Centers for Medicare & Medicaid Services
Special Open Door Forum:
The IMPACT Act and Improving Care Coordination
Moderator: Jill Darling
Wednesday, March 28, 2018
2:00 p.m. ET

Operator: Good afternoon. My name is (Chris) and I will be your conference facilitator today. At this time, I'd like to welcome everyone to the Centers for Medicaid and Medicare Services Special Open Door Forum - the IMPACT Act, Improving Care Coordination.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like ask a question during this time, simply press star then the number one on your telephone keypad. And if you would like to withdraw your question, press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: All right. Thank you, (Chris). Good morning and good afternoon, everyone. Thank you for joining us today for the IMPACT Act and Improving Care Coordination Special Open Door Forum.

Before I hand it -- hand the call off, I have one brief announcement. This Special Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at presss@cms.hhs.gov.

And now, I will hand the call off to Charlayne Van.

Charlayne Van: Thanks, Jill. Thank you all for joining us today for this special open door forum. Today, we will be providing you information and getting your

feedback pertaining to the development and testing of standardized patient assessment data elements as IMPACT -- as mandated by the IMPACT Act.

This special open door forum will provide an update on the national field test, ongoing stakeholder engagement activities, and we'll also highlight ways for stakeholders to remain engaged. I'm happy to be joined by Dr. Maria Edelen and Emily Chen, who will update us on the data element testing so far and also to give us an update on the stakeholder engagement activities.

So, with that, I will hand it over to Dr. Maria Edelen.

Maria Edelen: Thanks, (Char). Hi. This is Maria Edelen from the RAND Corporation. I'm the project director for the -- this project, the -- working on standardized data elements for post-acute care. And I guess I'm going to start on slide 4, if you're following along. And just to -- I know many of you have been at these previous open door forums. So, some of this should be old news by now.

But just to give you an overview of our work, CMS has contracted with the RAND Corporation to help meet the mandates of the IMPACT Act. And our project goal is to develop, implement, and maintain standardized post-acute care patient assessment data. So, that should be -- the focus is only on the patient assessment data, the data elements for patients, not on the measures.

There are other -- a lot of other excellent contractors, as you probably know, working on the measures for the IMPACT Act. And our project has essentially three phases. We spent the majority of the first year doing information gathering, deciding what's out there, where are the gaps, what do we want to think about in terms of developing or considering new data elements.

And then we went on to some pilot testing, which we did in August of 2016 through July 2017. And this was mostly testing data elements that were different enough from what's been used in post-acute care settings that we wanted to make sure that they were feasible to collect across settings and get it -- and wanted to identify whether they needed further modification prior to considering further.

Now, we're in the middle of our national data test, which started in the fall and is running through the end of May 2018. And in here, we're -- after all of these activities, several of the data elements are still being considered for standardization. And now, we're trying to gather some very strong empirical information about their performance to see whether they should be continued to be considered for standardization. And our focus in terms of the data elements that we've been considering is they all fall under the clinical categories that are outlined in the IMPACT Act.

So, the next slide, those categories that are outlined in the IMPACT Act are cognitive status; mental status; pain; impairments; special services, treatments and interventions; and also a handful of other categories including care preferences, global health, and medication reconciliation.

And so, for each of these categories, we have a handful of data elements representing each. And so, it adds up to quite a few data elements that are under consideration at this point in our beta test.

So, currently, as (Char) mentioned briefly, we're in the -- in a middle of a national field test of all of the data elements that are currently being considered for data elements standardization. And we're also concurrently conducting information gathering and consensus building activities.

And these include a survey and focus groups with the facility and agency staff members who -- and their administrators who've been participating in our beta field test and we're hoping through these activities to get a better understanding of the critical utility and feasibility as well as workflow issues and what's happening with the patients. So, we're hoping to get these perceptions from the people on the ground in the facilities and agencies who were actually trying out the data elements.

We're also doing some targeted outreach to professional and provider associations and post-acute care providers to hear concerns about standardization in general and maybe concerns or feedback on what's happening with the beta test and also to discuss ideas for going forward.

And like today, we're doing -- we're still doing these ongoing project updates, quarterly special open door forums as well as updating our information on the CMS website. So, I'm going to say a little bit about the national field test and then Emily is going to talk about the information gathering and consensus building activities.

OK. So, next slide. So, the goal of the national beta test is to evaluate the reliability and the validity of the candidate data elements and identify the best, most feasible subset of data elements for standardization in order to meet the requirements of the IMPACT Act.

