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National Provider Call Transcript

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Centers for Medicare & Medicaid Services
IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call
MLN Connects National Provider Call
Moderator: Amanda Barnes
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Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Amanda Barnes. Thank you. You may begin.

Announcements and Introduction

Amanda Barnes: Thank you, Kalia. I am Amanda Barnes from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on the IMPACT Act: Connecting Post-Acute Care across the Care Continuum.

MLN Connects Calls are part of the Medicare Learning Network®. The Improving Medicare Post-Acute Transformation Act, IMPACT Act, of 2014 requires the reporting and standardized patient assessment data by Post-Acute Care, or PAC providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. The Act specifies that the data elements must be standardized and interoperable to allow for the exchange and use of data among PAC and other providers, including common standards and definitions to facilitate coordinated care and improved beneficiary outcomes.

During this call, subject matter experts in the Office of the National Coordinator for Health IT discuss implications of the IMPACT Act for health information exchange across the care continuum. Before we get started, I have a couple of announcements.

You should have received a link to today's slide presentation email. If you have not already done so, you may view or download the presentation again from CMS, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the webpage, select the National Provider Calls and Events, then select the date of today's call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. Registrants will receive an email when these materials are available.

Lastly, registrants were given the opportunity to submit questions during registration, and we will address some of these questions before the live question-and-answer session.

At this time, I would like to turn the call over to Jennie Harvell.

Presentation

Jennie Harvell: Thank you very much, Amanda. Good afternoon. My name is Jennie Harvell, and I want to welcome you to this discussion today on the IMPACT Act Requirements: Standardize and Make Interoperable CMS Post-Acute Care Assessment Data Elements.

IMPACT Act: Requirements To Standardize and Make Interoperable Post-Acute Care Assessment Data Elements

We'll be looking at slide number 5 now. In October 2014, the IMPACT Act, the Improving Medicare Post-Acute Care Transformation Act, was signed into law. There are several pieces to this legislation, including: the Act requires that Post-Acute Care providers submit to CMS Standardized Assessment Data. Specifically, the law requires that long-term care hospitals submit standardized assessment data in the LCDS; skilled nursing facilities submit standardized assessment data using the minimum data sets, the MDS; home health agencies submit standardized data using the OASIS instruments; and inpatient rehab. facilities submit standardized assessment data in the IRF-PAI.

In addition, the law requires that CMS make interoperable standardized patient assessment and quality measure data and also data on resource use and other measures in order to allow for the exchange of data among post-acute care providers and other providers in order to facilitate coordinated care and improved outcomes.

Next slide, please. So why IMPACT, and why now? By requiring that post-acute care providers submit standardized post-acute care assessment data and requiring that CMS make assessment data interoperable, the IMPACT Act will address the lack of comparable information across post-acute care and other settings, which has limited the ability to evaluate and differentiate between appropriate care settings for and by individuals and their caregivers. Further, standardizing — that is, aligning, post-acute care assessment data across instruments will allow for continued beneficiary access to the most appropriate care settings, will also allow CMS to compare quality across post-acute care settings, and will enable post-acute care payment reform, such as site-neutral or bundled payments. Further, making available standardized and interoperable post-acute care assessment data supports service delivery reform and will allow for improvements in hospital and post-acute care discharge planning and the transfer of information across the care continuum.

Next slide, please. The goals of the IMPACT Act are supported by and are aligned with the CMS quality strategy. This slide depicts the CMS quality strategy, which seeks to improve — improve care, promote health, and support smarter spending. The goals of the CMS strategy include making care safer, strengthening person- and family-centered care, promoting communication and care coordination, promoting effective treatments, and making care more affordable.

The CMS quality strategy is built on several foundational principles, two of which I think are particularly relevant to this conversation. One is enabling innovation, and the other is strengthening the infrastructure and data system.

Next slide, please. This slide depicts why post-acute care matters and is a key component for achieving better care, healthier people, and smarter spending. In brief, there are almost 33,000 post-acute care providers who serve almost 7 million Medicare beneficiaries, and, on behalf of whom, Medicare spends almost $74 billion annually—nearly 15 percent of total Medicare spending. To make improvements in care, care coordination, and beneficiaries' lives and how we pay for services, it's imperative that we include a focus on post-acute care.

Next slide, please. The IMPACT Act requires that post-acute care providers submit standardized assessment data for identified quality measure domains that are listed on this slide. Providers are to submit this data to CMS by certain dates, which are also identified in the statute and identified on this slide. As you can see, the IMPACT Act includes some very aggressive timelines. Over a period of about 2½ years, CMS is required to standardize assessment data in these listed quality measure domains, and providers are required to submit to CMS date—to CMS this standardized assessment data beginning on the dates shown. The quality measure domains listed in the statute generally reflect functional and cognitive status, skin integrity, medication reconciliation, major falls, and the transfer of health information and care preferences.

I'm not going to identify each of the dates by which providers are required to begin submitting the data for these quality measure domains. You can see that for yourself. It begins starting October 1, 2016, and the last of the reports begin January 1, 2019.

Next slide, please. The quality measures established by the IMPACT Act on the transfer of health information and care preferences. There is particular mention for this presentation on connecting care across the care continuum. The statute requires that CMS establish a quality measure on the transfer of health information and care preferences of an individual, and that information is to be transferred to the individual, family caregivers, and service providers at times of transition from the acute care hospital or critical access hospital to another setting, such as post-acute care — post-acute care provider or home, or from post-acute care providers to other settings, including a different post-acute care provider, an acute care hospital, critical access hospital, or home. This is a critical measure that focuses on connecting and transferring information across the care continuum.

Next slide, please. In addition, the IMPACT Act requires that CMS standardize assessment data in certain assessment categories, and that providers are to report this standardized assessment data to CMS by certain timelines that are also identified in the statute. This slide lists the assessment categories and indicates that institutional post-acute care providers are to submit this data to CMS by — beginning

October 1, 2018, and that home health agencies are to start submitting this data to CMS by January 1, 2019. You can see on the slide the assessment categories that are identified in the statute.

Next slide, please. This slide is a graphic depiction of moving from the as-is state of assessment data to the to-be state. In the current state, each of the post-acute care providers has their own setting-specific instruments. And other providers, for example, hospitals, physicians, long-term service and support providers, do not have standardized data sets.

Moving forward, as a result of the IMPACT Act, the future will see increasing alignment of patient data across the care continuum. This alignment will support the exchange and reuse of data across care providers in order to support care transitions, promote quality of care, reduce provider burden, and support payment and payment reform activity.

Next slide please. So there's a lot of discussion in the IMPACT Act about data element standardization. So, what is it? Data element standardization — that is, the alignment or harmonization of clinically relevant data across the care continuum — data element standardization will allow for the reuse and shared understanding of clinical information across the care continuum, including the reuse of this information for transitions of care, care planning, a variety of decision support applications, and other uses.

