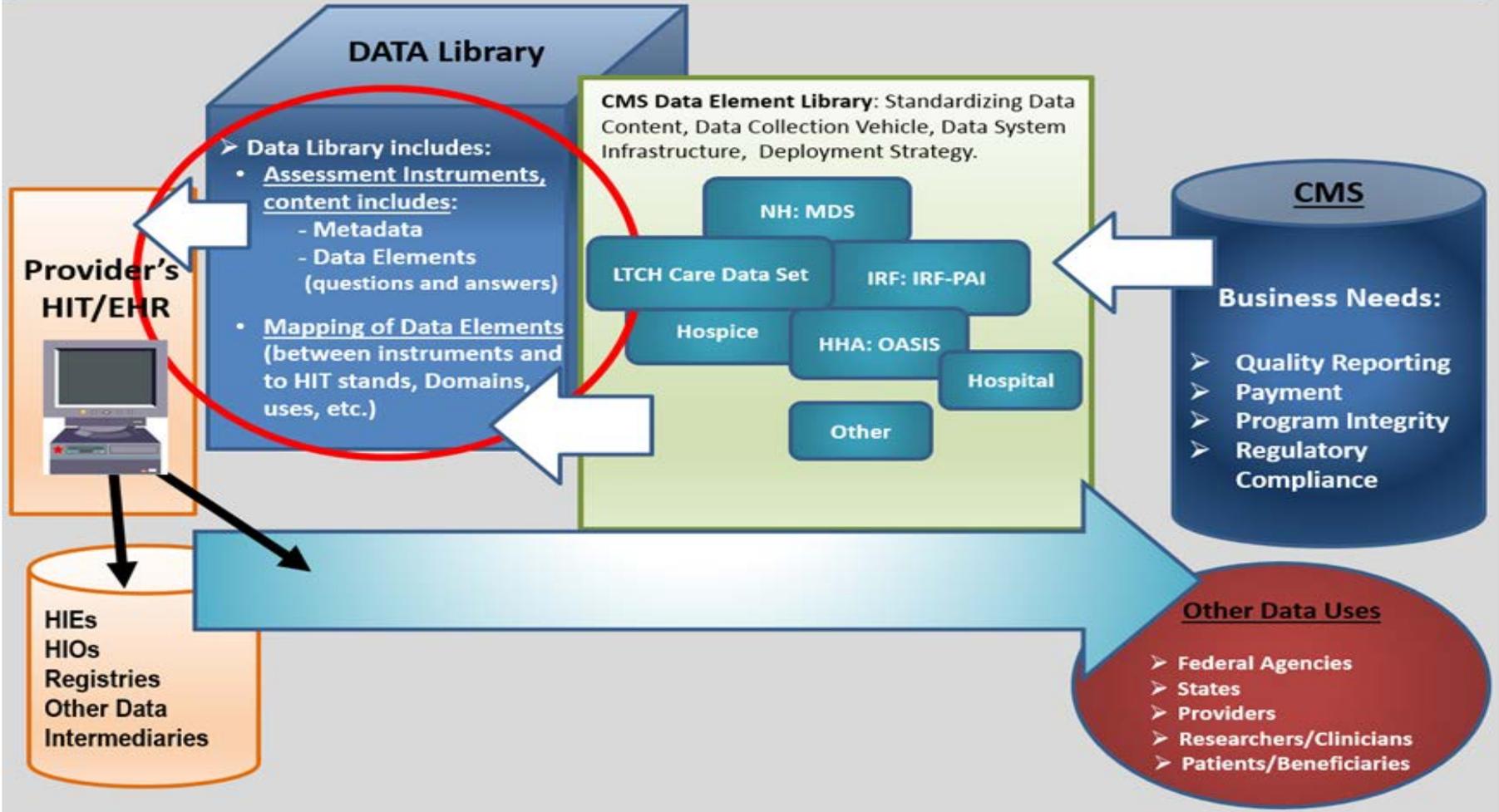
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Jennie Harvell, M.Ed, Senior Technical Adviser,  
Centers for Medicare & Medicaid Services

# CMS Data Element Library (DEL)

## Standardization and Interoperability

Standardized, Interoperable, Reusable EHR Data: Supports CMS and Multiple Other Users' Needs



# Data Element Library

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## The Data Element Library will include:

- PAC assessment data elements (including those that are standardized); and
- Data elements mapped:
  - To Domains,
  - Across instruments indicating whether data elements are standardized, and
  - To applicable HIT content and exchange standards to support interoperability

# CMS Data Element Library

## Content from the CMS Data Element Library (DEL) will assist:

- CMS in managing the standardization of PAC assessment data elements and identification of HIT standards for these data elements;
- PAC and other providers in accessing content to support interoperable health information exchange (HIE) and the adoption of interoperable health IT (HIT) products; and
- HIT vendors in accessing content to support the development of interoperable HIT and HIE solutions for PAC and other providers.

# Library: Content and Implementation

- **Content in the Data Element Library will include:**
  - Repository of Questions and Responses in Assessment Instruments
  - Assessment Instruments and versions
  - Relationships mapped to and between data elements including:
    - ✓ Question to Question, HIT standards, Domains, Other Mappings
- **Implementation of the Data Element Library:**
  - Phased implementation
  - Regular updates to include new and modified data elements, new assessment instrument versions, and new and updated HIT mappings

# Reports from the Data Element Library

- **Pre-defined public reports will include:**
  - Inventory of questions and responses in an assessment instrument
  - Standardized data elements in more than one assessment instrument
  - Assessment data elements and linked HIT standards report
- **Reports will be posted on CMS website in the following formats:**
  - PDF
  - CSV

# CMS Assessment Library Data Council (CALDC)

- CMS established the CALDC as the governing body for the Data Element Library.
- The CALDC provides guidance, direction and issue resolution to the development and maintenance of the Data Element Library.
- The CALDC has established workgroups (WGs) and Teams responsible for Library content, including:
  - Library Management Workgroup – responsible for approving new data elements and data element changes to support the IMPACT Act;
  - Stakeholder Teams – providing technical expertise on specific assessment instruments and use of their data elements; and
  - Health IT Standards Workgroup – responsibilities include mapping assessment data elements to health IT standards to support interoperable exchange and re-use.