The field test is happening now with a random sample of eligible providers that are in 14 randomly selected geographic metropolitan areas. And the beneficiaries within those eligible provider settings are beneficiaries selected who have Medicare only or duly eligible Medicare/Medicaid status. And we're gathering admitted -- we're gathering admission assessments for the most part. So, eligible participants are admitted to participating providers during the field period.

Next slide. This is just a map showing the lay out of the beta test markets. We have five markets in the west region, four in the central region, and five in east region. And the number of providers is not exactly equally distributed across the markets. Some of the markets have a few more and some have less.

I think the range of providers within the market ranges from somewhere like 6 to 15. I know Boston has a lot and Los Angeles has a lot. And then others like Chicago has only six or seven. And Harrisburg is also one that has fewer. So, it's really dependent on what's -- what was available in that market that the way the numbers worked out.

The other thing to say is just that all four settings are represented and we made every effort to have settings distributed across the -- at least across the three regions so that we have LTCH in the west, central and east and SNFs and home health -- across all three regions -- and hopefully across -- to the extent possible. We have representative of each setting in each market.

So, the beta test protocol involves two distinct patient resident test groups. The majority of the participants are those without communication impairments and those are the admission assessments that we're including. So, anybody who is admitted who is able to communicate either verbally or with gestures communicate meaningfully is eligible to participate and is hopefully given an admission assessment within seven days of their admission. And then we're also following up and attempting to get those same residents and patients at discharge.

And then we have a separate protocol of -- with a subset of data elements that have been developed specifically for patients and residents who have communication impairments. And for these, it's just a single assessment and it's not tied to an admission date. And this is mainly because we didn't want to limit our ability to get -- to get enough numbers. We know that these -- residents and patients who are eligible, who fit these criteria are less common and less frequent and we were concerned that if we waited for them to be admitted that we wouldn't have enough.

So, for the communicative, those without communication impairments, we're collecting the data from them on -- upon admission and discharge. And then for those with communication impairments, we're sort of just going in if they're in the facility -- in a participating facility we're going in sort of as it's convenient.

In the assessment, data elements that we're collecting are in the following categories. We have cognitive status, which includes expression and understanding; mental status, for example, depressed mood; we have several items about pain, pain interference with sleep, pain severity; impairments, including the ability to see and hear and continence; several questions about special services, treatments, and interventions; and then as I stated earlier, the other categories, which include care preferences, global health, and medication reconciliation.

And if you're curious to see the beta test protocols, they are all posted at the bottom of this page on the CMS website. If you have a chance to take a look

at that, they're in a PDF document. And if you do end up taking a look and downloading and have any questions, please feel free to reach out. We're happy to clarify and also really interested in hearing from you about that.

So, the next slide, slide 11, just lays out the number of providers that are participating and the number of assessments that are targeted to be completed per provider and overall. So, in this, these numbers -- the number of providers is current as of March 6. But actually, I think, it's current. I don't think we've lost any since March 6. So, I think we still have 158.

We had a lot of providers express interest and come to the training and then subsequently something happened and they dropped out. So, we had some drop outs earlier on, but we're now really holding steady with the numbers that we have. So, we have 24 LTCHs participating, 25 IRFs, 62 SNFs, and 47 home health agencies.

And our target is to have a total of 30 admission assessments per LTCH and IRF and 25 admission assessments per SNF and home health. And of those admission assessments, we are targeting to have 10 IRR assessments that is they're being assessed in pairs with our research nurse as well as the facility assessor, 10 in LTCHs and IRFs and 5 in the SNFs and home health.

And then -- and finally, we have a subset of the admission assessments that are targeted to be repeat assessments, so five in each of the LTCHs and IRFs and three in each of the SNFs and home health.

And these repeat assessments are just a subset of the data elements we're interested in learning more about how the performance of the data elements differs or whether it differs depending on the day that you asked the question. So, we're asking these questions at days three, five and seven post admission. And then we're going use that to inform the best -- the best assessment window to employ across the settings.

In the next slide, slide 12, just shows some of the activities that are going on and the dates (of them). So, the data collection technically started in November of 2017. It's a rolling start. And then we published these protocols

to the CMS website in December of 2017. We are targeting to have the data assessor survey launched actually in about a week. We might -- I guess it would be technically April.