It should be noted that, while data element standardization is required by the IMPACT Act for certain quality measure domains and assessment categories, CMS anticipates that data elements that are unique to each post-acute care setting will also persist, including, as necessary, to account for case-mix differences across settings.

Next slide, please. As mentioned, the IMPACT Act also requires that CMS make post-acute care assessment data elements interoperable. Making data elements interoperable will allow for the exchange and use of data among post-acute care and other providers, using common standards and definitions, in order to provide access to longitudinal information to facilitate coordinated care and improved beneficiary outcomes.

Next slide, please. This slide is a graphic of the future state, where electronic and interoperable data will follow the individual across the care continuum and is shared among all engaged providers, including emergency medical service personnel, hospitals, physicians, post-acute care providers, home- and community-based service providers, as well as sharing information with the individual and their family members and caregivers.

Next slide, please. In implementing the IMPACT Act requirements related to interoperable data elements, CMS is the linking post-acute care assessment data elements to nationally accepted health IT standards that are being used by acute care hospitals and primary care practitioners in their health IT applications that are used in a

variety of programs. By leveraging and aligning with these nationally accepted health IT standards, post-acute care and other providers across the care continuum will be able to use and exchange post-acute care assessment content in document templates, such as transfer summaries, care plans, and long-term post-acute care assessment summary documents. CMS will make available to the public reports that will link assessment data elements to nationally accepted health IT standards.

Next slide, please. So, in summary, the IMPACT Act requires that post-acute care providers report to CMS by certain dates, standardized assessment data elements in certain quality measure domains and assessment categories. And the Act also requires that CMS make assessment data elements interoperable.

CMS will standardize, that is, align, the data elements in post-acute care assessment instruments, will make data elements interoperable by linking those data elements to health IT standards, and will make available to the public reports that map assessment data elements to health IT standards. There'll be more on this activity, about how CMS will be making available reports to the public, a little later in this presentation.

Use of standardized and interoperable post-acute care assessment data elements are key enablers to achieving service delivery and payment reform envisioned by the CMS quality strategy. Before turning over the presentation to Dr. Terry O'Malley to talk about the exchange and reuse of clinically relevant data elements, Amanda will ask for information from the audience using keypad polling.

Keypad Polling

Amanda Barnes: Thank you. Thank you, Jennie. At this time, we will pause for a few moments to complete keypad polling. Kalia, we're ready to start.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad, and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling. Thank you for your participation. I'd now like to turn the call back over to Amanda Barnes.

Presentation Continued

Amanda Barnes: Thank you so much. Now I will turn the presentation back over to Dr. Terrence O'Malley.

Dr. Terrence O'Malley: Thank you, Amanda, and thank you, Jennie. As you can see, IMPACT is a very complicated act, and we know from your questions that you collectively have many concerns around the details of implementation, such as timing, who needs to pay attention, who doesn't need for you to pay attention, who's included, and who's not. These are all important issues, and they'll be addressed as the outlines of the Act are filled in over the next several months.

And you're the ones that are going to be wrestling with these details, and they may well consume most all of your attention in the foreseeable future. But, for a few minutes, I'd like you to shift your thinking from these details, important as they are, to look at the broader, and in many ways, the sweeping changes that are occurring in health care—changes that IMPACT supports and changes that we're all going to be part of. So, IMPACT starts at a very basic level. It starts by creating data elements that mean the same thing to everyone providing services to the individual. This is truly – this is revolutionary. There has never been an attempt to connect different providers of service by creating a vocabulary that they all can understand. And it's a vocabulary that we will all need to communicate with – with each other. And to be fair, this really hasn't been an issue under the current fee-for-service payments. And now for the first time, policy and payment and technology are pushing us and enabling us to better connect with each other and to the other parts of the health care and support services system.

And these new connections are driven by the business imperative to provide care more safely and efficiently. And these connections are based on the exchange of data that has two important characteristics. The data has to be standardized, so that means the same thing to everyone in the system, and it has to be interoperable, which means once you receive that information you can use it effectively.

Clinically Relevant Assessment Data Used for Multiple Purposes

So, what does IMPACT give us, and why is that significant? We're now on slide 19. And it's "What Will IMPACT Give Us?" Well, IMPACT sets us on the course to develop a set of standardized data elements — elements that will be of use to many different providers across the spectrum of care, from hospitals to home and all sites in between. So what, you may ask, why do we need this?

The current reality is that no one really needs to be well-connected under fee-for-service payments. The irony of fee-for-service is that when something is done poorly and paid for, the services needed to correct the poor outcome are also paid for. So there's less of an incentive to do something right the first time. So, if you can get paid twice for correcting it, then why correct it the first time?

So what, indeed? So currently under fee-for-service, there's not really a cost of having a poor communication — or for coordination of care except right now if it involves a readmission. But if you are paid for providing services, you'll get paid for providing more

services. Our payment system doesn't necessarily help to organize care for individuals with complex issues.

So, the so what is – is that fee-for-service is going away, and it's currently being replaced by new payment models that depend on better communication and coordination of care — two processes that require the exchange of standardized data. These new payment models are called value-based payments and will turn everything upside down in health care.

Slide 20. So, what value-based payments are going to give us is they're going to pay for outcomes. So, what happens to the individual? They're not going to pay for the volume of services. So, in fee-for-service, everyone gets paid for an isolated service, such as an admission, a day in the SNF, an episode of home health, a visit, or a test. Everyone is out for his or her own bottom line, and no one really cares about total cost.

CMS, and by extension the taxpayer, care about the total cost of care. We have to write the check. And it's gotten to be a very big check, it's 17 percent of GDP, with health-care costs consistently rising faster than inflation. So, enter value-based purchasing. First, it creates entities that are at risk for the total cost of care of a population, whether that's an ACO or a bundled payment model.

Essentially, CMS pays a discounted fee, which guarantees savings to CMS and us, the taxpayers, and places the risk of managing the total cost of care on the new value-based purchasing entity. Unlike fee-for-service, where you get paid more if you do more, in VBP, you get — only get paid more if you increase the size of the population you're responsible for and meet all the quality of care requirements and deliver all the needed services at lower costs than you were paid.

If your costs are higher than what you are paid, no one is there to pay you the difference. And you're not going to make more money by providing more services. If you don't meet the quality metrics, then you get paid even less, even if you provide the care at lower cost.

So, this is revolutionary payment model, and it's under way. Thirty percent is the target at the end of 2016, and 50 percent of all fee-for-service Medicare will be under this payment model by the end of 2018.

