MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
IMPACT Act: Standardization Patient Assessment Data Activities Call
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Contents

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 Leah Nguyen. Thank you. You may begin.

Announcements and Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects Call on the IMPACT Act – Standardized Patient Assessment Data Activities. MLN Connects Calls are part of the Medicare Learning Network®.

The Improving Medicare Post-Acute Care Transformation Act of 2014, or IMPACT Act, requires the reporting of standardized patient assessment data by post-acute care providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. During this call, find out about efforts to develop, implement, and maintain standardized post-acute care patient assessment data, including pilot testing results and plans for the upcoming national field test. A question-and-answer session follows the presentation.

Before we get started, I have a couple of announcements. You should have received a link to the presentation for today's call in previous registration emails. If you have not already done so, please view or download the presentation from the following URL – go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

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

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

At this time, I would like to introduce our first presenter, Dr. Tara McMullen, Senior Health Analyst for the Division of Chronic and Post-Acute Care. I will now turn the call over to Tara.

Presentation

Dr. Tara McMullen: Hi. Thank you, Leah. And good afternoon, everyone. This is Tara McMullen, and let's begin with our presentation.

You'll see with the slide deck that we have the first couple of slides – they address the acronyms, a short disclaimer on today's presentation, and the agenda. We will start with the first agenda item, which is to describe the goal of the IMPACT Act. It will be a short background of what is the IMPACT Act and why the IMPACT Act now. And then, I will turn it over to our team on the call to discuss the item standardization work and the field pilot.

The Goal of the IMPACT Act

On slide 5. As Leah stated, the Improving Medicare Post-Acute Care Transformation Act, or also titled for short the IMPACT Act, is a bipartisan bill, and it was passed on September 18th, 2014, and eventually signed into law October 6th, 2014 – passed through the House and the Senate and signed into law by President Obama. The IMPACT Act itself requires an abundance of really promising outcomes, such as improvements of quality of care, comparisons across PAC settings – that's longitudinal data comparisons for comparing a person across PAC settings as they traverse the PAC continuum, information exchange across PAC settings or enabling interoperability of data and data exchange, enhanced care transition, enhanced care coordination or coordination of care, person-centered and goal-driven care planning and discharge planning.

Moving into slide 6. Those said purposes or what the IMPACT Act enables also include improvement in Medicare beneficiary outcomes and the development of payment models based on patient characteristics and the development of longitudinal information to facilitate the said coordinated care.

Moving into slide 7. The IMPACT Act covers four care settings in the post-acute care continuum. They are skilled nursing facilities or SNFs, home health agencies or – we'll call them just home health – inpatient rehabilitation facilities or IRFs, long-term care hospitals or LTCHs.

Moving into slide 8. The IMPACT Act lists an abundance of activities in which CMS is to undergo – work to undergo to meet the IMPACT Act. So, really, one of the vast or the widest array of activities that CMS is undergoing is the work around the standardization of quality measures and standardization of domains for item standardization. So on this slide, first you'll see categories that are required, as said by the act, for the use of standardized data. And the categories are Function, for example, self care and mobility; Cognitive Function, for example, the expression and the understanding of ideas – mental status, depression, and dementia are examples of that; Special Services – treatments and interventions, for example, the need for ventilator, dialysis, chemotherapy; Medical Conditions and Comorbidities – for example, diabetes and heart failure; and Impairments – for example, incontinence, the ability to hear, see, or swallow.

Moving into slide 9. The IMPACT Act also identifies domains for quality measure. These quality measures – domains are functional status, cognitive function and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; incidence of major falls; and the communicating and providing for the transfer of health information and care preferences of an individual when the individual transitions. For today's presentation, we're focusing on the categories as delineated on slide 8.

So moving into slide 10. So as we stated prior, there are four post-acute care settings that are mentioned or really the focus of the work for the IMPACT Act: SNFs, home health agencies, IRFs, and LTCHs. These settings use different assessment instruments to be able to collect and report on quality data – on quality measures and domains in each care setting. So, we'd like to show you on this slide that for skilled nursing facilities settings, the assessment instrument in which CMS is working to standardize data items and assessment instruments is the Minimum Data Set. For home health agencies, the assessment instrument for standardization work or work towards is the Outcome and Assessment Information Set or the OASIS. For IRFs or inpatient rehabilitation facilities, the assessment is the IRF-PAI or the IRF Patient Assessment Instrument. And for long-term care hospitals or LTCHs, the assessment instrument is the LTCH CARE Data Set, or we call it the LCDS. And we'd like to have a note here that overlapping domains and purposes for those specific items – they differ across settings.

So moving into slide 11. This is just a fun graphic we – this is one of our favorite graphics. We like the coloring of it, we usually say. But the graphic is rich in detail, really showing or illuminating that with standardization of– in multiple settings with multiple assessment instruments and multiple routes of collection of data that we're able to get to an ideal state, that ideal state where we're able to assess for appropriate coordination of care, improved discharge planning, creating those longitudinal data sets and information to look at beneficiary outcomes, comparable data to look at what's going on with the patients and their characteristics, to look at payment models. And to get to those outcomes, we need to meet right in the middle of this glorified Venn diagram to see what we call the ideal state. That's, to us, what uniformity is. And we like to talk through in this graphic that uniformity is the ideal state, and that's why the IMPACT Act exists. We're working towards that ideal state.

And on slide 12. To work towards this ideal state, there's a lot of work that needs to be done. And we like to demonstrate here that – showing Section GG, which is our functional assessment. And you'll see that in the MDS, in the IRF-PAI, and the LTCH CARE data set, that a data item and the collection of those items or quality measures or for reporting purposes, for risk adjustment – there's a lot that goes into it.

And a data item has many uses. A data item can be used for care planning and decision support. It could be used for quality indicator or quality improvement purposes. It could be used for a payment. It could be used for reporting. It could be used for care transition. And a lot of work goes into the development of one item or a set of items to develop things like measures or just for item standardization. CMS really works through choosing items that are clinically appropriate, analytically sound, usable, feasible, really items that are interchangeable, items that could be used for all the purposes as delineated on this slide.

So we – what we are driving home here is that in this work, it takes a lot of time to develop the items for standardization or items that are used in quality measurement and that a lot of time goes into that because we're trying to make sure that not only items are clinically feasible, but analytically sound and that they meet all the intents of the element and response code graphic here. So at this time, I'm going to stop and turn over the presentation to Leah for keypad polling.

Keypad Polling

Leah Nguyen: Thank you, Tara. At this time, we will pause for a few minutes to complete keypad polling. Holley, we are ready to start polling.

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 one. 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 nine. Again, if you are the only person in the room, enter one. 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 nine.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Please continue to hold while we complete the polling.

Again, please hold while we complete the polling.

Thank you for your participation. I'll now turn the call back over to Leah Nguyen.