The data collection is targeted to end in June. And the beta assessor focus groups are occurring in -- this summer in June and July. And we're targeted to have a summary report published to the CMS website in the winter 2018-2019.

And I think that's it. I'm going to turn it over to Emily. Thank you.

Emily Chen: Great. So, starting on slide 13. In previous open door forums, we have described our plan for engaging stakeholders in the SPADE development work. And as Maria said, in one branch of the work that we think is really important is hearing the perspective of the assessors who are collecting patient and resident data within the beta test.

This is our best chance we think at getting the on the ground experience of actually completing these data elements from the clinicians who are doing it. So, we'll be gathering feedback from these folks in two ways. First, we'll be doing a web-based survey of all the beta data collectors.

We are fielding it soon, well into the field period, to make sure everybody had sufficient experience with the surveys so they could really answer our questions accurately. We have questions for them related to the burden of the item, the clinical usefulness of these items, and also about how patients did with the assessment, which items were confusing, were some difficult to answer on the part of the patient, because that will play into the decision making about which of these items might be best to move forward.

After the results of the survey are in -- and we staggered it deliberately -- we'll be doing a set of focus groups over the summer. We'll work within a couple different of the test markets and bring together groups of beta assessors to have them sit together and talk about their experiences. Some questions we have for them wouldn't really work well in the survey, so questions about the processes, the challenges related to data collection. And we expect there are

some going to be some things we see in the survey that we will want to hear more about, have them explain to us a little bit what might be happening in those or what we're seeing. So, that will be another opportunity for us to hear from the clinicians who are actually working with these data elements now.

On the next slide, here are a few more details about that beta assessor survey. The survey is going out next week. And it's not a small number of people. It's over 300 field staff who we're going to invite to participate in the online survey.

The next slide talks about another branch of the stakeholder engagement work. This involves engaging in dialogue with the PAC provider and professional associations. So, if you have attended conferences in the last couple of months, you may have seen people from RAND or our CMS colleagues presenting on this standardized patient assessment data element work. And for us, these opportunities have been really terrific, not just to talk more about the work and to talk to you and explain about it, but to hear questions or concerns from the public.

So, we've heard – and everything we've heard, we promise, we've taken back to the team and we're documenting everything we have heard -- they're on our list to address some of these issues and just to be aware of what's happening in the minds of stakeholders. We've also done a set of small group telephone interviews, which I'll talk a little bit more about later and tell you what we've been hearing there.

On slide 16, this is a list of our upcoming work with stakeholders. So, we're going to be doing some targeted webinars with special population over the summer to start talking and thinking about how the standardization work needs to -- where it needs to go next, how it can be extended.

And then in the fall, we're doing what we've been calling either the mini conference or the forum on data elements standardization. This is an event that CMS will host in the fall. We're still figuring out exactly what this is going to look like. So, stay tuned for details. But I've been thinking of it as

the bookend on this year of stakeholder engagement work we've been doing and the testing work.

So, we're going to know a lot more from both the testing and stakeholder engagement work in the fall, and I think that conference will be a chance to synthesize what we know and to kind of check back with stakeholders to make sure that we have heard everything that's important and we're bringing the right information forward.

So, next slide, slide 17 shows the timetable for these activities. So, we're about midway through this now. We'll, of course, be back with another special open door forum in June. Hopefully, give you a little bit more about how the beta test was going and what we've heard from assessors. And then we have certainly more work to do over the summer before we can check back again in the fall.

So slide 18, this is where we are with these small group interviews. We've done about 15 so far and then the conference presentations. And today, we want to share a little bit about what we've been hearing across all these conversations.

First, I'll mention that the groups we talked to were selected from organizations that submitted public comments on the SPADEs, and that was a public comment either through the rule making public comment process or in the sub-regulatory "blueprint" public comment periods that RAND's held over the last couple of years as we've tried to get a feel for how stakeholders responded to some of the items that we are considering.

So, on slide 19, what have we heard? I think we have to say and it's important to say we've heard a lot of support from stakeholders. Most people we talk to fully grasped and they support the goal of the standardization. We also heard a lot of appreciation for CMS for slowing down the process and kind of taking this extra time to listen, to communicate, and to do more testing, but we've also been hearing requests for more information and for clarification about what's happening and where is it all going. I think it's probably one of the most common questions we've gotten.

So, a few things on the next slide. On slide 20, is an interesting one because I think even people who thought they know what we are doing, you know, we kind of get halfway into the conversation and say, "Well, what exactly do you mean by standardized data elements?"