And the impact is going to be profound. And what this really means, if you think about it, is that the at-risk entities have to manage the most complex and costly individuals in their populations. And so, let me tell you who these high-cost individuals are.

So on slide 21, it's a small group that – that drives the cost, so, therefore, the title "Focus on the Top 1 to 5 percent." So this is a very busy slide. And let me break it down for you a little bit.

I want you to just look at that – that curve that starts in the left lower corner of the slide and rises to the upper right-hand corner, and if — this is called a cumulative spending curve. So, in the left lower corner with the hollow black arrow, it starts at 0-0, meaning you're paying zero money for zero percent of your population. And as you go up – up this curve to the upper right, you get to 100 percent of the population, and now you've spent 100 percent of your cost. Makes sense?

So we're going to move from right to left then up the curve. So in the middle of the slide, at the bottom, there's the double-lined arrow. And it's at 50 percent of the population. So, 50 percent of the population spends 2.7 percent, an average of $234 per person per year. A lot of people don't cost much. The higher-cost half accounts for 97.3 percent of the total spent.

Move along the X-axis, and the next hollow dashed arrow, in the right lower corner, is at 95 percent of the population. This intersects the cost curve at 50 percent of the total spending at the other hollow dashed arrows. What this means is that the bottom 95 percent of the total population accounts for half of the spending. Ninety-five percent spend 50 percent; 5 percent spend 50 percent. This 5-percent average is $43,000 per – per year compared to the $234 for the lowest 50 percent.

The solid black arrow in the right lower corner is at 99 percent of the population. This 1-percent line crosses the cost curve at the other solid black arrow. Seventy-seven percent — 99 accounts for 77 percent; 1 percent — 1 percent accounts for 23 percent of the total cost, with an average yearly cost for these folks of $98,000. This is a very high-cost group of individuals, and the ones we're going to have to pay attention to.

So, the next slide, 22, just runs through some of the similarities among the 5-percenters and 1-percenters. And, you know, if we're responsible for the total cost of care of a population, who do you think you're going to pay attention to? These are the same individuals that drive Medicaid, dual, and Medicare costs. And anyone who's charged with lowering the costs and approving the outcome of care for these groups will pay attention to this 1 and 5 percent.

So, this slide indicates who's on the list. It's really individuals with complex medical and serious behavioral health issues — certainly a group that's not currently well-managed — individuals with complex functional impairment and the disproportionate share of adverse social determinants of health. These groups, which can — can include young adults with traumatic brain injury, children with severe developmental delay, as well as the elderly with an accumulation of chronic medical issues, all share a common set of characteristics. They use the emergency room and hospitals a lot. They get care in multiple sites from multiple providers. They experience frequent transitions of care, and the current system of services and payment for them is in total disarray.

So, without standardized and interoperable data, this system — our current system — will remain fragmented. So, IMPACT is a start to get to this essential capability — the ability to exchange standardized information.

So, the next few slides are going to expand on the characteristics of this high-cost group. So, slide 23 is a graph of the per-beneficiary Medicare spending. This comes from the Medicare Chart Book 2012. And it divides the Medicare beneficiaries into four groups, based on the number of chronic conditions that they have.

So, zero to one chronic condition, two to three, four to five, or six or more. And you can see how the costs lay out across these different groups, with the six-or-more folks spending an average of $32,000 per beneficiary compared with those at the bottom of the left curve at $2,000 per year. So, the highest group was over 3 times higher than the lowest group or, actually, the median.

So, another way of looking at this data, on the next slide, which is slide 24, again we have the same groups, but they have different colors now. So, the purple group are the six or more conditions, the orange is four to five, the green is two to three, and zero to one are blue. And you see the associated costs. So, 46 percent of costs are driven by 14 percent of the population. If you combine the groups with four and five and six or more conditions, together they account for over 75 percent of the total cost. So, this is a dramatic change. This is just a dramatic example of how these groups – the cost is focused in a small group of folks.

So, the next slide, 25, looks at Medicare readmissions, 30-day readmissions by the number of chronic conditions are at 14 percent of six or more account for 70 percent of readmissions — total readmissions. If you combine that with the four-to-five condition group, together these two groups account for 90 percent of all 30-day readmissions.

The final slide in the chart book, which is slide 26, looks at the impact of disability on spending. So, the — if you're on Medicare and you're disable — and you're under 65, it's because you have a disability. So, the blue bar in this graph are — is the spending for individuals with disabilities. They're under 65. And you see that at every cohort, based on chronic condition, the disabled population spends significantly higher. It's more complex, drives more cost than their compatriots. So, they're younger and disabled, and disability is tightly linked to the social determinants of health. These are characteristics of the population that are influenced by forces external to the individual, like neighborhood, income, and access to care.

So, our current health system doesn't manage social determinants very well, because we get paid whether we're successful or not, and it's difficult to actually move the bar on social determinants. Under value-based purchasing, however, social determinants become critical targets for intervention. And this is because they drive more health-care

spending than do the clinical conditions. And the current health-care system doesn't manage social determinants well.

So, on the next slide, number 27, this is just a very brief list of social determinants. So, these are health conditions that reflect how well the individual is able to function within society. And the effects of these social determinants are significant. The top 5 percent also claim a disproportionate share of adverse social determinants of health. And these social determinants create mutually reinforcing barriers to care, coordination, and payment. And of note, there's not a standardized vocabulary yet to apply to social determinants. So we can't even share that information with each other. But that'll be an important gap that we'll fill over the next few months, I'm sure.

So, our current system is not well-organized to deal with these issues. The data on the earlier slides speaks to the high cost associated with them. And the fact that, under value-based purchasing, we'll not only need new systems, but we're going to need more complex teams, multiple sites, and the ability to address some of these social determinants.

So, the other important aspect is that social determinants are really outside — largely outside the purview of the medical team — the hospital and the physician. They really force us to expand our system of care to include home- and community-based services, as well as a whole host of other services that may be provided by local governments and/or foundations, private and public.

So, value-based purchasing is going to force the current health care system to reorganize and address these different drivers. And the new system that's emerging – one — one version of the new system has been called the Accountable Care Community instead of an Accountable Care Organization. It's a community because it takes many more moving parts than you get in Accountable Care Organization.

So, the next slide, on slide 28, is a sketch of what that community might look like. And in the center is a shared common information platform. And that will be developed, and there are many models out there. But it — this is supposed to be generic. We just need to figure out a way of how we can exchange this information electronically, and there will be a platform that emerges. The blue arrows, double-ended, are the exchange of standardized data. And the content of that are the data that are in our standardized assessments, which will be more standardized under IMPACT.

And you can see that you've got the hospitals and the doctors and care coordination sort of between 8 and 11 o'clock on the clock. At the top of the curve is the individual at home. Then you have home- and community-based services going around — continuing around the clock face, and then finally EMS. Which if you think about it is – is really a mobile platform for assessment and stabilization. And it's going to be used differently in this Accountable Care Community.