# CALDC/Health IT and Standards Workgroup

**Mission:** The HITWG provides expertise, seeks consensus and provides input on assessment data elements (i.e., questions and answers) and their associated HIT terminology and exchange standards, and other HIT issues and other topics identified by the CALDC and CMS Assessment stakeholders.

**Membership:** The CALDC HITWG is comprised of: CMS assessment data owners and leaders knowledgeable about CMS assessment tools and HIT terminology and exchange standards. Participation may include other HHS representatives (e.g., ASPE, NLM, and ONC) and private sector expertise obtained by CMS contractors.

HITWG recommendations are brought back to CALDC for approval

# HITWG Activity: An Example

## Evaluating Data Elements Standardization (i.e., Alignment) and Mapping to HIT Standards

Evaluating Data Element (Questions and Answers) Standardization across PAC Assessment Instruments

OASIS

MDS

LCDS

IRF-PAI

Data Elements Mapped to HIT Vocabulary Standards (include)

LOINC

SNOMED

ICD

Selected Data Elements Mapped to Standards for Continuity of Care

C-CDA  
Templates

### Prioritizing DEs in need of standards:

- DEs in QM Domains
- DEs needed for health information exchange

# Summary

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- The IMPACT Act requires that CMS make PAC assessment data elements interoperable to provide longitudinal information for PAC and other providers to facilitate care coordination and improved beneficiary outcomes.
- CMS will make available public reports that map assessment data elements to health IT standards (as well as other reports).
- Use of standardized and interoperable PAC assessment data elements are key enablers to achieving the goals of service delivery and payment reform envisioned in the CMS Quality Strategy.

# Resource Links

- IMPACT Act: [Improving Medicare Post-Acute Care Transformation \(IMPACT\) Act of 2014](#)
- CMS IMPACT ACT Website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html>
- NICHM Foundation: <http://www.nihcm.org/concentration-of-health-care-spending-chart-story>
- 2012 Medicare Chart Book: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/2012ChartBook.html>
- [PACQualityInitiative@cms.hhs.gov](mailto:PACQualityInitiative@cms.hhs.gov)

# Resource Links (continued)

- Federal Health IT Strategic Plan 2015-2020:  
[https://www.healthit.gov/sites/default/files/9-5-federalhealthitstratplanfinal\\_0.pdf](https://www.healthit.gov/sites/default/files/9-5-federalhealthitstratplanfinal_0.pdf)
- Connecting Health and Care for the Nation: 10 Year Vision to Achieve an Interoperable Health IT Infrastructure:  
<http://www.healthit.gov/sites/default/files/ONC10yearInteroperabilityConceptPaper.pdf>
- Shared Nationwide Interoperability Roadmap Final Version 1.0:  
<https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf>
- ONC 2015 Edition Health IT Certification: <https://www.healthit.gov/policy-researchers-implementers/2015-edition-final-rule>
- ONC 2016 Standards Advisory: <https://www.healthit.gov/standards-advisory/2016>

# Acronyms in this Presentation

- ACC: Accountable Care Community
- ALFs: Assisted Living Facilities
- ASPE: Assistant Secretary for Planning and Evaluation
- CAH: Critical Access Hospital
- CALDC: CMS Assessment Library Data Council
- CCD: Continuity Of Care Document
- CCDA: Consolidated Clinical Document Architecture
- CMS: Center for Medicare & Medicaid Services
- CSV: Comma Separated Values
- DE: Data Element
- DEL: Data Element Library
- EHR: Electronic Health Record
- EMS: Emergency Medical Services
- HCBS: Home and Community Based Services
- HHAs: Home Health Agencies

# Acronyms in this Presentation (continued)

- HIE: Health Information Exchange
- HIOs: Health Information Exchange Organizations
- HIT: Health Information technology
- HITWG: Health Information Technology Standards Workgroup
- ICD: International Statistical Classification of Diseases and Related Health Problems
- IMPACT Act: Improving Medicare Post-acute Care Transformation Act
- IRF-PAI: In-Patient Rehabilitation Facility- Patient Assessment Instrument
- IRFs: In-Patient Rehabilitation Facilities
- LCDS: LTCH Care Data Set
- LMWG: Library Management Workgroups
- LOINC: Logical Observation Identifiers Names and Codes
- LTCHs: Long-Term Care Hospitals
- LTPAC: Long-Term/Post-Acute Care
- LTSS: Long-Term Services and Supports

# Acronyms in this Presentation (continued)

- MDS: Minimum Data Set
- NIHCM: National Institute of Health Care Management
- NLM: National Library of Medicine
- OASIS: Outcome and Assessment Information Set
- ONC: Office of the National Coordinator for Health Information Technology
- PAC: Post-Acute Care
- PCP: Primary Care Providers
- PDF: Portable Document Format
- QM: Quality Measure
- RxNorm: US-specific terminology that contains all medications available on US market
- SNFs: Skilled Nursing Facilities
- SNOMED: Systematized Nomenclature of Medicine
- VBP: Value Based Payments

# Question & Answer Session

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# Evaluate Your Experience

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- Please help us continue to improve the MLN Connects® National Provider Call Program by providing your feedback about today's call.
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# Thank You

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