So, CMS has defined the standardized patient assessment data element as questions and response options that are the same across the four PAC assessment instruments, so identical standards and definitions, the same questions and the response codes, and these are just -- these are what we call the data elements. We may call them items, the questions. They're not quality measures. They're just kind of pieces, little building blocks of the patient assessment. So, that said, they're not quality measures, but they might be used in quality measures, either existing quality measures or quality measures that have yet to be developed.

The other thing that we did really want to clarify is that the entire assessment for each provider type will not be standardized. There's not one instrument that's going to work and be the same across all four settings. Rather some items, the standardized items, the data elements, the questions, will be inserted across the four assessments. So, we'll have little pieces that are common across the four item sets that will continue to be different in order to respond to the different needs of those settings.

So, the next big question, what's in the used case for this? How will they be used? Just the question of: where is this all going? And this is a hard one -- this is certainly a challenge of the RAND work we've been doing. The goal is to identify standardized items that have the potential to be used for many purposes.

So, these items should be able to support data exchange and inter-operably across settings. They should be -- they should certainly be comparable across the different providers. Through data exchange and interoperability, they would foster care coordination. Payment analysis support -- they should have the potential to support payment use in the future, and also outcome analysis -

- if you follow a patient with the same items across the four settings to be able to see how that patient or resident changes.

So, similarly, there are multiple used cases here. If they have multiple uses or uses cases then high among them is supporting clinical care, supporting decision support so that they're useful to the clinicians who are collecting that in the settings.

The next slide -is the next question: If they're going to use for many things, well, how will you select them? What are the criteria for selecting the ones that will go forward? How will CMS choose? And I think this is consistent with the idea that the SPADE should be able to serve multiple purposes. The evaluation criteria is also multidimensional. So, any items that would be proposed for standardization must be, I think, first, valid, reliable, feasible across PAC settings.

And you heard Maria talk a little bit about how the beta data collection is designed to help us determine that -- from all of the items in the beta protocol which ones really do show strong reliability, validity, and feasibility across the settings? Those items also need to be clinically meaningful.

And we're getting information on that in several ways. We're asking beta assessors. We have clinical advisors and test input and things like that because by being clinically meaningful, that's how they're really going to -- we see them as being able to drive quality, if they're actually relevant to the clinical care.

And at the same time, they have to be able to accurately reflect patient acuity as it relates to the level of care needed. Because if it's capturing that aspect, it will really help with describing case mix and with potentially tying these items to payment later on.

The next slide, the last one here, just shows our milestones or timeline for this work. You know, 2018 is a big deal for this work because we have the beta field test happening. And as I said before, I think in the fall we're going to know a lot more from the beta field test but also from spending this time

talking to stakeholders and gathering feedback, so more to come in the fall on that.

The last slide on this is just -- it's points of contacts. And as Maria said, if you have thoughts or questions about the field test or the beta protocol or concerns or suggestions for this work, please reach out. We're here and we're in listening mode.

So, we have certainly some time now for questions. Jill, if I can hand it back to you.

Jill Darling: Great. Thanks, Emily, and thank you, Maria. (Chris) will open the lines for Q&A please.

Operator: Certainly. And as a reminder, ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. And if you would like to withdraw your question, press the pound key. Please limit your questions to one question and one follow up to allow other participants time for questions. And if you require any further follow-up, you may press star one again to rejoin the queue.

And with that, our first question is from (Caitlyn Jeruli) with American Hospital Association. Your line is open.

(Caitlyn Jeruli): Hi. Thanks so much. I'm just wondering if there's a list of all of the participants, the 158 participants, who are doing this, anywhere that's publicly available?

Maria Edelen: Hi. This is Maria. Thanks for that question. We have not yet published the list of participants. My sense is that we would do that -- they would be listed in a report if they -- unless they requested not to be listed. It's not a secret per se, but we are trying to sort of respect their preferences. So, our plan was to list them if requested or with their permission in the report, which would be in the -- like about a year from now.

(Caitlyn Jeruli): OK. Great. Thanks. That's helpful.

Maria Edelen: Sure.

Operator: The next question is from Nancy Richard with Spalding Hospital. Your line is open.

(Samantha Colby): Yes. This is (Samantha Colby). I'm a colleague of Nancy's. My question is let's say that all of these data elements passed the beta test. Would they all be added -- would every single one of them be added to the existing patient assessment tools? So, is it possible that come July 1, 2019 every element that's being tested right now would start showing up on these tests? And conversely, if all of the items fail the beta test, would any of them show up on the assessments? Thank you.