Leah Nguyen: Thank you, Holley. I would like to introduce our next presenter, Barbara Gage from RAND.

Presentation (Continued)

Dr. Barbara Gage: Thank you.

I'm going to take you through the next few slides. I'm the Co-Director of this effort, along with Dr. Maria Edelen, who will speak next on some of the results. So, as Tara mentioned, the focus on the RAND project is really on the development of the standardized data, those elements that were included on slide 8.

Timeline of Activities

If we move on to the next slide, slide 14. Our goal in this project is to develop, implement, and maintain standardized PAC patient assessment data. So, as Tara pointed out with that graphic, there are a lot of items on each of the respective tools that won't be standardized, but that overlapping group in the middle are the standardized items. So to determine what items should be standardized, we have three phases.

The first phase, which has been going on for the past year, is the information gathering. And we've been speaking with a lot of the clinical communities across the country that work with post-acute care populations to identify the appropriate items, the appropriate data elements that target the categories mentioned on slide 8. That work has evolved and will evolve into pilot testing to test the feasibility of the proposed items. We have two different pilot tests, Alpha 1 and Alpha 2, which have already – Alpha 1 has been completed and Dr. Edelen will be presenting on some of the results from that, and Alpha 2 is just going live.

The results of the two pilot tests will then be used to identify data elements to actually be tested in the national beta test, which begins this fall. This will be a nationally representative sample where we can test the reliability of the items whose feasibility had been tested in one of the earlier alpha tests. So, as I mentioned, we're focusing on six domains under this work. We're looking for standardization of items under cognitive status, mental status, medical conditions, impairments, care preferences, and med reconciliation. And as you know, the last two categories have much less consensus across the different field than the others. So there's been a great deal of developmental work and a lot of input from the different communities, for which we're thankful.

Slide 15 shows – gives the big picture of this project. So, we started in September 2015 with some information gathering. We've had some focus groups. We've done case studies in the different settings, each of the four post-acute care settings. We've had ongoing special open door forums. These are quarterly forums, which I know many of you have sat in on in the past. And as you see, they'll continue quarterly throughout the course of this project. We've also had a lot of input from our subject matter experts. These are different clinicians that practice in the different topical domains. They work in the area of cognition or they work in the area of medical treatments. And when we talk about the standardization, we have different experts that are representing different

levels of care so that we have a good conversation about what's appropriate to be measuring.

And then we've also had two technical expert panels at this point to present some of the results from the first alpha test, get some feedback, think about the items that need to go into the second alpha test. If you go back to the top of this chart, you can see the activity that's underway following the information gathering. We had the first alpha test in late summer of last year. We then issued a blueprint public comment where CMS requested public comment on a set of items that were being considered for standardization. We then went into the Alpha 1 data collection. That work continued – as you can see, the ongoing public input. We've just now started the Alpha 2 data collection. We had trainings last week. There'll be a public comment period to get feedback on the proposed items as we're going through this process. And then, by September, we'll be going into the national beta testing.

So one thing to keep in mind as we go through this presentation is how to get involved. And Terry Moore, our colleague from Abt, will be speaking to some of that at the end. There is a lot of opportunity both for public comment as well as participating in the beta test if you have not already participated in one of the alpha tests.

So, I'll say a little bit about each of those stages.

Slide 16 talks about the information gathering. You know, we worked with the – to identify the candidate data elements, we used the literature, we used focus groups, technical expert panels. We've had ongoing stakeholder engagement of various types. And we always welcome input at the PAC Quality Initiative mailbox.

We've had the candidate data elements – because we are trying to maintain – limit the number of items that are standardized and make sure that they really need to be standardized to follow a patient's complexity across the four different levels of care, the most intensive LTCHs to the less intensive SNFs and the mixed populations in the home health agencies. Every element that gets suggested in one of those six categories is assessed for its potential for improving quality, as well as its validity and reliability. And that's why the beta test is so important. You don't want to use an item in any of these efforts if it's not reliable and valid.

We've also taken into consideration the feasibility for use in post-acute care. And that's part of the goal of the alpha tests that have been done so far. And the items should also be useful for describing case mix, because if you think about the quality metrics and the payment models that the IMPACT Act requires, you want a standard way of describing somebody's complexity if it's a factor that's going to drive a need for difference in treatment resources or expected outcomes.

So slide 17. We have three types of data elements that we've been focusing on with this work. The first track were the easiest out the door. There's already strong evidence for certain items for their feasibility and their reliability in all four PAC settings. They were tested. Many of them were tested in the PAC payment reform demonstration that quite a few of you participated on in the past. And they were posted for public comment in August. So, that was the first group of items. And you can look back at the August materials to see what's in there.

The second track of items are items that are rated highly by our technical expert panel last April and by stakeholders, but we needed to test their feasibility in the post-acute care setting. And we are testing them in the cross-setting PAC facility field test. So, that second group of elements is important for the Alpha 1 and the Alpha 2 – the Alpha 1 data elements.

The third track are the even less consensus-based items that are in our Alpha 2 test. So we identified and developed them during the summer and fall following the development of the Alpha 1 group. They were all rated highly by the technical expert panel that we held last January and by different stakeholders. And we'll be testing them as we move forward.

So if you move to the next slide, I'm going to pass the baton to Dr. Edelen from RAND, who will talk about some of the results from the Alpha 1 testing so far.

Alpha 1 Results

Dr. Maria Edelen: Thanks, Barb. Hi, everybody. My name's Maria Edelen. I'm a psychometrician at the RAND Corporation and am directing the project. I'm just going to cover some information about the Alpha 1 field test, which we conducted last August through October, and then I'll pass it back to Barb.

So starting on slide 19, we conducted the Alpha 1 field test – we were in the field from August through October of 2016. And we were in eight facilities, two of each provider type, in the Greater Hartford, Connecticut, area. And all together, we completed 120 admission assessments. And that averaged it out to about 15 per setting.

And as Barbara was saying, the goal of this test was to evaluate the feasibility of some of these data elements that we identified as promising but just didn't know how they were going to perform. So the design of this data collection was that all of the assessments were double coded. So we had trained research nurses that we had – that were hired by RAND and not affiliated with any of the providers but – so four of these research nurses worked together with the facilities staff to double code all of the admissions that came in – for those who were eligible – admissions that came in during the field period. So these 120 admission assessment were double coded by both the facility staff and the research nurses. And this allows us to get just a kind of a preliminary sense of the interrater reliability and then how – what's the performance like? How long does it take to complete these data elements? Are they missing? Are they difficult?

So, in addition to the quantitative data, we also wanted to get some sort of verbal feedback on the process from the assessors. And so we also conducted a series of debrief interviews with the facilities staff and the research nurses to just get more information about how things were going.