But the important part is that all of these parts are going to have to communicate with each other, and communicate in real time, particularly if you're sending someone to the emergency room via EMS, you need to know allergies and meds. So, there are going to be issues that require us to exchange information electronically in order to take advantage of the kinds of electronic exchange.

So, the next slide, slide 29, you know, value-based purchasing means bigger teams. Bigger teams mean we're going to have to communicate better, particularly around transitions and through improved coordination. So, our challenge will be to connect this communication through — this new community through effective communication. And all of this rests on the exchange of standardized and interoperable data elements. And we'll do this because we have to in order to manage the most costly and complex segment of the population.

So, having created the vocabulary needed to improve transition and coordination in order to improve care and outcomes, we will get additional benefits as well. And some of these benefits, in addition to efficiency and coordination, they will generate huge cost savings, but we'll also learn some information about how our system as a whole works.

The next slide goes into some of the potential reuses of this information beyond just the care of the individual. And there, as you would suspect, the quality measures. You know, creating quality metrics that are based on the reuse of data exchange for the purposes of patient care becomes an important way to make collecting this data much less onerous.

So, in this example, the exchange of information becomes a quality measure. Is it complete? Is it accurate? Is it usable? Is it received in a timely manner? These characteristics can be measured as part of providing care. But they now require additional reporting mechanisms. Imagine if you could send a cc to public health so they could track reportable conditions and monitor disease outbreaks. You could create a care plan using these data elements, again, reusing them in a different way and using them to tie new care team members together.

So, if you bring all the care team together and they're reporting standardized information, you can get, finally, a picture of the total needs of the individual, who's on the team, and who's doing what, and what outcomes they are trying to achieve. And finally, you're able to use this information yet another way to actually measure how well the system as a whole, not just individual parts of it, are — how the system as a whole works. So, these are the added benefits.

So, finally, slide 31, why this matters. So, I hope you've gotten a chance to sort of look a little bit more broadly at the issue of where IMPACT is trying to take us. I know the IMPACT details are going to matter a lot to you, but it also is important to keep in mind

a larger vision of where health-care and supportive care services are going and how the evolution of these new systems of care will rest on the exchange of standardized and interoperable data.

So, the world is changing for the better, particularly for the care of individuals with complex needs. And these changes will rest on this exchange of information. So, IMPACT has launched us down this path. It's up to us to figure out how to use this new tool that enables us to communicate better.

And I'm going to pass it on now to Liz Palena Hall, who will take you to the world of HIT standards. So, how do we exchange this information? What does it take to be standardized and interoperable?

Health Information Technology Standards

Liz Palena Hall: Thank you, Terry. And now we'll move on to slide 33.

So we certainly live in an exciting moment for health information technology, where rapid investments in health – in the health-care field have led to new opportunities and everything from precision medicine to value-based care, as we heard from Terry.

A strong health IT foundation is critical to advancing many of these important initiatives. In 2015, ONC published a series of reports in support of the establishment of an interoperable nationwide health information infrastructure. Two of these key reports were the Federal Health IT Strategic Plan and the Shared Nationwide Interoperability Roadmap. The Health IT Strategic Plan described how the Federal Government intends to advance the nation towards achieving high-quality care, lower cost, a healthy population, and engage individuals through the effective use of information and technology.

The fourth goal of the strategic plan will be met through the implementation of the Shared Nationwide Interoperability Roadmap. The roadmap presents an actual and incremental timeline over 3-, 6-, and 10-year increments to guide how the country can achieve an interoperable health IT infrastructure to support a learning health system by 2024. It is important to note that the actions called out in the roadmap target a broad range of stakeholder groups to include individuals, clinicians, post-acute providers, community-based providers, researchers, and payers, with a near-term focus on sending, receiving, finding, and using priority data domains to improve health and health-care quality.

Slide 34, please. The roadmap defines interoperability as 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. An analogy would be sending a letter to the recipient, but the recipient only speaks English and the letter is written in French. So, while the letter may have been transmitted, the contents of the

letter cannot be understood and meaningfully used. Likewise, it was interoperability it's not enough to simply send information, but it includes the ability to meaningfully use that information.

So, what are the benefits? The electronic exchange and reuse of information means that individuals or families and health-care providers have the appropriate access to health information that allows them to be active partners and participants in their health and health care and improve the overall health of the Nation's population.

Slide 35. To get to the level of interoperability we need as a nation, we must adopt and use a core set of technical standards. This image is taken directly from the interoperability roadmap. The ONC recognizes five categories of standards:

- Vocabulary and code set standards;
- Format, content, and structure standards;
- Transport standards;
- Security standards; and
- Service standards.

In general, standards are developed in response to specific clinical or business needs. Standards are also specified at different levels and combined in different ways to properly address user needs and expected data requirements. Typically, these five sets of – types of standards with an accompanying implementation specification are necessary and used together to achieve interoperability for a given purpose. In the next few slides, we'll dive a little deeper into the first two categories of standards: vocabulary or semantic standards and content standards.

Slide 36. ONC recognizes the need for specificity when outlining the value proposition for leveraging health information technology and establishing an interoperable data infrastructure. So, when we think about leveraging technology standards for interoperability, we should keep these – keep in mind these six questions:

- For what purpose are we exchanging the information?
- With whom are we exchanging the information?
- What are – what data needs do recipient of that information have?
- Via what infrastructure?
- And by when will that information be needed?
- And towards what benefit?

Slide 37. This slide provides examples for the first category of standards, vocabulary code set standards, and shows three commonly used standards in this category. So, the first example is RxNorm, which is a standard that is used to represent medication. So, in

this example, we have the medication Metoprolol, and it's represented by the RxNorm code set as seen on the slide.

The next example is a LOINC — is a LOINC standard, which is used for patient assessment questions and answers. And in this example, we have a weight loss question which — and its representative LOINC code, as well as the response option codes – the response options and their LOINC codes. And finally, there's SNOMED CT, which is used to represent clinical meanings and, again, the example there is weight loss findings.

Slide 38. The second category of standards refers to those needed to format information. A common example is the HL7 Consolidated Clinical Document Architecture, or the CCDA, and is used to meet the requirements of the CMS Meaningful Use Program, and it's been adopted by the ONC Health IT Certification Program. We like to think of the CCDA as a large Lego construct, consisting of multiple modular Lego pieces that come together to form a consolidated implementation guide, or IG.

The Legos, or pieces within the CCDA, are referred to as templates that come together to form electronic clinical documents. These templates are reusable and interchangeable, so a variety of clinical documents may be built for specific uses from the same standard, so that system implementers can use the CCDA implementation guide to update their systems so that the system is capable of capturing and sharing electronic information.

