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Centers for Medicare & Medicaid Services
Special Open Door Forum:
The IMPACT Act and Improving Care Coordination
Moderator: Jill Darling
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Operator: Good afternoon. My name is (Amy) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services, The IMPACT Act and Improving Care Coordination Special Open Door Forum.

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

I will now turn the call over to Ms. Jill Darling. You may begin.

Jill Darling: Thank you, (Amy). Good morning and good afternoon everyone.

My name is Jill Darling in the CMS Office of Communication. As always, we do appreciate your patience. I know we don't start on time. It is a matter of getting many participants in, and the pieces of information that we ask of you. So thank you very much. We will begin shortly.

I just have one short 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 today's call. If you have inquiries, please contact us at press@cms.hhs.gov. And I will now hand the call over to Charlayne Van.

Charlayne Van: Thank you. I'm Charlyane Van; I'm (inaudible). I'm joined today by Barbara Gage from the RAND Corporation (inaudible)...

(Off-mike)

Barbara Gage: Thank you, Char.

I'd like to welcome everybody to this national discussion. This is an important effort and we appreciate everybody joining in to these Open Door Forums. As you can tell by now, we're having a series of Open Door Forums each quarter, hoping to get input on different areas as we move along.

The slide three tells you what the focus of this special open door forum is. We want to hear from you, the provider community and others, about the IMPACT Act and get you thinking about how it can help you.

So, the IMPACT Act is about Facilitating Improved and Coordinated Care Delivery. We're going to talk a bit about the goal of the IMPACT Act, some of which you may have heard before. But we are trying to bring more people into the discussion.

Secondly, we'll talk a little bit about the expected impact on outcome and get you thinking about why the IMPACT Act is actually a beneficial law for each of you providers. And then third, bringing it to the role of the PAC provider in improving coordinated care. And this is pretty important because we're going to turn to a set of discussions and we're hoping to hear from you and thinking about how the IMPACT Act can help you better coordinate patient care.

Slide four just briefly goes over the IMPACT Act at a very high level. Our colleagues from CMS have given much more detail on other open door forums that you can find on the special open door forum. But just to put everybody on a level playing field, the IMPACT Act was a bipartisan bill introduced in March 2014, passed on September 18, 2014 and signed into law by President Obama in October 2014. So, there was great agreement on the importance of standardizing how we communicate about our patients.

The IMPACT Act requires standardized patient assessment data that will enable several things to happen that will improve the care of the Medicare program and the provider's services provided. First, it will enable assessment and quality measure uniformity so that we can be setting expectations for actual outcomes that make sense. And we can risk adjust those expectations to recognize that some providers are admitting more complex cases or less complex.

Secondly, the standardized patient assessment data enables better quality care and improved outcomes. And part of this is because we're improving the communication. If the nurses in the acute hospital or the rehab hospital or the LTCH are using the same language to describe a patient as the nurses in the nursing facility or home health or one of – or the rehabs or the LTCH. If you're all using the same language to describe the patient, you're going to improve communication, and ultimately, improve quality and outcomes.

Thirdly, the standardized patient data allows for comparison of quality across post-acute care settings. For many of you who've (journey-ed) with us across the post-acute care payment reform demonstration and other related work, there are a lot of controversial issues about where a patient (goes), what is the most cost-effective appropriate setting for a patient that looked likes X to be treated? And we can't answer that without having standardized data.

Fourth, improving discharge planning. Again, if the discharging organization is using the same language as the admitting organization to describe how complex this patient is in terms of their medical acuity, their functional severity and their cognitive complication, you're going to have a much better discharge process.

Interoperability. Interoperability is all about the related efforts of exchanging data between providers, moving away from putting the pink sheet in the ambulance with the patient as they're transferred from the hospital to the post-acute care setting and actually being able to hit a button and pull up a record that tells you concisely and precisely about the medical complexity of that patient. But you can't have interoperability without having standardized items to transfer.

And then lastly, the IMPACT Act is important for facilitating care coordination. So you can see how all of these initiatives are related and they're all key to improving patient care. Additionally, there are also payment directives included in the IMPACT Act.

The IMPACT Act requires the Medicare Payment Advisory Commission to evaluate and recommend – make recommendations on a unified PAC payment modeling approach – like how you might think in terms of standardized case mix measurements. So that if a patient has these types of medical complication, they should require a certain level of resources which should be available and paid for regardless of the other requirements -- so, a unified PAC payment model. I believe, the MedPAC issued in their June report this year their proposals. And then CMS is also responsible later on for working with MedPAC and submitting to Congress a set of recommendation.