So slide 20 just gives you a sort of overview of the content of the data elements that we tested. And I'm going to – then, the next series of slides goes into more detail and shows you actual screenshots of each of the data elements that were in the testing protocol. But, just briefly are items – they included assessment of pain, hearing and vision, bladder and bowel continence, some aspects of cognitive function, an assessment of mood, also documentation of the medication reconciliation process, and, finally, some new questions about care preferences.

Now, I'm going to go into each of the data elements briefly. And, then, I'll go over some results at the end.

So slide 21 shows the data elements for pain. We first asked whether or not the resident or patient was experiencing any pain. And then if they said yes, that they had experienced some pain in the past 3 days, they got these questions. So we asked them

about the pain frequency, the pain's effect on their ability to sleep. And then for those who were in – who were undergoing therapy activities, we asked about the pain's effect on their ability to complete the therapy and then, also, the impact of pain on other activities that were not part of their rehab therapy. And, finally, we asked – for those who were – had some treatment or medication for pain, how much relief have they been feeling from the pain.

Slide 22 shows the data elements that we tested for hearing and vision. So, we set this up with some questions about the severity of impairment of hearing and vision. And, then, for those who had impairment – well, actually, for everybody we were asking as well whether or not they were using a hearing aid or appliance and whether or not they were using glasses. And, then, for those with severe impairment, we were asking their date of their last hearing test and/or the date of their last vision test.

Slide 23 shows some of the data elements that we used to assess bladder and bowel continence. And many of these were tested in the PAC-PRD and – but they – we didn't feel like they were ready to proceed to public comment without testing because of the way that they were presented in the PAC-PRD was a lot difference from how we were advised to assess them. And, so, because the format of the items was so different, these went into the feasibility phase.

So, for – these are – the ones on the screen here on slide 23 are about bladder continence. And so the first question is – the first series of questions is about device use. And if the patient or resident is using a device, there is a documentation of when it was placed, why it was placed, and whether the patient or resident needs help to manage the device. And then in the bottom right, you can see there's also an assessment of the frequency of any incontinent events and when these occurred relative to the current illness. And this is all typically completed by the staff not really as an interview question but just through their observations of the patient or resident and maybe looking at the chart.

Excuse me. Then we have corresponding items for bowel. This is actually – sorry – a little bit out of order. So, focus first on the right-hand column here on slide 24. So, similar to bladder, for bowel there's a series of questions about device used, when it was placed, and whether or not they need assistance with it, and then a question about the frequency of events and when that – events occurred relative to the current illness.

And, then, on the right-hand side – now, these are the new ones. So, there's – they're correspondant items for bowel, which are on the next slide.

But what I'm looking at now is the left-hand side of screen 24 where there's a series of – a handful of questions asking – directly asking the patient or resident as well as the caregiver, first their experience of bladder incontinent events and then how much of a problem or bother were the events. And then on slide 25 you see those corresponding questions to the patient and resident and caregiver for bowel incontinence.

Slide 26 shows the cognitive function items that we tested. And these are meant to evaluate executive function. The first question is just coding the patient or resident's success at what we call the trail-making task. And what it is is the patient or resident is given a piece of paper that has – it's just a picture of – it has the letters A through E in circles and the numbers one through five in circles. And the patient or resident is asked to start at one and draw an arrow to the letter A and then go from the letter A to the number two and then go from the number two to the letter B and then three, C, four, D, etc. And then the assessor just codes whether or not it was completed successfully and whether or not the person – if they couldn't do it, why couldn't they do it.

And then we also tested the serial seven subtraction tasks, which asks the resident to start at 90 and serially subtract by seven – subtract seven. And then the assessor just notes the number of successful intervals that they were able to report, up to five. And then there are two complex sentence repetition tasks. So here the assessor reads the sentence and asks the patient or resident to exactly repeat the sentence. And if they – if their first response is incorrect, they give two more tries to exactly repeat the sentence.

Slide 27 shows our assessment of mood or depressed mood. And this is a modification of the PHQ-9, which is currently being assessed as part of the MDS. And – but, in addition to the PHQ-9, frequently, the PHQ-2 is used. And, actually, the PHQ-2 was tested in the PAC-PRD, and it's also included as part of the OASIS. So, there are pros and cons to the 2 and the 9. Obviously, the 2 is shorter and the 9 – but the 9 gives you a little bit more information.

So the idea behind this setup that we had here was to sort of get the best of both worlds to the extent that that's possible. So we're using the first two questions to sort of screen for whether or not there might be a potential problem. And then if the results

from the first two questions indicate that the patient or resident might be having a problem with mood – with depressed mood, then the last seven questions are asked.

So – and the other thing that's sort of different about this is that the assessor first asks about the presence of the symptom and then asks – if they say yes, they've had the symptom, then they ask how frequently within the past 14 days have they been feeling that way. And so the assessor first asks about little interest or pleasure in doing things and feeling down, depressed, or hopeless. And these are the two sort of cardinal symptoms for depressed mood. And, typically, if you don't have either of these, then it's not likely – less likely that you're going to have a depressed mood problem. So these are nice candidates for a screener. So, we were testing out the feasibility of this in terms of the instructions and the coding. Anyway, I'll – we can talk a little more about how that went further down.

Slides 28 and 29 show a series of items that we developed to document the occurrence of a medication reconciliation process. And as Barb mentioned previously, this is really sort of breaking new ground. These are really – these were developed by our team in very close consultation with some pharmacists and physicians and other clinical advisors who've been really, really involved and helpful. But just sort of needing a lot of development work because it's so new.

So idea is that they identified five steps to the medication reconciliation process. And the 12 questions on slides 28 and 29 are meant to sort of reflect the occurrence of those five steps. So the five steps are obtaining the list of medications, comparing the list for multiple sources, adjudicating and deriving a final list of meds, communicating the correct list to patients and other stakeholders, and then, finally, notifying the pharmacy. So, as you'll see in a minute, we had a lot of issues with this protocol and made a lot of revisions. It was tough for people to conduct.

Slide 30 shows – let's see – the items that we evaluated having to do with patients' preferences for care. And the first had to do with the presence of an advance care directive and then a question about whether or not the patient wanted the involvement of their family and friends in their decisionmaking. Then there were a series of questions about the patient or resident's goals for care. And these actually didn't do very well. I think we ended up dropping them. But these are about the importance of being physically active, of being mentally involved, emotionally healthy. And then, as you go to

slide 31, you see a final one about how important is it to be socially involved? And then, finally, there were preferences – more preferences about decisionmaking, but it was more about the patient, how involved does that patient want to be in their – in the decisionmaking of their own health?