Slide 39. The latest version of the HL7 CCDA standard required for the 2015 Edition ONC Health IT Certification is Version 2.1. 2.1 builds on earlier releases of Consolidated-CDA, which include, for example, the Continuity of Care Document, the CCD, and relevant sections to post-acute care, such as the Functional Status Section.

This slide is meant to show how the CCDA Implementation Guide harmonizes templates at multiple levels. For example, at the document level we see, for example, the CCD and the Care Plan. At the section level, for example, sections that include allergies and medication. And at the entry level, for example, nutrition assessment and nutrition recommendation.

The latest version of the Consolidated-CDA includes 12 documentation — document template types, which include three new ones: the Care Plan, the Transfer Summary, and the Referral Notes. These three new document templates are relevant to post-acute care and were developed in collaboration with and in response to the care coordination needs raised by the post-acute care community. The new release also includes six new section templates and 30 new entry templates.

Slide 40. To understand the relevance of the reusable template, let's review an example for the Transfer Summary document. So, here you can see — and we'll compare that to the next slide in a minute, which will be the Care Plan document.

All CCDA — or CDA documents are built using the same structure. They consist of a document header and a document body. Within the body, you may have one or more section templates with applicable entry templates. If we look at the Transfer Summary document, it consists of a header, which includes information such as patient demographic information like name, gender, language, etc. And within the body, you can find, for example, a Physical Exam section with entries such as longitudinal care wound observation, high-pressure ulcer state, and the number of pressure ulcers.

The body of the document may also contain a Plan of Treatment section that consists of entries, such as instructions, supplies, and nutrition recommendations. What is important here is that all the information is captured in a structured and standard way and can be easily — easily reused in other sections once it is captured in one section.

Slide 41. This is an example for the Care Plan document, where you will see a similar structure to the document from the previous slide, the Transfer Summary. It also contains header data. Hence, if the Transfer Summary was completed for the same patient, the header data could be — also be used to populate the Care Plan Header data.

The same applies for the Intervention section. Although the Transfer Summary did not include an Intervention section template, the entries contained within the Care Plan Intervention section are the same entries contained within a Transfer Summary Plan of Treatments section. And you can see that on the previous slide. What we want to show here is that these entries within the section are reusable in other sections. They are, in effect, the Lego pieces that can be used to populate multiple sections.

Slide 42. So, we also want to note that ONC last year published a new version of the Health IT Certification. And in this newest version of certification, it builds on the foundation established by the 2011 and 2014 editions. It also contains new and updated vocabulary content and transfer standards for the structured recording and exchange of health information.

It also supports data capture and exchange by various types of Health IT technologies that include EHRs, but can go beyond EHRs to include other kinds of technology, and it can be used by multiple care and practice settings beyond providers eligible under the Meaningful Use program. The Health IT Certification program is agnostic to settings and programs and, as mentioned, can support the EHR Incentive program, but other kinds of use case needs as well, including needs of long-term care, behavioral health, and chronic care management.

Slide 43. To complement the requirements of the 2015 Final Rule and to propel the call to action in the interoperability roadmap, ONC also published the final version of the

2016 Standards Advisory. The 2016 Interoperability Standards Advisory identifies the best available standards and implementation specifications for interoperability for clinical health information as of 2015.

For example, it includes care plan standards for documenting patient care plans and summary care record standards to support a transition of care or referral in other health care provider. While the standards included in the advisory may be adopted in regulation, the advisory is nonbinding and serves only to provide clarity and predictability for the public regarding ONC's assessment of the best available standards for a given interoperability need. It is also plausible and even expected for the advisory to be ahead of where regulatory requirements may be and, in fact, may serve as a basis for further action by industry or government.

ONC is currently accepting public comments on the 2016 Interoperability Advisory – Standards Advisory to begin the process of developing the 2017 Advisory. And the comment period will be open until Monday, March 21st, 2016, at 5 p.m., and we have links to the advisory among other resources at the end of this slide deck.

So, slide 44, in summary. Nationwide interoperability will require stakeholders to agree and follow common sets of standards, services, policies, and practices to facilitate the appropriate exchange and use of health information nationwide. Standards must be acceptable nationwide to ensure no one is left on the wrong side of the digital divide.

So, what does near-term success look like? Well, it includes an increase, certainly, in the proportion of individuals, physicians, hospitals, behavioral health, and long-term post-acute care providers that can send, receive, find, and use electronic health information; that have electronic health information available from outside sources and can contribute electronic information to those outside sources; and then can use electronic health information to inform decision-making.

And now, I'll pass it back to Jennie Harvell, who will talk about the CMS Data Element Library.

CMS Data Library

Jennie Harvell: Thank you, Liz. So we'll now be on slide 46. So, CMS is supporting an advancing data element standardization and interoperability through several different activities, including the development of the CMS Data Element Library. The creation of the library started first with an understanding of what are the various CMS business needs or uses of assessment data elements from post-acute care and other providers, including quality measurement and reporting activities, payments, program integrity activities, and the need or recognition that information is to follow the person in order to support service delivery and payment reform initiatives.

The CMS Data Element Library is being designed to support CMS in its management of these and other requirements and will also assist providers in the health-care environment that is being transformed. Content in the library will be made available to the public, for example, to providers and vendors to assist them in designing and implementing systems needed to support improved care coordination, quality monitoring and improvement activity, and other activities that are important in supporting and providing value-based care.

Providers and their vendors will be able to use content from the library to support health information exchange activity across the care continuum with providers and caregivers in order to support caregiving, with health information exchange organizations, and for various other Federal and State activities and other purposes as well.

Next slide, please. The CMS library will initially include post-acute care assessment data elements. The library will map these post-acute care assessment data elements to a variety of factors. For example, the library will map the data elements to domains in order to make searching for data elements in similar categories easier. The library will also map data elements across post-acute care assessment instruments to support analyses and determinations of whether data elements are standardized, that is, whether or not data elements are aligned across more than one assessment instrument. The library will also map post-acute care assessment data elements to applicable health IT content and vocabulary standards.

Next slide, please. Not only will the CMS Data Element Library assist CMS in managing standardization of post-acute care assessment data elements and linking these data elements to health IT standards for purposes of interoperable health information exchange, the library will also support post-acute and other providers in creating, sending, receiving clinical information needed for interoperable health information exchange. And the library will also support health IT vendors, be able to access content from the library to support the development of their interoperable health IT and health information exchange solutions for post-acute care and other providers.

Next slide, please. The Data Element Library will include a repository of questions and answers on the assessment instruments. It will include assessment instruments and versions, and it will include relationships mapped to and between data elements, including question-to-question mapping, mappings to health IT standards, mappings to domains, and other mappings. The library will be implemented in phases and will be updated to include new and modified data elements, new assessment instrument versions, and new and updated health IT standards mappings.