Tara McMullen: Hi. This is Tara McMullen from CMS. So at the current point in time, CMS is just exploring the use of the items. We're interested in the outcomes and what, you know, the national test shows us. CMS currently per our administrator and our secretary, we have an initiative going – initiative running called Meaningful Measures and also initiative called Patients over Paperwork. The crux of these initiatives are to decrease burden in collection and reporting across the board, so that providers can focus on the patient. So with that said, CMS most likely would assess all data elements and assess basically the burden of adding any data element, any one or multiple data elements into our assessment instrument. I do not think that we would be adding an influx of data elements that would increase burden significantly.

(Samantha Colby): Thank you.

Operator: The next question is from Renee Kinder with Encore Rehabilitation. Your line is open.

Renee Kinder: Thank you. I have more of an (AIM) question. When I look at what's in the beta test PDF in comparison to what's on slide 9, it looks like we would only be allowing ourselves the opportunity to measure functional gains and those with the communication impairment, if we had the opportunity to assess at admission and discharge.

And so if we look at the beta test PDF bullet 3, it looks like we're doing admission and discharge for those with communicative patients and then it has the three additional data elements for those willing to communicate.

And I just feel like we could be missing a huge opportunity, and I'm a speech pathologist by background, to measure quality functional outcomes or even there's a mention of a tie to reimbursement on today's call if we're not assessing at admission and discharge for those with communicative impairment.

Because, we do know for speech, and if there are any OTs on the line if they want to speak out as well, that's an evidence-based for us to provide care to those folks. So if someone could just provide some clarification on why those with an impairment only get one assessment versus two.

Female: Well I will – Maria, do you want to go? I think we should reiterate the IMPACT Act as well (in fact).

Maria Edelen: Yes, I can speak to that and then maybe Tara you can – you can fill in. So in terms of just the design, we're really just trying to see if it's feasible to collect this information among patients who meet these criteria in the four settings. And ultimately – I mean the way that it – the way that it's implemented is not true to life.

So for example, if you're doing an intake assessment and admission assessment on a patient and then you finally realize that they can't communicate, you would then – you would then revert to doing a cognitive assessment that doesn't require their communication. It would be more of a, you know, it would be more of a smooth transition to that.

This is – this is sort of an imposed testing design just to find out – just to make sure that these data elements work in a way that we want them to work. And yes, it would be ideal to have them at admission and discharge. And in terms of if they were ever to be implemented, as I said they wouldn't be collected in the way that they're being collected right now in beta.

Tara McMullen: Yes, thanks, Maria, that was helpful. This is Tara McMullen from CMS again. So, I just want to reiterate that the intent of the IMPACT Act is to have data elements – data element use for measures, data elements use for payment, standalone, anything at admission and discharge, collected at those two points in time in the assessment instrument. Implementing this on a national scale, on a national level, your quality reporting programs, your data elements will look a little bit different.

Renee Kinder: Very good, thank you.

Operator: The next question is from Melody Malone, the CMS Health Quality. Your line is open.

Melody Malone: Yes, I noticed on page 8, the beta test market, it doesn't appear that any of these are rural provider areas. How are you addressing rural providers in these testing?

Hello?

Maria Edelen: Hi, this is Maria, you know, I'm not sure exactly what you mean by that question. So, I was waiting for someone else to jump in, maybe you can clarify.

Melody Malone: Well, all of these metropolitan areas and their admin …

Maria Edelen: Oh rural, I thought you – OK, I thought you said rule, R-U-L-E.

Melody Malone: Rural.

Maria Edelen: So the – there are some slightly rural providers in the sample there. It's centrally located in urban areas but there is a two-hour driving distance and so it does, you know, it does sort of favor more metropolitan areas but there are – there is some rural representation in the sample.

Melody Malone: OK, I look forward to seeing that, thank you.

Maria Edelen: Sure.

Operator: The next question is from (Julie Harris) with (JE) Harris Consultant. Your line is open.

(Julie Harris): Yes, my question is the first, slide 11, when it was mentioned in the last category, the repeat assessment, that assessments were repeated on a sample at some different intervals post the initial assessment. And I believe the comment was made, so that we could take that information and determine at what time frame maybe the best time frame to collect that data as you might find differences over time.