Slide 32 attempts to summarize the results – the quantitative results from the Alpha 1 field test. So on the left-hand side, you can see the domain for the data elements. And then the next column shows the data elements that I just reviewed with you. So for pain, we had severity; frequency; effect on sleep, activities, and therapy; and relief. The next column shows the reliability, which was that interrater reliability. So that just means how similar was the facility nurse's rating to the research nurse's rating. And these numbers go from 0 to 1. Actually, I think they can be negative. But you don't – you want them to be around – you know, you want them to be close to 1 and something around 0.7 is actually sort of what we are looking for.

So as you can see – oh, and, then, the final one that we documented on this slide was how long it takes to complete because we're really acutely aware of the burden that even one of these data elements is going to place on providers. So we want to make sure that they don't take too long to complete.

So as you can see, most of the data elements showed pretty good reliability, excellent with the exception – very notable exception of medication reconciliation where the reliability was really low. And part of this was just, we think, an inability to find the information in the chart or looking in different places for that information. So the two coders just weren't getting the same answers.

And there was also a – there was an option to say the information is not available and, also, an option to say no. And a lot of coders were getting – you know, were using those codes sort of indiscriminately. And so, some people might say "No" where others would say "I don't know; I couldn't find it." Anyway, there were a lot of problems with that. And also, as you can see in the rightmost column, this was an extremely time-consuming set of questions to complete.

The other data elements mostly looked okay for time to complete. I guess, 6 – you know, taking 6 to 7 minutes is a little high. So the care preferences were a little high and even the mental status, the PHQ-2 to 9. But you can see here that the screening – you

know, this hybrid approach really helped because we were able to ask the PHQ-2. And so, for those who screened negative, it only – you know, you were done in 1 or 2 minutes. And for those who screened positive, you kind of want to spend a little more time with them and find out what's going on. So, although that averaged about 6 minutes, it was a large subset of the population that was actually getting those questions.

Slide 33 gives just a little bit of what we heard in our debrief interviews with the assessors. So with pain, there were just no issues. This was straightforward. It was easy to complete.

For hearing and vision, there were some issues around the instructions and the wording of the items. And also there was a lot of confusion about the date of the last exam. And we've actually subsequently decided not to move forward with those questions because we felt that they were much more trouble than what they – you know, their value was not worth the trouble it was taking to collect that information.

For bowel and bladder, we weren't getting completely consistent information from those interview questions. The patients and residents were saying slightly different things than the caregivers. But those were kind of the idea. It was to try to triangulate that a little bit if you can do that with two people.

And then for cognitive status, even though the cognitive status executive function items really performed well quantitatively, there were a lot of issues about just implementing it, like the nurses were having difficulty exactly or consistently following the instructions. And it was – some of the patients – some of the questions are sort of difficult and – I mean, cognitive assessment is tricky anyway. It's a sensitive area and a lot of patients and residents sort of resent being asked or get frustrated when they realize they're getting things wrong.

And so, for example, that sentence completion, the person is asked to repeat the sentence. And, then, if they get it wrong, the assessor says – the assessor doesn't say, "That wasn't quite right. Do you want to try again?" The assessor just says, "Can you try again?" And then the patient gets a little unnerved by that because they thought they got it right the first time. So we were just hearing a lot anecdotally that there was some confusion by the assessors and then frustration – some frustration by the patients and

residents who were being asked these questions. But, on the other hand, they performed really well and also seemed to add some value to our understanding of executive function.

The mental status questions for the mood, the PHQ-2 to 9 mood section – there was a little bit of a trouble with moving from the 2 to the 9. And so, again, just learning a lot about how we need to clarify our instructions so that these mistakes don't happen again.

And for the medication reconciliation, the comment indicated several revisions and instructions. And the group was working almost – after like the first debrief interview, we got some signal that, you know, that this needed some work. And so, we were working on it really from September through like last month trying to get things revised and cleaned up to be refielded in our Alpha 2 test.

And, finally, for the care preferences, they were relatively straightforward overall. But, as I said, those important questions, they ended up – there was almost zero variability. Everybody just said that everything was important to them. And after discussing with advisors and with the TEP and with other people, we decided to not proceed with those questions because they weren't really giving us any unique information.

So, I guess, I've indicated a little bit already what's on slide 34. We used the empirical results in addition to the qualitative results to inform improvements to the data elements and the instructions and we are – we revised them. So – and we also identified some that really just weren't worth continuing with. And the revised data elements are going to be – some of them are being tested in Alpha 2. Some of the revisions are really, really minor like a slight change in wording on the continence items, and we didn't feel like that involved additional feasibility testing but that we wanted to make that change prior to the national beta test if indeed we decide that it's going to go forward to that stage.

So the revised – so some of the revised data elements are being considered for inclusion in beta. Some of them are in Alpha 2. And all of them will be posted for public comment, which actually – this says May. It opens – public comment – keep your eye out because this going to open at the end of April. And it's going to include all of these data elements

plus all of the data elements that are about to go into the field for Alpha 2, which Barb is going to talk about, I believe, starting on the next slide.

Thanks.

Alpha 2 Progress

Dr. Barbara Gage: Okay. Thanks, Maria.

Yes. So, if we go to slide 35, I'm going to talk a little bit about what's coming up. So slide 30 – I'm sorry – slide 36.

The Alpha 2 field test is currently underway. We are in three U.S. markets: Houston, Texas; Chicago, Illinois; and Denver, Colorado. This test is a little bit bigger than the Alpha 1. We have 16 organizations participating: four LTCHs, four IRFs, four SNFs and four home health agencies. We're collecting three different types of assessments. We'll be collecting on 120 cases a set of observational items. So, rather than interviewing the patients or simply relying on the charts, these are items where the patient is unable to communicate and currently each of you have some type of observation. So we're testing some standardized versions of observations on pain and some of those areas. We'll also be collecting 120 assessments for admission and 60 assessments for discharge. And, again, Alpha 2 is a feasibility test like Alpha 1. So, it is building on Alpha 1.

Slide 37 talks about those items that Maria mentioned needed revision. The med rec items, some care preferences are being tested. They were changed substantially and are being now tested in Alpha 2 for feasibility. We also have some new items of testing cognitive function, getting at more of the executive function areas. We've had a lot of recommendations from the different clinical communities on existing and proposed practices for measuring executive function. So, we're testing the feasibility of those in Alpha 2. And then the observation items, as I mentioned – pain, cognitive function, and depressed mood. So, Alpha 2 is underway and will continue through July.

On slide 38, you see that we'll be looking – the purpose of Alpha 2 is to determine the feasibility of the items using the same criteria that we listed at the beginning. We're looking at the corresponding results between the RAND research nurse and the organizations' nurse assessors. Like we did with Alpha 1, we're looking at the time to complete and we're looking for qualitative feedback from the assessors. So we'll have

both empirical and – both quantitative and qualitative results, as well as an understanding of the time to complete on the different items.