Next slide, please. CMS will make available to the public reports on an inventory of questions and answers or responses in an assessment instrument, data elements that are standardized across more than one assessment instrument, and assessment data

elements and their linked health IT standards. Reports will be posted on the CMS website in both PDF and CSV formats to enable the reuse of that information.

Next slide, please. CMS has established the CMS Assessment Library Data Council, the CALDC, as the governing body for the Data Element Library. The CALDC provides guidance, direction, and resolves issues related to the development and maintenance of the Data Element Library.

The CALDC has established workgroups and teams responsible for library content, including the Library Management Workgroup, which is responsible for approving new data elements and data element changes to support the IMPACT Act. There are also stakeholder teams that provide technical expertise on specific assessment instruments and their uses of data elements. And there is also a Health IT Standards Workgroup, which is responsible for mapping assessment data elements to health IT standards to support the interoperable exchange and reuse of this content.

Next slide, please. This slide describes the mission of the Health IT Workgroup, which is to provide expertise, seek consensus, and provide input on assessment data elements, that is, questions and answers, and their associated health IT content and exchange standards. The Health IT Workgroup also provides expertise and guidance on other health IT issues and topics identified by the CALDC, CMS stakeholders, as well as standard development organizations. Membership of the CALDC Workgroup is — HIT Workgroup — is comprised of CMS assessment data owners and leaders knowledgeable about CMS assessment tools and persons with expertise in health IT terminology and exchange standards.

Participation may include representatives from other HHS components, such as representatives from the Office of the National Coordinator for Health IT or the National Library of Medicine. And also private sector expertise may be obtained through various CMS contractors. The Health IT Workgroups recommendations will be brought back to the council, the CALDC, for their approval.

Next slide, please. This slide is a graphic depiction of some of the activities that are being undertaken by the Health IT Workgroup. The Health IT Workgroup is examining data elements across post-acute care assessment instruments to evaluate whether or not these data elements are standardized, that is, aligned, across these post-acute care assessment instruments.

The workgroup is also mapping data elements to nationally accepted health IT content standards, such as LOINC, SNOMED, and ICD. The Health IT Workgroup is also mapping post-acute care assessment data elements to templates in the Consolidated-CDA to support the reuse and exchange of this content in various interoperable documents. The HIT Workgroup has been prioritized to first focus on data elements in quality measure domains and then on data elements needed for health information exchange activity.

Next slide, please. In summary, the IMPACT Act requires that CMS make post-acute care data elements interoperable to provide for the longitudinal information for post-acute and other providers to facilitate or support care coordination and improved outcomes. CMS will make available to the public reports that map assessment data elements to nationally accepted health IT content and exchange standards and will also make other reports available as well. And finally, a key driver for the IMPACT Act activity is the premise that the use of standardized and interoperable post-acute care assessment data elements are key enablers to achieving the goals of service delivery and payment reform across the care continuum and as envisioned in the CMS quality strategy.

Resources and Acronyms

Before I turn it back over to Amanda for questions from the audience, I want to point out that at the end of the PowerPoint presentation, there is a list of resources, including the webpage for the CMS IMPACT Act site. In addition, there is a list of abbreviations and definitions that have been used during the course of this presentation. I'll now turn it back over to Amanda.

Question-and-Answer Session

Amanda Barnes: Thank you so much, Jennie. Many questions were submitted prior to this call. We're going to start the question-and-answer session by answering a few of them.

The first question we have is: What do I need to do to prepare for the IMPACT Act?

Stace Mandl: Hi, this is Stace Mandl from CMS. I'll go ahead and answer that question. So, just to kind of clarify, there isn't a single thing that is to be done to prepare for the IMPACT Act. The IMPACT Act really haven't — has numerous requirements throughout it. So there isn't really an associated event.

There's a multitude of requirements associated, from quality measurement using — quality measures, using standardized data that has to be implemented across the four programs. There's the resource use and other measures that are stated in their domains, as well as the standardized data and the assessment instrument categories that you've heard — just heard a lot about. In addition, there's all kinds of requirements in the IMPACT Act for change of hospice services. There's reports that need to be generated and analysis.

There's a tremendous amount of work and — related to the IMPACT Act, some of it which fall upon the – our Government entities and it also – and some of it falls on the private sector for implementation. But most of the activities affecting providers will necessitate the implementation of the various requirements over time and in increments. So, there isn't an event.

There are many requirements, you know, as I was sort of describing, requirements of CMS as well, such as public reporting of the data, the development of the measures, implementation, engagement and measures application partnership, research reports, and so on and so forth. For your programmatic requirements, we encourage providers to ensure that they read our proposed and final rules. And as time goes on and we near the implementation of various aspects of the requirements, that providers watch for LISTSERV announcements and follow our website updates and attend our Open Door Forum calls, vendor calls, trainings, and so forth.

In addition, the CMS IMPACT webpage is a helpful resource for monitoring IMPACT Act implementation-related activities. So really, it's a matter of – of keeping pace with the information as it's sort of brought forward.

Amanda Barnes: Wonderful, thank you.

Our next question is: Will there be PAC provider training on the IMPACT Act requirement?

Stace Mandl: Hi, this is Stace Mandl again, and I'll respond to that question. CMS has already started hosting and intends to continue to host PAC provider Train-the-Trainer sessions regarding changes in the standardized assessment data elements and the update — the assessment instruments, for sure, including how to properly code the new required items in the assessment instruments. We also intend to provide additional training resources such as YouTube videos, webinars, and downloadable information, including educational slides. We'll also be hosting training sessions regarding the IMPACT Act requirements related to the post-acute assessment data elements and the interoperability aspects of it. That was just also described in great length.

So, please monitor the CMS Act webpage, as well as the quality reporting program-specific webpages for upcoming training information. And if you haven't already done so, I would suggest signing up for the LISTSERV announcements for the Open Door Forum calls and then making sure that you're receiving the eNews through MLN. Thank you.

Amanda Barnes: Thank you.

Our next question is: How will the content of the PAC assessment instruments change as a result of the requirements of the IMPACT Act?

Jennie Harvell: So, this is Jennie Harvell. I'll start. As you've just heard, the IMPACT Act requires that CMS standardize, that is, align, certain post-acute care assessment data elements that are specified in the quality measure domain and assessment category. CMS intends to standardize data elements across the post-acute care assessment

instrument so that there will be greater comparability of data to support quality measure comparison, the transfer of health information across care — care settings, supporting care coordination and payment reform.

It is important to note that CMS anticipates that there will be a need for assessment-specific data elements to also persist so that providers may address the care delivery needs of the patient population that is unique to the particular provider type, such as skilled nursing facility or home health agency.