So, what does the IMPACT Act cover? If you look at slide five, there are certain categories that were called for standardization. There are the areas of function, and much work has been done on this already. You've seen the standardized items moved into the MDS and the IRF-PAI and the LCDS. And I believe there's work underway for the OASIS on self-care and mobility, cognitive function and mental status. There's been some works done on this, but much more is needed, including areas of expression and understanding the communication skills that a patient has. Their mental status such as depression and dementia.

A third area specified in the act are special services, treatments and interventions. So factors that really identify the differences in resource needs among medically ill patients. Things like the need for ventilators. The need for hemodialysis, chemotherapy, TPN. These are factors that really underscore the different nursing needs and physician monitoring needs in patients who don't require those interventions.

Fourthly, the IMPACT Act called for standardized ways of describing medical conditions and comorbidities, which seems like it should be simple. Doesn't everybody use an ICD10? Well, the answer is no. All settings don't use

ICD10s, some use check-offs, et cetera. So, standardizing what the primary condition is and how we define that and the comorbidities is very important for thinking about expected outcomes of the patient and potential cost.

Impairments is another category that in complement to the medical condition is important for understanding complicating factors that will be related to both the cost and the outcomes of the patient. Things like incontinence, ability to hear, to see, to swallow. If you think about the Medicare population and how many different reasons for hospitalization might have swallowing impairment following the hospitalization in the initial treatment that generates different resource needs than someone without those types of impairments.

And then the Act last leaves it up to the Secretary to identify other categories that may be important to standardize. So that if a patient is ending up in more than one type of setting for reasons other than medical complexity, perhaps it's bed availability, you'll be able to systematically to consistently measure how complex they are, set expectations about the cost of caring for them and monitor their outcome.

So, why these data categories that were mentioned above as shown on slide six, these are key factors for measuring patient complexity in order to determine the resource needs, in order to monitor outcomes and to pay providers equitably. So you might think of them as a minimum set of important information.

So, the next few slides underscore the importance of the IMPACT Act. Slide seven talks about how one in five beneficiaries are admitted to the acute hospital each year. That's a lot of people, one in five beneficiaries. And out of them about 42 percent go to at least one post-acute care setting. A large proportion are discharge directly to home health or discharged directly to skilled nursing facilities. Or discharge directly to inpatient rehab hospitals or long-term care hospitals. But even more importantly, a substantial number of those people will go on to use at least the second post-acute care service following discharge from the initial one.

So slide eight give you an overview of the different episode patterns that we've seen in the past. When we think about that group, that 42 percent of all hospital admission that are going on to post-acute care, 23 percent of them are just going from the acute hospital to home health. So that's important care, home health is where they're getting continuing nursing or therapy treatment.

Another 17 percent are going from the acute hospital to the skilled nursing facility. And then they're going home. They're fine, they've – they're back to walking, breathing, all of that. Another 7.8 percent are going from the acute hospital for the skilled nursing facility and still need home health care when they get home.

And as you look down this list, you can see that there's a lot of movement between settings before a beneficiary's complete episode of care is done. And that kind of underscores the importance of standardizing the data elements that we use to describe the patient need.

So slide nine gets at that the outcome, like why bother with the IMPACT Act. Well, standard terminology will allow measurement of patient complexity at any point in time during the stay or across services. So, as I've been saying, that's pretty important.

Secondly, it allows you to evaluate the outcome. What has been the change in the medical complexity between admission and discharge from care? It allows for communication across caregivers because you'll be able to transfer that data electronically. It allows you to measure costs equitably, and more importantly, set the payments equitably. So that if you are treating a similar case in a setting that may have a different rate associated with your case mix group, that case mix group can be looked at more consistently.

Not that it wouldn't take into account, you know, the payment models as you look at the MedPAC report, it proposes the additional setting specific factors to continue the recognition of the higher fixed cost in a hospital versus the SNF versus home health. But the patient characteristics can be consistently measured and considered for resource intensity.

So slide 10 goes on to talk about those additional outcomes. Besides that administrative stuff, you can actually improve the value of care. As the healthcare environment is changing and we're getting more competitive market, and ACOs are growing up and bundled payment, it's important to be able to answer whether similar patients are discharged to different types of post-acute care and if they are – do the outcomes differ because that's really where the value proposition is.

Can I transfer my patients to a different type of setting that may have a shorter or longer length of stay who have similar input or at least achieve similar outcome? We can't answer that without standard data. And you can't really demonstrate the true value that we know is out there.

How can the IMPACT Act help you improve care coordination? There are a couple ways that we think it can help. And we'll be interested in hearing from you about ways that you think it could help or things that might be useful for its implementation that would help you improve care coordination.