The report from Alpha 2 will be prepared in early fall. And following that analysis, we'll be holding a webinar for the participants to review the results and think about the lessons learned from the field test. And we similarly held a webinar for our Alpha 1 participants. So, it's really worth it to be involved and give us your direct input on the items, on the use of the items, the problem – potential problems.

So, that's what's happening. If you look at slide 39, this is what's coming up. And this is where we're really opening the door for provider organizations across the country to get involved in a large-scale reliability test of the items. So, our goal for the beta test which will be starting in October and running through May is to get a national sample that looks at – that reflects the U.S. provider and patient or resident variability so that we have the appropriate number of for-profits and non-profits, of hospital-based and freestanding LTCHs in all of the different parts of the country, IRFs in all the different parts, etc.

So the data from the national test will give us setting-specific reliability and validity data. So not just feasibility, but now we're going for large-scale reliability on those items that come out of the Alpha 1, Alpha 2 tests and are proposed for national testing, including the feedback. So public comment is very important. We – as Maria pointed out, there was opportunity for public comment throughout the Alpha 1 process. There will be throughout the Alpha 2. And as we go into the beta – it will affect what goes into the beta test.

So, I'm going to say a little bit about the design of the best test, and then pass it over to Terry Moore to talk about the recruitment.

So, the beta test – as I mentioned, it's national. We are going to enroll 210 organizations from 14 different geographic metropolitan areas. And as you can imagine, a geographic area has a pretty wide spectrum. So it's a 2-hour radius around identified areas. We'll be enrolling 28 rehab hospitals, 28 LTCHs, 84 SNFs, and 70 home health agencies. And that reflects the distribution of post-acute care providers across the country. We'll be going into each of the markets and looking for two rehab hospitals, two LTCHs, six SNFs, and five home health agencies, although that exact number may vary by market given that

some markets have more and some have less. But, on average, that's what we're looking for.

Providers will be randomly selected. So, we are going into the market areas and doing a random draw of providers. Some of that work is underway and, I think Terry will be saying a bit more about that. The patients that are in the participating hospitals and facilities and agencies will be enrolled upon their admission. We'll be collecting both admission and discharge assessments on them. And on a subset of patients, we'll be having IRR tests. So, there'll be both research staff and facility staff paired up to evaluate the reliability of the data collected.

So, on that note, I'm going to pass it over to Terry Moore from Abt, who's heading up our recruitment team. And she'll talk a little bit more about where we're going and how you can get involved. Terry?

Plans for Beta Test

Terry Moore: Yes. Thanks so much, Barb.

On slide 41, you can see – Barb just mentioned that we've done a random selection of post-acute care providers across 14 metropolitan areas. On the slide, 41, you can see those areas listed. These represent nine different geographic regions. So, we've got Boston; Chicago; Durham, North Carolina; Fort Lauderdale, Florida. In Pennsylvania, we've got two areas: Philadelphia and Harrisburg; two in Texas: Houston and Dallas. Excuse me. We have Phoenix, Arizona. And we've got a couple areas in Missouri: Kansas City as well as St. Louis. And, then, we've got San Diego and Los Angeles, California. So those represent the geographic areas or markets from which we'll recruit. If you are a post-acute care provider on this call – and there's lots of you on this call – and you're in one of these markets, these metropolitan areas, we hope that you'll consider participating in the national beta test.

A couple of slides down, I'm going to show you an email that you can use to express your interest. So you'll see that shortly. But, if you are in one of these markets, we're really appealing to you and we hope that you would agree to participate.

On slide 42, we present many benefits to participating in the national beta test. They're all listed here. In particular, you know, Maria just did a very comprehensive look for you

at what we've done in the Alpha 1 test and what we've learned. These – if you were to participate, this kind of information – number one, you have access to early information about the data elements that are being tested. You'd have that level of detail that you just saw about the testing that happened in Alpha 1. And your staff is basically – would basically be providing input and comments to CMS, as well as the project team, on do those elements work? How long did they take to do? You'd have the opportunity to participate in and have an influence over this eventual set of what will be mandated data elements.

So, there are many benefits to participating in the beta test, and that's just one of them. We also think that if you're a participant, you can really be seen among your peers and your networks as really on the cutting edge of quality and being – you know, your staff would be being trained in what the new elements – data elements might be and a little bit ahead of the game. So, we hope that you see that those are – there are several benefits to participate.

How To Get Involved

In terms of getting involved in the project, if you go to slide 43, we have a number of – we're engaged in a number of outreach activities that are intended to spread the word about our work, both the work that's been presented here and the upcoming national test. We have a series of stakeholder meetings planned for April. Those would be with your post-acute care professional associations, corporate colleagues, any PAC stakeholder essentially. We are trying to do some outreach to spread the word about what the beta test is all about.

Our project team, with CMS, has attended and hopes to continue to attend several post-acute care industry conferences. For example, we presented at the American Medical Rehab Providers Association last week, again, just trying to get the word out about the project and about the opportunity to participate. In terms of public comment, both Maria and Barb have already talked about the importance of providing comment on our proposed data elements. And recall that Barb showed you the timing of the blueprint public comment period. If you – if you downloaded your slide deck, go back to slide 15 and you'll be able to see when those upcoming dates for future comment are.

And, also, Maria mentioned that there is an opportunity at the end of April for formal public comment. I'll show you an email very shortly that if you're not already on the

Listserv or getting notifications about these kinds of opportunities, you can sign up and be added to the Listserv. So I'll show you how to do that. Okay. I think, those are the opportunities that we wanted to talk about.

On slide 45, we have a summary of what to expect for the beta test recruitment and the data collection effort. We talked a little bit about timing, but let me give you a little bit more specifics.

We will be sending out mailings to eligible post-acute care providers in those 14 markets. And we expect to send these recruitment packages out in late April and early May. This will be your call or your invitation to participate in the beta test. The staff in – at Abt Associates will be calling you and asking you to participate, walking you through the package, answering any questions. We also have some webinars that we'll hold, informational webinars for groups of providers that are interested where you can all come together and hear our presentation at the same time, ask any questions you'd like. If that's a preferable way to learn more about the project, we will be offering that.

We'll be asking post-acute care providers who agree to participate to identify your clinical team of assessors who will participate in the project. Those folks will be trained and learn how to use the data collection protocol to learn what the data elements are through all the instructions for collecting the data elements that we'll ask you to collect in the beta test. We'll get into the field with those of you who participate, beginning in October, and that will run through May of 2018.

And early next summer, once data collection is through, we'll ask those of you who have participated to participate in a series of debriefing meetings. And these are to give us the kind of feedback, again, that Maria shared with you from the Alpha test – what took too long? What was cumbersome? Could we do better on the instruction set for those items that work well but just seemed a little confusing? So all of that input is taken into account as we make our recommendations to CMS about going forward with a set of mandated data elements.