Amanda Barnes: Thank you.

Our next question is: Will the CARE instrument be used in implementing the IMPACT Act? If so, how?

Dr. Tara McMullen: Good afternoon, this is Tara McMullen. The Continuity Assessment Record and Evaluation Item Set, otherwise known as the CARE Item Set, was developed for use in a CMS demonstration and evaluation program. CMS, its measure developers, assessment developing – development contractors, technical expert panels, and the public utilize the CARE Item Set as a portfolio of tested items, which are evaluated for use in quality measures and in cross-setting applications to meet the standardized data requirement that are nested under the IMPACT Act. The CARE Item Set, also known as the CARE tool, serves as a resource.

Amanda Barnes: Thank you.

Our next question is: Could you please list in order all the items that are included under the IMPACT Act? I am getting conflicting views. For example, quality measures, please list each one, RTA, other items. I just think that it's the QM.

Dr. Tara McMullen: Yes, yes, OK so, Jennie in slide 1 or 2 listed and so – to what's mandated under the IMPACT Act. But this is Tara McMullen. I'm going to reiterate, kind of, the two major crux of the IMPACT Act. So, the Act — the Act itself mandates for the development of standardized quality measures for post-acute care and the standardization of data items nested under clinical assessment categories.

So in short, the implementation of quality measures fall under two domains. The first major domain lists five quality measure categories. The first category is skin integrity and changes in skin integrity. Second category is functional status, cognitive function, and changes in function and cognitive function. The second category is medication reconciliation. The fourth — or the third category — the fourth category is incidence of major falls, and the fifth category is the transfer of health information and care prefer — care preferences when an individual transitions.

There's also the domain of resource use and other measure domain, and there are three measure categories under that domain. They are the resource use measures, including total estimated Medicare Spending per Beneficiary, the Discharge to Community measure category, as well as a third category, the all-condition risk-adjusted potentially preventable hospital readmission rates. There is also, under the Act, a mandate for the standardization of data items. And again, those are implemented under specific assessment clinical categories.

In short, clinical categories for the standardization of data items are functional status, including self-care and mobility; cognitive functions, such as ability to express ideas, to understand, mental status, depression, and dementia; special services, treatments, and intervention, such as the need for ventilator use, dialysis, chemotherapy, central line, and PPN; medical conditions and comorbidities, such as diabetes, congestive heart failure, and pressure ulcers; impairment, such as incontinence and impaired ability to see, hear, or swallow; and other categories seen necessary by the Secretary.

Amanda Barnes: Thank you.

For Section GG – girl – as GG, G as in girl, G as in girl, of the MDS, will this be based on only therapist input, or will it need to be a collaboration of all disciplines in this stiff environment?

Dr. Tara McMullen: So, thank you, Tara McMullen once again. CMS does not proscribe who is to perform these functional assessments for the items that are nested in Section GG. We ultimately defer to providers for who should — who, in turn, should follow their State and local regulatory requirements.

Amanda Barnes: Thank you so much. Now our subject matter experts will take your questions about connecting post-acute care across the care continuum. Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, we ask that you limit your question to just one. All right, Kalia, we're ready to start.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Betty Hardesty.

Betty Hardesty: Hi, when patients are transferring from one level of care to another, how is the information getting to them, and what is the timeline for that information getting to them? Thanks.

Stace Mandl: This is Stace Mandl. I'll sort of tee this up for the team. So, just some points of clarification. CMS is taking great actions here to enable the transition of health information across providers as they are able to. And so, there isn't a sort of timeline requirement for that at this time.

So, I just want to make sure that that's clear. And this is not an unusual or a new activity. It's been going on for quite some time. We're just sort of helping to facilitate the engagement in that activity for timely information transfers. So, I'll turn it over to the team.

Jennie Harvell: So, this is Jennie Harvell, and what Stace said is absolutely correct. There are no requirements for using particular document templates for the transfer of health information in terms of the IMPACT Act requirements. However, as part of the CMS supportive activities in the library, CMS will be linking the post-acute care assessment data elements to different health IT standards, for example, different document templates that could be used to support the exchange of that information.

We will be pointing to nationally accepted health IT standards that have been identified by the Office of the National Coordinator in its health IT requirements. So, for example, there are different document types that ONC has highlighted in its various rules and advisories, for example, a care plan document or transfer of care document. And so, we will be linking to those document types and making that — those linkages available to the public.

Terry O'Malley: And this is Terry O'Malley. Just a comment on the standard of, really, timeliness; when do you need the information? This is a great example of something that's really outside of CMS. CMS is keying up the platform to help you get the information moving. But how you get the information and when you get the information, that's something you have total control over by negotiating with your treatment partners. So, if the hospital is sending a patient to a SNF and you get the information a day late, that's not good. And you won't accept it, and you shouldn't accept it. But that's a standard you can impose within your own, you know, Accountable Care Community. Just figure out what you need and when you need to get it, and that's a nice place to start in pulling your system together.

Amanda Barnes: Thank you. Next question, please.

Operator: Your next question comes from the line of Wendy Wintersgill.

Wendy Wintersgill: Yes. Will there be a way to measure staffing patterns and staff mix? If we're now going to be able to compare apples to apples, the different post-acute care settings, how will we accommodate for differences in staff mix?

Dr. Tara McMullen: Hi, Wendy, it's Tara McMullen. Thank you for that question. So, it's a great question, and it's something that CMS wrangles with often when we're talking about quality of care outcomes. As we know, the center of all these quality measurement situations is workforce. Workforce is handling that. So, as we move through developing quality measures, we will most definitely take into consideration workforce, including caregivers, paid caregivers, direct care workers, and so forth. We do collect for —different types of staffing information for many of our settings, including nursing homes.

In partnership with survey and certification, we do analyze different staffing patterns, and we hope to utilize or leverage that type of data in the future with the measures that we're developing to meet the mandate of the IMPACT Act.

Amanda Barnes: Thank you, next question, please.

Operator: Your next question comes from the line of Thorrenna Lewis.

Thorrenna Lewis: Hi, this is Thorrenna Lewis, and I'm from Navarro Regional Hospital which is an acute care setting. I've been listening to you all talk about transition of information, and we are actively working on that with discharge rounds on that. But we're running into an issue with some of the Medicare patients, including your disabled patients, that we set up home care and we get everything in with the home care company. And this is just an example, but home care goes to see the patient and the patient won't let home care in. How do we document that, that this is the patient's choice not to follow through on the discharge claim? How are we going to be able to validate that we set it up, but the patient's using their choice and saying no? And how does that not — come back and get us and the home health care company?

Amanda Barnes: One second, please. One moment, sorry.