So, it facilitates consistent and reliable definitions of patient complexity and needs. It can improve communication across an episode of care by having that common language across the medical professions, even when the nurses are talking to the PTs or the doctors are talking to the nurses. If we're all using the same term and thinking about the severity using the same coding approach, then we'll be improving that language and thereby improving the communication across the whole caregiving team. As well as allowing the interoperability across the organizations involved in the episode of care.

It can also have another impact. By improving that communication, we can improve care transition. And that in turn can prevent potential adverse events from ever occurring. So, improved communication is really at the heart of care coordination, which is at the heart of the Triple Aim and trying to reach better outcomes.

So slide 12 starts a – hopefully starts you thinking about the roles of yourselves as post-acute care providers in supporting coordinated care. Right, CMS is setting up the tools, doing the work with all the different clinical

communities to define what the standardized element ought to be, make sure they're reliable, but then, you as a provider, how can you use these standardized elements to improve the communication with the PAC liaison? You're in a hospital or a rehab hospital or our long-term care hospital, you're thinking about transferring that patient. How can the IMPACT Act help you?

And think of this not only in terms of the policy but in terms – operational terms, what is it – how can this help you better communicate with the liaison who are coming in to identify what patients are getting ready for discharge and what's the appropriate setting?

Secondly, as a PAC provider, receiving the patient or discharging the patient, having timely transfer of information about the patient's medical status, their functional status, their cognitive status, their care preferences, all of that information when you're admitting that patient from somewhere else that you wish you had at the time that that patient showed up at your door. And we're going to ask you a little bit about what you wish was in that list.

And then thirdly, the timely transfer of the information to the patient's other caregivers. How often have we heard that the primary care physician didn't even know the patient was in the hospital? Let alone the skilled nursing facility? The family members are trying to relate what just happened during the hospital stay and they don't really have the accurate language. The residential support system, the patient is going home and they need, depending on their level of severity, they may need support at home. Everybody needs at least an informed caregiver on the first day of discharge home without home healthcare.

So why are we having this Open Door Forum? Slide 13 highlights that we're trying to facilitate a discussion with the whole range of post-acute care providers about how the IMPACT Act can help you improve care, measure outcomes, improve value and build systems that achieve the Triple Aim. So this isn't about the Fed's activity, it's about you're using the new tools to demonstrate in the healthcare market why you're the best provider to be admitting that type of – that individual post-acute patient.

So, put on your thinking hats because on slide 14 we want to gain your input on potential ways. The IMPACT Act can help improve patient-centered care coordination and develop better delivery system. We want your input on potential barriers to improving the care coordination. And we want your input on the roles the providers can play in implementing the IMPACT Act. So, this open door forum is all about helping you guys get involved as the people that are touching the patient, how they the IMPACT Act help you improve care?

We put together a couple questions to get us started. I'll walk through them quickly and then I think we're going to open the line so we can start hearing from you on these issues.

So slide 15, something to think about. How can standardized information help you improve care coordination? As a provider – and with over 600 people on the lines, I know we have all different types of providers, so think about where you're sitting. As a provider, what information do you need to facilitate a safe, effective care transition?

When would it be helpful to have this information? Do you want this information two day after the patients come in? Do you want the information a week before they're coming? Do you want the consult to be involving you way before you're talking about actual discharge?

So when would it be helpful to have the information? How would you suggest it be presented? This is the opportunity. We've seen a lot grow up around benchmarks with the initiatives that have come out of CMMI. What would you like to see and how would you like to see the Medicare program facilitate some of that information transfer?

Secondly, what elements do you think are important for distinguishing the value or the importance of your care in the patient's episode of care? This is the time to come forward and talk about what's really important to include so that you're not having arguments about whether a patient actually needs your level of care.

Thirdly, what types of information do you currently share when coordinating patient care that you think could be better conveyed? So, maybe you're doing something locally with the providers that you interact with regularly. Are there lessons that can be carried out on a national basis, you know, to improve that information transfer? And why is this information important to care coordination? We (inaudible) that just increase the burden on providers, we want to be thoughtful about what items ought to be standardized. Why is it important to have that information across more than one type of provider?

Page 16 asks you to start thinking about the different information needs that the different professional groups have and the different levels of care have. So, what type of information would be helpful for improving care coordination across an episode of care for the hospital staff? For that hospitalists, they've never met the patient before they were admitted. To the surgeon or from the surgeon, the case manager. At the PAC level, the medical directors are just seeing this case. The case manager, the treatment team. What types of information is important to convey back to the patient's primary care physician? What types of information is needed by the patient's family and social support system? What types of information is important for the patients to have and to understand?