On slide 46, you'll see the email addresses that I promised earlier. If you aren't already on the Listserv and you want to be able to comment, you want to be able to express your ideas about this project or about any of the data collection that's going on, you can go to pacqualityinitiative@cms.hhs.gov. If you have general inquiries about this project

that we just described, what we have done before, what we plan to do, we have the Impact...

Leah Nguyen: Terry, are you still there?

Dr. Barbara Gage: Terry, did you go on mute?

Leah Nguyen: Barb, do you want to take over?

Dr. Barbara Gage: Sure.

So, as Terry was mentioning, we have the three different mailboxes. Many of you have already been using the pacqualityinitiative@cms mailbox, and please continue to do so. For comments on the – or questions about the project, RAND has set up the mailbox impactact@rand.org. These are on slide 46. And if you want to get involved in the field testing or you want information about the recruitment, Abt has set up a mailbox impactsignup at Abt Associates.com. Please do feel free to use that. If you're in one of the 14 markets, feel free to submit your email asking for more information or asking to get involved. As I mentioned earlier, providers will be randomly selected. But we have a very large list that covers the 14 markets. So, if you're in one of those and you want to get involved, please do send Abt a note at the impactsignup at Abt Associates.

Then, the last two slides are really standard MLN information, so you can find more information on the IMPACT Act or the PAC quality reporting.

And I'll turn it back to Tara to – well, the very last slide is very important. We want to thank you for attending today, and we look forward to hearing you questions and answering them.

So, I turn it back to Dr. McMullen at CMS.

Dr. Tara McMullen: Hi, everyone. Thank you, Barb for that. And thank you, everyone, for the presentation.

At this time, looking at the time on the clock, we are going to open it up for Q&A. But, just a note about Q&A. We received an abundance of questions from everyone calling in

today and listening in, and we thank you for those questions. At this time, CMS is in a formal rule writing process, which means that we are limited in what we can discuss about future directions for item standardization or quality measurement or really just work in general. However, we are open to discussing questions that pertain to today's presentation and the work specifically discussed in today's presentation. We are limited to discuss anything outside of that. And we thank you for that consideration.

And I am going to turn it over to Leah now.

Question-and-Answer Session

Leah Nguyen: Thank you, Tara.

Now, our subject matter experts will take your questions. 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. If you would like to ask a followup question or have more than one question, press star, one to get back into the queue, and we'll address additional questions as time permits.
All right, Holley, we are ready to take our first caller.

Operator: To ask a question, press star followed by the number one on your touch-tone 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.

And our first question will come from the line of Laura Hughes.

Laura Hughes: Thank you. This is Laura with Maxim Healthcare Services. My question is actually a dual question. If the patient has both Medicare and Medicaid – they're still a Medicare beneficiary – I'm assuming that they would be included in this IMPACT Act and trial session?

Dr. Barbara Gage: Tara, would you like me to take that?

Dr. Tara McMullen: Yes, Barb.

Dr. Barbara Gage**:** Okay. Thank you for asking. I just realized we didn't put on the slides. Yes, all Medicare beneficiaries in Part A or A and B or Part C – regardless of whether they are dual eligible or not – will be included. Thank you for asking.

Laura Hughes: Thank you.

Operator: Our next question will come from the line of Eugenia Smither.

Eugenia Smither: Hi. My question has to do with the acronym used on slide 11. I didn't see it on the list. It's HCBS FASI. And I thought it probably had to do with home and community-based services, but I didn't want to make an assumption.

Dr. Tara McMullen: Hi. It's Tara McMullen. And, yes, you're right. It is home and community-based services and it is work we call FASI going on in that area. And good catch on the acronym list. We will make sure we add this acronym to the acronym list. Thank you for that.

Eugenia Smither: Can you tell me what the FASI stands for?

Dr. Tara McMullen: Yes. FASI. Barb, keep me honest on F-A-S-I.

Dr. Barbara Gage: It is the functional assessment standardized items. So, the HCBS FASI Initiative is part of the test grant program. And the Section GG items that have already been standardized across the LCDS, the IRF-PAI, the MDS, and the OASIS are being tested in the different waiver populations for applicability. You know, there we have young populations with intellectual and developmental disabilities as well as people with severe mental illness as well as the more typical Medicare beneficiaries, the elderly, the frail elderly, and the people with TBI and the people with physical disabilities. So...

Eugenia Smither: Okay.

Dr. Barbara Gage: Thank you.

Eugenia Smither: Thank you.

Operator: Our next question will come from the line of James Muller.

James Muller: Hi. James Muller from TSI. So, Tara, the study design samples only, metropolitan regions. Are you folks concerned about the bias introduced by excluding rural providers in that they do tend to have different data paths?

Dr. Tara McMullen: Hi. It's Tara. Thank you. That's a very, very interesting question. I think I'll turn it over to Terry Moore and Barb.

Dr. Barbara Gage: Terry, do you –I'll take the question. She may still be on mute.

So, the – thank you for bringing that up. As I mentioned earlier with – in talking about the beta tests, those are simply the geocentric locations. And we're talking about 2-hour radiuses around them. So, the final selection of providers will be stratified by rural and urban, as well as for-profit and non-profit, as well as freestanding and hospital-based providers.

James Muller: I would also add to increase your sample size a bit. It's a relatively small sample size.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Kate Stinneford.

Kate Stinneford: Hi. Thank you. I just have a question that relates to the measures. If there is not an appropriate answer there, how will somebody do it? For instance, in the hearing and vision, it asks if you have a hearing aid or glasses. What if you don't have either but you have severe visions problems that are obvious to the person that's interviewing you?

Dr. Maria Edelen: So, hi. This is Maria Edelen again. Thanks for that question. So, there is – there was a – there is a question that directly assess hearing impairment. And that's not included in this slide because we weren't specifically testing that question.

But, there is a question that asks whether or not the patient has impairment in vision and impairment in hearing. And then these questions were sort of followups to that. So, these aren't meant to convey a level of impairment. It's just wanting to document that they have an assistive device.

Kate Stinneford: Okay. And, then, for the same issue with the cognitive, will they have a choice of putting down if the patient has aphasia or apraxia so they're not answering but it's not that they don't understand it but they can't physically answer the question?

Dr. Maria Edelen: Right. So, again, this – so that's – it's a great question. You – these questions that I presented in this slide deck are somewhat out of context because there's a sort of a set of screening questions to determine whether the patient or resident is even able to answer these types of questions.

And, so, that's done first. And, then these questions – they don't even get presented unless the patient or resident screens through.

Kate Stinneford: Thank you.

Dr. Tara McMullen: Hi. This is Tara McMullen. Just to add to that question. And I'm joined here with our Deputy Director, Stace Mandl. We think it's a very interesting question. If you can send your input to our PAC quality initiatives email box – I believe we posted that on one of these slides here. I don't know which slide off the cuff.