Dr. Tara McMullen: So, thanks. That's a great question. It's good when we sit in a circle and go, oh yes, yes, that's a good question. So, this is Tara McMullen. We definitely appreciate that.

So, the way that we perceive your question is, is, there's a fine line between the quality of services that are given or rendered and what's going on with the claim, AKA payment, how your claim's being — what services are triggering that, and what happens post-discharge. This is something that we are definitely going to have to look into as we develop our resource use measures, like that of Medicare Spending per Beneficiary,

these issues — they become real. And we'll have to figure out a way to disentangle these types of issues as a person transitions through the care continuum.

And I'll turn it over to my colleague Jennie Harvell to add input on this one.

Jennie Harvell: Right. And so, just to be clearer, the purpose of today's conversation was talking about the IMPACT Act requirements related to data element standardization and the requirement that CMS link post-acute care assessment data elements to health IT standards. And CMS – and so we talked about all of that. And so, CMS will be making available to the public reports that will support the provider's, for example, ability to exchange information.

We're not talking about the patient's right to refuse services today. We are not talking about the patient's right to refuse services and what happens when a patient refuses services. Today's presentation was describing the IMPACT Act's requirement for providers to submit standardized assessment data. And CMS is making available to the public information related to health IT standards and those data elements.

Thorrenna Lewis: I understand that.

Jennie Harvell: Thank you.

Thorrenna Lewis: But — and I do understand that. But still we have to put the documentation down that validates what we're doing and how we're doing it. But again, if you get the — you get a claim from us that says we set this up, but then the home care company can't give you that, like you do now, can't — hasn't been able to provide their services within that 72 hours. Then we get dinged in the acute care setting that we didn't — we have to go back and change our — we get a penalty from you all. So, I'm just trying to figure out. Because this is part of this documentation that falls under these slides with future Accountable Care Community, social determinants, and that. That's where I'm coming from this from. It's like, OK, if we're doing what we're supposed to do and we're submitting the documentation we're supposed to submit, how do we validate this or how do we document this so it puts the onus not back on us but puts it back on the patient's choice?

Dr. Tara McMullen: Yes, yes.

Thorrenna Lewis: That's what I'm asking for, is that – for this documentation.

Dr. Tara McMullen: Right, totally. This is Tara McMullen again. I — we hear you and we understand it. We do appreciate the input in this comment, and it's not being dismissive. It's — this is an issue that we do work with and wrangle with, particularly when we're developing quality measures that really align the acute and the post-acute care worlds. So, thank you again for your comment. And please reach out to us and

submit these types of inputs. This is the type of input we need to hear. So, thank you again.

Amanda Barnes: And you can find the PAC Quality Initiative resource box on slide 55. Thank you so much. Next question, please.

Operator: Your next question comes from the line of Juliana Hart.

Juliana Hart: Hello everyone, and thank you for a really great presentation and such a difficult arena to move things forward in an organized way. One of the speakers mentioned that there's an — a newsletter. I wasn't sure if that was a specific IMPACT newsletter, but I can't seem to find it on my email subscriptions. So, if that could be repeated or sent in a link to the registrants or somehow connect me with that newsletter, I'd appreciate it.

Amanda Barnes: Absolutely, thanks for your question. So, this is Amanda Barnes. You can actually find the link to register for the MLN Connects Provider eNews. If you go to slide 62, you'll find more information about the National Provider Calls Program, and there's a link to subscribe to the eNews.

Juliana Hart: OK, I've got that one. I thought it was a more narrowly focused one on IMPACT. Thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Betty Hardesty.

Betty Hardesty: Hi again. I wanted to find out when a patient is going from one level of care to another again, there can be what look like changes in function, where they become — suddenly become more dependent when they get from acute care to acute rehab or from acute rehab to home health. But it's really just a difference in the conditions of observation. So, when I would complete the — my assessment, it may look different than a physical therapist at another level. How is that going to be accounted for when we collect the data?

Dr. Tara McMullen: Yes, hey. That's a — this is Tara McMullen. That's an excellent observation, and we were all nodding our heads around the table because this is quintessentially why we need standardized data items to collect standardized and uniform data, right? So that we are able to compare appropriately across different, you know, care settings what's going on with the person as they transition. And so, with the, you know, the functional measures that were proposed and finalized in the IRF and the LTCH and the SNF Fiscal Year '16 rules last year, they were proposed, and there's that Section GG that now will become a live specified application date 2016 for the MDS, the IRF-PAI, and the LTCH Care Data Set. Jennie alluded to this as well.

We're collecting items, use and reuse with the same scales, the same questions and response options, and, hopefully through the training, we're backending that type of – training for the providers where we are collecting and coding that information in the same way. So that we have information that's generalizable to one another coming in and basically talks to one another speaking the same language across the settings. What the team today was presenting on was backending that quality information and applying the appropriate standards to that information so that data becomes interoperable through many lenses.

So, precisely, there's an issue that we're not talking to one another, that we're coding function and collecting it and interpreting it in many different ways in many different care settings, and that kind of creates walls, right? We're siloing out the information that we actually need. It's critical for us to understand as a person transitions through the care continuum. It's almost like data needs to follow the person and that's what we're trying to do now through the IMPACT Act.

Amanda Barnes: Thank you so much. Kalia, we have one — time for one final question.

Operator: OK. And that question will come from the line of Christina Clark.

Christina Clark: Yes, good afternoon. How will the IMPACT Act affect critical access hospitals that utilize swing beds? Currently we don't use any type of standardized collection tool like the IRF-PAI or the MDS, yet we may function as inpatient rehab or a SNF.

Stace Mandl: Hey, this is Stace Mandl. You really want to follow the regulations associated with critical access hospitals and the data reporting. And there's a difference between the IRF units within critical access hospitals and swing beds. Specifically with swing beds – swing beds are called out in the IMPACT Act as included — you have to dig a little bit. You actually have to go back to the Social Security Act. But in the Act for swing beds of critical access hospitals, they are exempt. That's our interpretation.

Christina Clark: OK, great.

Stace Mandl: And — but for the IRF units of CAHs, you need to probably — I would just want to refer you back to the *Federal Register*, where we had included critical access hospitals. Those — what we call the R-units, the rehab units, they are included in the IRF program so just –

Christina Clark: OK.

Stace Mandl: Just check back in the regulation.

Christina Clark: OK, thank you.

Stace Mandl: OK.

Additional Information

Amanda Barnes: Thank you so much. Unfortunately, that's all the time we have for questions today.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these become available.

On slide 61 of the presentation you will find information in a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your call experience.

Again, my name is Amanda Barnes, and I'd like to thank our presenters and also thank you for participating in today's MLN Connects Call on the IMPACT of 2014. Thank you, and have a great day.

Operator: This concludes today's call. Presenters please hold.

-END-

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