We're running a lot of continuous opportunities for stakeholder engagement and this is one of many where we've had small group discussions with some of the PAC providers and researchers. There's been technical expert panel, focus group meetings, open door forums, conference presentation. And as I said at the beginning, we will be having quarterly Special Open Door Forum. So there's a continuous opportunity but today is the opportunity for you to give us your input on these issues.

So, I will turn it back to Jill.

Jill Darling: OK. Thanks, Barb. (Amy), we'll open the line for our Q&A, please.

Operator: As a reminder, ladies and gentle, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw you question, please press the pound key. Please limit your questions to one

question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may again press star one to rejoin the queue.

Your first question comes from the line of Roxanne Yaghoubi of Healthcare Leadership. Your line is open.

Roxanne Yaghoubi: No, I'm sorry, I don't have a question. That was a mistake.

Operator: Your question today comes from the line of Vicki Baukner of Ridgeview Medical Center. Your line is open.

Vicki Baukner: What day does this impact or date does it go line?

Barbara Gage: That's a very good question. It is already in law and there've been quite a few activities underway associated with the IMPACT Act. This particular contract to the RAND Corporation is responsible for item development. Many of CMS has a library of items, some of which have been tested in all four post-acute care settings under the post-acute care payment reform demonstration, but the goal of the RAND contract is to expand upon that.

So we are looking for input from yourselves. And in fact, that work has been underway since last October. There are calls for technical expert panel participation, which you can find on the CMS website. We are currently beginning the first of three phases of item testing based on input from earlier focus groups and technical expert panels and are going live in the first round of alpha testing or pilot testing a small number of data element.

There will be a second round of pilot testing or an alpha two test beginning in January. So if there are considerations that you think should be included, now is the time to submit. And the very last slide showed the PAC Quality Initiative's URL. Thirdly, towards the end of next summer, we'll be doing a national reliability test on the items that come out of the alpha one and the alpha two.

Along the way, we are holding continuous opportunities for input on the items. The – last week, a 30-day window just closed where CMS was asking

for public comments on the first set of items that has been circulating. There will be additional opportunities for public comment as the item set keeps evolving. The goal of these efforts is to have items within the areas of the medical complexity, functional complexity and cognitive complexity. That are the same items used across the post-acute care settings.

And as many have pointed out, there had been requests that it also be used – the episode starts in the hospital for these complex cases and they need common language there as well. So, it's an ongoing effort and all input is welcome.

Vicki Baukner: Thank you.

Operator: Your next question comes the line of Carrie Wendel-Hummell of University of Kansas. You line is open.

Carrie Wendel-Hummell: Yes, I was wondering; if the care assessment is still going to be implemented as part of the IMPACT Act? And if not, then can you detail a little bit more exactly how you are going to standardize the items across the assessments that are already being used in these post-acute settings? You know, the MDS, OASIS, IRF-PAI and so on, and basically, what is the status of that care assessment.

Barbara Gage: Are you referring to the care tool that was used for item reliability testing in the PAC-PRD?

Carrie Wendel-Hummell: Yes. It was my understanding that that was supposed to replace the MDS, OASIS and IRF-PAI.

Barbara Gage: No, that was – that was used to test the reliability of the items that had been identified by the different clinical communities as important for distinguishing severity and expected outcomes based on treatment. So that works then led to information for CMS in Congress. There's an entire report on the CMS website on the reliability of the items that were in the care tool. And then many of those items have moved forward into the respective MDS, OASIS, IRF-PAI and the development of the long-term care hospital data set. So it's about standardizing items, not changing tools.

Operator: Your next question comes the line of Serena Roth of AccentCare. Your line is open. If you're on mute, please unmute.

Serena Roth: That's a good thought. Thank you. Thank you very much. With the CMS initiative in place to pre-affirm home healthcare, what is being done to ensure that all the required data element are present in the medical record before a referral to home health is made? Such as homebound status, reason for skilled care, length of service anticipated and community physician.

Barbara Gage: Thank you for the question. That's really a good question for the next home health open door forum. It's a little out of the scope of the IMPACT Act work. Although the different groups are all – the different units within CMS are all working together on these issues. And what I hear you saying is that it would be good to look to those regulations and thinking about standardized items.

Serena Roth: Right. So that you can make a referral that can go through rather smoothly.

Barbara Gage: Thank you.

Serena Roth: Thank you.

Operator: Your next question comes from the line of Pam Harris of Medical Records Management. Your line is open.