Leah Nguyen: Forty-five.

Dr. Tara McMullen: Forty-five. We would appreciate that input. We would love to take that into consideration.

Kate Stinneford: Okay.

Leah Nguyen: Thank you.

Kate Stinneford: But, I might send you something you've already addressed from the response to these questions. Is that okay?

Dr. Tara McMullen: Yes, that's fine. We actually addressed this work that your questions – in much of our work. We're just very interested in your input. Thank you.

Kate Stinneford: Thank you.

Operator: Our next question will come from the line of Carolyn Zollar.

Carolyn Zollar: Yes. Hello. Can you hear me?

Dr. Tara McMullen: Hi, Carolyn. We can hear you.

Carolyn Zollar: Hi, guys. Hi. Thank you, again, for the explanation. I just have a clarifying question on timing and a little bit on substance. And that is on page – slide number 34, where you seem to be giving us – and we deeply appreciate it – a heads up that the next large opportunity for public comment will be on the – it says revised data elements.

And so, I want to just clarify that, does this mean the Alpha 1 data elements will be revised and then posted again for public comment now towards the end of this upcoming month, April versus May, just so we can get prepared? And what is it that will be posted for public comment?

Dr. Tara McMullen: So, Carolyn, I'm going to turn this one over for Barb Gage. But, to answer the last part of your question, what will be posted for public comment, we – that will be presented to the public when it's actually posted on that MMS Blueprint website when we have that call for solicitation. We'll have a full – I want to say packet, but it's kind of like a full document that will have everything in its full detail per the usual process. You're familiar with that?

And, Barb, can you just detail what the wording means without speaking to future directions?

Dr. Barbara Gage: Sure. I'm actually going to pass it to Maria as she's really tracking the different public comment periods.

Dr. Maria Edelen: So, is the question the discrepancy between April and May or – I'm sorry.

Carolyn Zollar: No. It's – I'm just curious when it says, "Revised data elements will be posted." Are these – and the slide says, "Alpha 1 data elements." So, that's the first thing we're doing right now? And that is – so, it's revised Alpha 1 data elements will be posted for comment and, then, based on those comments, those data elements will move on to Alpha 2?

Dr. Maria Edelen: No. They're actually – I mean, it's a little bit of an overlap. Some of the Alpha 1 items were revised and are now being tested again because revisions were so substantial that they needed to be gone through – go through feasibility testing again. Other Alpha 1 data elements are – the revisions are very slight. And so, we didn't feel like those slight revisions warranted a full-on retake of the feasibility. So those are going to go on to the next step, which in our process is public comment. So, the final – the revised versions of the Alpha 1 and Alpha 2 – and, as Tara said – I mean, you'll see that when it is posted at the end of April.

Leah Nguyen: Thank you.

Carolyn Zollar: So, it will be Alpha 1 and Alpha 2.

Operator: Our next question will come from the line of Debra Lee.

Debra Lee: Yes. Hello. I'm Deb Lee. I'm with Five Star Senior Living. And my question is on – early on in the process when you're speaking about assessors, you keep saying nurses. And at the facility levels, that might not be the person that's filling out certain sections. So if that's taken in to consideration of how you're getting your reliability studies on filling out these sections? Are you including, in other words, social services, activities, doctors and managers? Or is it just nurses? And if you're using nurses, what levels of education are you using?

Dr. Barbara Gage: Thank you. Maria, shall I take the question?

Dr. Maria Edelen: Sure. I was sort of waiting for Tara. But, sure, Barb, you can go ahead.

Dr. Barbara Gage: Sorry. This is a great question. We did use the term "nurses" on the slides for the assessors. But there may be some organizations that look at the cognitive items and think one of the therapists is more appropriate or one of the social service practitioners. So those are all things that we'll be talking through as Abt calls the individual organizations to – that will be participating to make sure that we get the right people doing the assessment that is both effective for your organization as well as effective information for the reliability results. Thanks for bringing that up. So you can think more broadly than just nurses in thinking about your clinical team.

Debra Lee: Yes. A lot of those are on – you know, they're not always – at an educational level, I think of how we're doing some of this assessing. And so, it wouldn't be a practical view that a facility level, whether that's SNF or a home health or etc. So, when you're looking at time and what it takes to involve other disciplines like that, although it's overseen by a nurse, we still don't want to eliminate the interdisciplinary process and what that educational level is.

Dr. Barbara Gage: Thank you very much. Yes. The interdisciplinary process is very important in post-acute care. And we will be asking for licensed professionals to be collecting the data, just as you have to do in your regular practices, but, obviously, involve the lower level, the certified people, where appropriate. And, of course, that will vary by level of care and individual organization.

These are all things to bring up as you're working with the Abt team, to think about the – who you have involved from your organization in the data collection. Feel free to bring up these types of questions so that you can – so that we have the right assessors within your organization.

Leah Nguyen: Thank you. And I'm going to turn it over to Tara for a brief announcement.

Dr. Tara McMullen: Hi, everyone. Quick for clarification for Carolyn Zollar. Too many Cs in that line. So, Carolyn, your question was about Alpha 1 data elements and Alpha 2. So the next public comment period – we can't speak to directly what's in it. But it could contain an array of Alpha 1 and Alpha 2. We're definitely working through what's going on in Alpha 1. We'll probably end up including some of those items. But we cannot make a definitive suggestion to what's going to be in there. We're still figuring that out.

Also, we see on the slide here that we said posted for public comment in May, yet we're saying April on the call. We will revise the slide and give a definitive date. Please be on the lookout for your announcements through the CMS MMS Blueprint site. And our communications team will also post some spotlight announcements to let folks know when this public comment period will be live.

So, Carolyn, if you have any questions, just contact us. But I hope that clarifies that part for you.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Troy Hillman.

Troy Hillman: Good afternoon, guys. It was great seeing you at the AMRPA Conference. Just one question regarding slide number 32. As far as the time to complete, is this just based on one assessment being done or is this for both an admission and discharge timeframe? It looks like the initial estimates are somewhere between 20 to 40 minutes, again, depending, I guess, on the medication reconciliation inclusion. But, just wanted to know, was this for one assessment at admission or is this for both admission and discharge? And then, secondly, you're mentioning the reliability CAPA statistics, which measure just the interrater reliability. Are additional statistical tests being done to determine whether these items have correlation or relatability to things like outcomes, costs, or quality? Thank you so much for your time today.

Dr. Tara McMullen: Thanks, Troy. It's Tara. I think I'm going to turn this one over to Dr. Gage.

Dr. Maria Edelen: Barb, you want me to take it?

Dr. Barbara Gage: Yes. Thank you, Maria.