And I guess my question was how can that be determined if each of those assessment is accurate to the condition of the patient at that time? How would the determination; be made of which of those is the best time for an assessment? Could you expand on that please?

Maria Edelen: Sure, thanks, this is Maria. It's a good question and we've – we've been thinking about that a lot as we plan our analyses. The idea for this is more to see whether it really makes a difference. So to – for example if we ask about a patient's pain that – on their third day post admission and then again on day five and day seven, do we – do they give different – do they give markedly different responses? So – are the rates of pain reporting different or is it essentially the same?

We want to be able to say either, it doesn't matter which day you asked and so you can make it work best to the workflow or it does matter and here is why. And this appears to be the timeframe that provides the most accurate information or the information that is most relevant for what the – what the data element is trying to measure or assess.

(Julie Harris): I used them as example, you said the most accurate and who's to say each of those assessments aren't accurate for that patient at that time. So, I guess that's where I was a little confused in regards to determining multiple time periods of data collection to determine the best accuracy or relevance for that patient when all of them maybe accurate and relevant, so the condition that's going on with them at the time.

Maria Edelen: I completely agree and I've actually been struggling with this too in terms of how we talk about it. And I should probably not have said accurate because I agree that these – that even if they differ, that doesn't mean that one is more accurate and another is not.

I think what we want to do is determine first of all whether it even differs and then have – and then if it differs, to sort of understand how it differs and have some dialogue together with CMS and with stakeholders around, given that this differs and here is how it differs. So on day five, we get a much wider range of pain reporting or we get a lot more information about pain interfering with activities or the interference with activity tends to diminish by day five or whatever the pattern is that we see.

And then, speak, you know, check in with stakeholders and with CMS around – I mean what is it that that we're trying to really pin down with this data element and given these nuanced differences on these days, which day appears to give the best information I guess is the way I would say it. Does that help?

(Julie Harris): Well, it helps to understand more where you're thinking, how to possibly utilize the information but I agree with you. I think it is a challenge to make, you know, final determinations with some of these data elements in regards to when it's most appropriate. But I understand the interest and at least looking at it and maybe it will or won't drive decision-making because it may just prove to all be a (washing) away. All right, thank you very much.

Operator: And as a reminder, please press star one if you like to ask a question. And our next question is from James Mueller with Mueller Consulting. Your line is open.

James Mueller: Hi, we're looking down the road and noting a point of these measures are ultimately to be used in payment which is clear. It's inevitable the IMPACT measures will be used to contrast, adjust to the quality between the post-acute settings.

The question, what (stages) of research are controlling the otherwise unobserved clinical reasons why patients are discharged between the post-acute settings? This obviously could cause some significant unintended incentives down the road in this policy (track).

Maria Edelen: I'm sorry this is Maria Edelen. Emily or Tara, do you want to take this one?

James Mueller: And understanding this is a little bit of a high-level question.

Maria Edelen: Or if nobody is going to jump in, maybe you could reiterate.

Female: Can you repeat the question please?

Maria Edelen: Yes, sorry.

James Mueller: The set of IMPACT measures, the cross-setting measures expanding SNF, home health and LTCH, there is a reason why they're common between the settings. And that's ultimately to be able to compare between the settings and the ultimate use is to be used in or to set up payment policy that would adjust between the settings.

One of the things that is needed in that sort of research work is to look at ways of adequately controlling for the reasons that patients are sent between the settings. SNFs, discharge decision SNF is different to discharge decision to IRF, LTCH and home health. Is CMS doing and what is the state of the research in CMS about exploring how to build those kinds of factors into the measures that are being applied across the different settings?

Tara McMullen: Hi James, it's Tara McMullen, sorry, we were talking internally. It's a good comment and I guess the best way to get about this is, that in standardization – so for full disclosure, on this call, we're talking about standardized data elements and not quality measures.

James Mueller: Right.

Tara McMullen: And at this time, there are no plans to use the standardized data elements in any other effort because simply we're just exploring their use. However, if

you want to go past this, the idea of standardization – we used to say apples to apples, you know, when we're trying to compare apples to apples.

And the further we get into it, we realize apples to apples was such an elementary way to talk about comparative outcome – comparing outcomes and comparability. And there is a lot of analytical work we have to do to reach that state of comparability. Standardization is just the beginning.

So in developing models around data elements and measures or whatnot, yes, there's a lot of work that goes into it. And we simply just don't have the answers right now but we concur with what you're saying and I can tell you we are actively in many other roots of work, looking at some of these relationships and exploring what these relationships mean to the outcome overall in totality.