Dr. Maria Edelen: Yes. Hi. This is Maria Edelen. So, thanks for your question. So the time to complete – I guess I never actually added them all up. I think of them as discrete data elements that are being considered. But, yes, if you add it up, this was one assessment. This wasn't admission and discharge. It was just admission. So that's the answer to that question.

And in terms of the additional quantitative information, again, I mean, this is a feasibility test. We did some things like we looked to see, obviously, the percent of patients or residents who responded "Yes" versus "No" and, you know, looked at sort of – looked at different groups of patients and what their scores were. But, really, just – the object of this test was really for feasibility. For the beta test, the national test, we're going to be focused much more on some of the more sort of validity types of looks that you were mentioning in your question. And so, we're going to be looking, you know, how these relate to one another, how they relate to patient characteristics, and we're going to have a much, much bigger sample. So we'll be able to look a lot of that and also looking

at discharge and where they discharge to. We have a pretty extensive plan to really, really get into it about how these are performing and what they might be useful for.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Tom Ferrone.

Tom Ferrone: Hi. This is Tom Ferrone from the Shirley Ryan AbilityLab, formerly Rehabilitation Institute of Chicago. And I just wanted to thank you for your time on the call and ask a question about enrolling in the beta. I'm a little bit confused about asking us for our interest in participating in the beta but then also saying that participants will be selected at random. So, can you talk a little bit more about that, if you can.

Terry Moore: Sure. This is Terry Moore. I'm back on the line. I apologize for having dropped off. You are absolutely right that it was a random selection. And if you are in one – like yourself, you are in one of those 14 markets, we'd like to hear from you so that we can see if you are in our sample. So that is the – that is the simple answer to your question. It could be that your particular facility was not in our sample. One of the things that we've seen a little bit is – I'll say I got a call from a particular corporation who has one facility in the sample but would prefer that a different one in that same region be – you know, be used instead of the one that was in the sample. So, if you're interested, let us know. We'll look and see if you're in the sample and we'll evaluate whether or not it's possible that you meet the same metric as somebody else.

Tom Ferrone: Thanks.

Leah Nguyen: Thank you.

Operator: And our next question will come from the line of Andrew Baird.

Andrew Baird: Hi there. This is Andrew Baird with HealthSouth. Thanks for taking the time. I'd certainly like to reiterate the comments of Mr. Troy Hillman about the emphasis on total time assessment for all these put together since these assumingly would be used completely on each patient as well as the hope for a tie eventually to actual patient outcomes as well.

My quick question is just about slide 32 and the CAPA scores. Will you all be able to release the settings in accordance with these scores and, generally, the data that you produce from these varying tests by setting? I've seen there's a significant range in a couple of these.

The one that you highlighted specifically was the range associated with the med rec measure. And I was wondering if you could provide any more detail, like which post-acute care setting was the one that had such a low interreliability rating?

Dr. Tara McMullen: Hi, Andrew. It's Tara McMullen. Thank you. First, for your comment. We appreciate what you were pointing to there, and we will take that into consideration. Second, yes, we will be able to release more detailed analyses when we post our final summary of – per the findings from this actual effort. So we'll be able to delineate that out soon.

Leah Nguyen: Thank you.

Andrew Baird: Great. Thank you.

Operator: And our next question is going to come from the line of Jose Dominguez.

Jose Dominguez: Yes. Good afternoon. Thank you for taking my question and thank you for the presentation. One, is any proposed plans or methods of reporting this data as we move forward? And, also, the second part to that question would be, how would this be presented or how would it impact the proposed unified post-acute care project? Thank you.

Dr. Tara McMullen: Thank you. So, this is Tara McMullen. Speaking to your first question, we are not able at this time to talk about public reporting validation, all outcome efforts. Can you repeat your second question? I'm sorry.

Jose Dominguez: Yes. The unified post-acute care project.

Dr. Tara McMullen: Instrument?

Jose Dominguez: Yes, instrument. Yes, ma'am.

Dr. Tara McMullen: Oh, okay. Are you asking if there is one?

Jose Dominguez: One – there is one. That is the talk that we hear. But, also, if this – if this beta testing go through, how would that be implemented?

Dr. Tara McMullen: Okay. Yes. So, at the top of the presentation – I think it was around slides 5 or 6 where I was pointing to the assessment instruments. So, just to draw you back to that – so, at this time, there is not a unified assessment instrument. So, there is no one assessment instrument. So, to be able to meet all the activities as outlined in the IMPACT Act – so that's like all standardization efforts – we are using our currently leveraged assessment instruments. So if you're a SNF provider or are affiliated with a skilled nursing facility, that would be the MDS, for example. I think that a lot of folks also asked us about the CARE tool. But, we are not using the CARE tool as one standardized assessment instrument.

Does that help clarify a little bit?

Jose Dominguez: Somewhat. Yes. Thank you.

Dr. Tara McMullen: Okay. Thank you.

Leah Nguyen: Thank you. Holley, we have time for one final question.

Operator: Okay. Our final question, then, will come from the line of April Mundy.

April Mundy: Hi, there. Thank you for taking my call. And, actually, my question is kind of in followup to the questions both Mr. Baird and Mr. Hillman had in regard to slide 32. Do these proposed new data elements – is the expectation that these assessments will be done both upon admission and discharge? Or are these likely to be just admission assessment items?

Dr. Tara McMullen: So, thank you for that question. This is Tara McMullen. The intent of the IMPACT Act is to be able to collect information on all patients and residents on admission and discharge to be able to look at a full stay – patient or resident stay. Thank you.

April Mundy: Okay.

Leah Nguyen: Thank you.

April Mundy: And, actually, I have one other question. In regard to slide 32, did you also include the time required for transcription from the clinical chart document to, you know, all of our respective data warehouse or, you know, the software that we use to submit the IRF-PAIs, etc.?

Dr. Tara McMullen: What is the question in that?

April Mundy**:** Did you include the transcription time in the estimated time to complete the assessments? You know, as we – you know, there are those of us that pull the data out of the clinical documentation to import it into – you know, specifically, I work in an acute rehab, into the IRF-PAI. Was that included in the time calculation to do the assessment?

Dr. Barbara Gage**:** I can take it.

Dr. Tara McMullen: Thank you, Barb.

Dr. Barbara Gage: Yes. So, thank you for that question, April. We know that there's a lot of documentation that goes on in taking care of your patients. And, yes, when we were estimating the time to complete, the time was based on finding the answer to the item. So if the patient was interviewed, then it was largely the time of the interview. If it was an item that was in the charts, then whatever process was used to pull the information from the charts, whether it'd be automated, as you're referring to with some – that may have been pulled off the IRF-PAI or whether it was looking through the charts for information that is in the patient record but not on one of the assessment tools, that's all counted as the time to complete.

April Mundy: Okay. Thank you.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address listed on slide 46 of the presentation. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website.

On slide 48 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's MLN Connects Call on the IMPACT Act. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.

-END-


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