And I could also tell you we're working with sister agencies to look at things like social risk factors and successful discharges and what do transitions mean and how does that line up in our modeling. So, I think overall there's more to come. And to be able to report out based on condition, which is hopefully where we end up someday. And so, yes, it's a great point and definitely – I don't have all the answers right now but there is more to come on that.

James Mueller: Right, thanks, Tara.

Operator: The next question is from Thelma Dibble with UPMC Home Health Care. Your line is open.

Thelma Dibble: Hi, I actually have a question and a comment. First of all I know that in looking at the number of data elements that they are exploring at this time, there is a significant number of them. And you know my comment just surrounds the fact that you know in the Patients Over Paperwork that they are trying to right now eliminate a lot of the OASIS for home health, the OASIS questions.

If we add even a portion of these element in without removing some of the elements that are duplicated in our current OASIS assessment, it is truly going

to be a huge impact to the amount of time that we have to spend to assess patients on some of these elements. So, that's kind of just my take on looking at a lot of those elements.

But my question also surrounds sort of what the last gentleman was talking about, in that whenever you are assessing the areas at different levels of care, so whether you're looking at SNF or LTCH or home health, the patient may do well in one area upon discharge. But when they get to the next area because of a lot of environmental and social factors that I think sometimes are not taken into account in the assessment areas that we complete or that are looked at, it does show a great variance.

And I just wondered based on the last gentleman's question as well, how was all of those going to be taken into account? Because, there are significant number of environmental factors, whether a patient is in a skilled nursing facility and walking on a level area that has no carpeting versus walking in a home health or in a home where there are various levels and numerous steps and different types of carpeting and all of those things to take into account makes a big difference when you are assessing them.

Tara McMullen: Hi, this is Tara McMullen. Yes, that's – it's a great point. It's a great question. It's something that we're wrangling with in coordination with our partners and ASPE. And so within the IMPACT Act, CMS is to work with ASPE on looking at social risk factors.

And within a lot of that work, a lot of the – a lot of what's being discussed are environmental factors. Within our quality measure work, we're also beginning to look at social risk factors and environmental factors. And again, what does it mean to be able to compare cross-settings where services are different and populations are different, the makeup is different. And this is a very complex set of work and we're currently talking through preliminary analyses of some of our work.

But what I can tell you is specifically for some of the IMPACT Act quality measures such as the claims of these measures, taking an environmental

factors such as in the discharge community measure and looking at what would be "successful" based on that setting, we are exploring roots on how to be able to not only assess that but to be able to report that, to be able to use that – those types of coefficients and models, to mediate relationships.

And so you're absolutely right, it's so important and the one thing that we've always discuss here at CMS with this standardization assessment data element work and with the quality measure work and all work under the IMPACT Act is that no one population is the same. Even within a skilled nursing facility, Part A population, you have multiple cohorts.

And we recognized that the data elements that we are testing could be assessed in different ways, in different populations, LTCH, home health. And that's the tough part of standardization is trying to find that even – that even-keel to find an element that would work for so many different people, with so many different conditions in four different settings and really maybe even beyond.

Operator: And again, please press star one if you like to ask a question. And the next question is from Diana Kornetti with Kornetti & Krafft. Your line is open.

Diana Kornetti: Hi, thank you very much. Tara, actually I have a question, just a follow-up on the previous question, when you are talking about settings and the social determinants of health. Do you anticipate that there will be an opportunity regardless of the measures chosen across settings that there will be a different way to have them (wade), in other words how they will be – how they will contribute it to payment, how they will contribute to quality measures, how they will contribute to the way they are being managed?

They can be asked the same but do you think that they might have the opportunity? And that might be just you know (asked me) to look prospectively at it but have them (wade) different in different settings.

Tara McMullen: Hi Diana, yes, good to hear from you. Yes, you know, that's a great question and it's one that we're actively exploring right now in a few of the settings for a few outcomes. And right now I think the answer is it depends on the item or

the quality measure used. So right now, with our quality reporting programs we developed and maintained data elements and quality measures for quality reporting.

And so when you're reporting on a national scale, I imagine the weights would be different for that activity versus that of such as modeling for payment. I think overall if you are looking at the definition of value and you know that we have to break the mutually exclusive relationship between quality and payment. However, I'm not – I'm not in payment, I don't make those final determinations but I would imagine, yes, based on the activity probably. And based on what you're trying to assess, I mean it would be difficult to have that be completely aligned and identical across settings, across activities.

Diana Kornetti: So just – so just to follow up, you think that this information and what you're gathering on these elements may inform or have the capacity to inform payment?

Tara McMullen: Yes, I mean that's the intent of the IMPACT Act. It's clearly laid out on page one that standardization is to back in care coordination and discharge planning and to really focus back – put the focus back on the person, if it wasn't there on the first place.

But really was also to be used in consideration of payment modeling, was to be used in consideration for longitudinal data which could be leveraged by different assessment or different agencies and things of that nature. Yes, that's clearly defined in the act. It's how that's going to happen, that's not defined. And I believe that CMS has not laid the roadwork or the roadmap to that yet.

Diana Kornetti: OK, thank you very much.

Operator: The next question is from a (Neil Markham) with UT Southwestern. Your line is open.

(Neil Markham): I do. I had a question about what is the rationale for not including activities of daily living in this – as one of the (space)?

Tara McMullen: This is Tara McMullen from CMS. We have finalized self-items and self-care mobility, those motor activities as a standardized data elements not only in the domain of quality measure domains, of functions – functional status but also in the categories of function.

So, we already have existing standardized data elements, patient assessment data elements for ADLs and that's in Section GG. We're currently exploring the use of IADLs and that's via a different task.

Operator: And the next question is a follow-up from (Julie Harris) with (JE) Harris Consultant. Your line is open.

(Julie Harris): Thank you. Yes, this question refers back to slide 23 and I see when during the data – beta data collection period there was also stakeholder outreach. And as you all receive some input on the questions or the ease of collecting the data, were changes made to the questions during beta testing and how do you see going forward with additional stakeholder input being able, if you make changes, being able to revalidate and check reliability on future changes?

Emily Chen: Hi, this is Emily Chen. The particular engagement we did leading up to that really informed the beta and was different activities than we're doing now with the beta assessors. So, we did – we did talk to folks with – after alpha testing. We made some changes based on that feedback. We had environmental scan work and we brought it in front of the TEP, but also in two public comment periods outside of rulemaking that we heard from some people on.

And that did inform some changes to the items, alignment with existing work or changes to the instructions, some the importance of some things relative to others was also kind of –we've drawn on stakeholders to discern that and to figure out what needed to go into beta. As far as future testing goes and

refinement of, you know, taking stakeholder engagement into account after the beta testing, I think we're trying to assemble a set of information for CMS.

And it's what stakeholders are kind of sensing out of these – the items which resonate more, which seemed more feasible or, you know, more clinically useful potentially. Plus, the findings, the empirical findings from the beta test itself, I think those things will be brought together to help CMS make their decisions about what to move forward with in the fall.

Tara or Maria, would you add anything to that?

Maria Edelen: I would just say that all of this is still ongoing. It's not done and the beta test is – the beta test, we're not, you know, we're not on the ground changing items, given feedback. So, I think that was one of the concerns that you raised in your question.

So, we're really – we're really just sort of – its two streams of information data collection. We're collecting empirical data with the data elements in the protocols that are posted and we're getting this qualitative information and those are going to sort of combine to help aid the decision process.

(Julie Harris): So in your – say for instance in the assessment, so in your empirical and you qualitative data, maybe certain elements definitely didn't have the strength that you expected. Would a recommendation come from the report that this particular elements be revamped, relooked at, reconsidered? Is that the type of recommendations you want to give?

Maria Edelen: I'm not sure exactly – I mean I'm sure that we will – we will, you know, analyze the data and hope that that will go into decision-making. But we're less, you know, it's more of a team effort in terms of making recommendations. We're really working with CMS and our job is to provide them with as much information as possible and to help them with their decision process.

(Julie Harris): All right, thank you.

Jill Darling: All right Chris, we are out of time. So, I'll hand it over to Charlayne to close up the call.

Charlayne Van: Great, thanks Jill. I just wanted to thank everybody for joining us today. And I wanted to remind you if you didn't have a chance to get your question in or if you think of additional questions, please send those questions to our PAC Quality Initiative mailbox and that's PAC, P like Paul, A, C like Charlie, qualityinitiative@cms.hhs.gov. And also for more information on item development, you can visit RAND's website at impactact@rand.org. Thank you so much for joining us today.

Operator: Ladies and gentlemen, this concludes today conference call. You may now disconnect. Thank you.

END