Pam Harris: Thank you. Good afternoon. I believe were are in 2016. I believe so. And I started my career as a medical record consultant, specifically skilled nursing facilities in Florida in 1981. My concern is when a resident is transferred to a skilled nursing facility and to this day we do not receive a hospital discharge summary. We see limited information from the hospital setting and will need to be able to receive the discharge diagnoses and the ICD10 code that have already been created and dropped into the hospital system into the skilled nursing facility on day one.

And I'm not really certain why in 2016 we don't have access in the skilled nursing facility to the entire electronic medical record in a hospital for a

regiment that we just received. And I'm not certain why the hospital is not sharing the discharge diagnoses with us and related ICD10 codes so we can better care for our resident.

Barbara Gage: Thank you. That is exactly the underpinnings of the IMPACT Act. And we appreciate the issue. At the CMS we encourage you to have a conversation with your sending facility and encourage you to look at the (positions) of participation and the requirement for those providers. Thanks.

Pam Harris: You're welcome. And actually I've done so and hit doors on that. Closed doors on that where hospital are not willing to share that information. I think it needs to come from a national level where CMS mandates it instead of going hospital by hospital and skilled nursing by skilled nursing. It needs to be – it's a universal need and it needs to be mandated. Thank you.

Barbara Gage: Thank you. In fact, the hospital conditions of participation rules that came out this past year do mandate it. So you may want to circle back to your hospital.

Jill Darling: We would encourage you also to submit your comment and question into the PAC Quality Initiative mailbox as well. Which is the last – which was given on the last slide and we'll be going through that at the end.

Pam Harris: Thank you. Will do.

Operator: Your next question today comes from the line of Marcia Musgrove of Northwestern Home Heath. Your line is open.

Marcia Musgrove: Hi. Thank you for taking my call. The question that we have here and the struggle we have is the goals of care discussions that do or do not happen across the continuum of care. And the lack of a standardized assessment of the trajectory of illness sign as may be the PPS, the Palliative Performance Scale. And so, it'd be really helpful if that was tracked somehow so that we would know whether or not those goals of care discussions have been held and where to find them.

Barbara Gage: Thank you for that suggestion about the Palliative Performance Scale. The – this is an issue, probably, for more than just the end-of-life populations, but

more broadly all patients and thinking about their options and choices for subsequent care following hospital discharge.

Marcia Musgrove: Thank you.

Operator: Your next question comes from the line of (Katie Steinford) of AAPM&R. Your line is open.

(Katie Steinford): Thank you. I think it's great to be trying to standardized elements and that sort of thing I think it would be very helpful. My concern now is that it's very passive step goes towards the least common denominator. So if you have these four different entities and they can handle four different complexities of patient, you're not cannot going to be raving the things that only the most complex facility could do or you're just going to start with the ones that all of them can do which would be the least common denominator.

Barbara Gage: That's – that is a great question, (Katie). And it's something that comes up regularly in the discussions about whether the IMPACT Act requires focus on only items that are applicable in all four settings or the whether the point is to be including items that identify the complexity, that distinguishes between any two settings. And I hear your point about the importance of distinguishing between patients and not just limiting to the items that are expected to have variation in all four settings.

Thank you.

(Katie Steinford): Thank you.

Operator: Your next question comes from the line of (Michelle Jones) of Happy Home Health. Your line is open.

(Michelle Jones): Good afternoon, everybody. I wanted to know, are the IMPACT Act item being – the answers being entered on a tool that is common to all the post-acute care providers, PAC providers, across the board? And if so, it would be nice if there was one database that we all went to to deposit that information, as opposed to receiving information and having the need for perhaps interfaces between EHR and EMR systems.

So the way I'm looking at it is each entity can certainly login and provide the information or see what the last provider left and then the changes as needed and, you know, see a history of that. But what's most important is to have a universal place where we're all on the same page. Because if these things are hidden in between EMRs and then the next place doesn't have an EMR or is on paper and this one doesn't share it's interface, I'm wondering now that the communication vehicle in between receiving PAC place – going to the new PAC place the sending and the receiving, where – you know, where – is that coordination in between there and how's that, you know, pass on to the person. So a universal place would be a very good thing for all of us. And that's it.

Charlayne Van: Hi, this is Charlayne with CMS. Thank you for your question and your comment. The goal of the IMPACT Act was not to create one common tool. In order to meet the goals of the IMPACT Act the four PAC settings will continue to collect the data by means of their respective setting. So, for home health, that would be the OASIS.

In terms of being able to locate the data from other settings, one of the goals of the IMPACT Act is interoperability which will allow the different setting to share the data amongst themselves. So, that's one of the goals of the IMPACT Act. And we will – it is CMS's responsibility to make sure that goal is met. Thank you.

Operator: Your next question comes from the line of Joy Sexton of Jewish Social Service. Your line is open.

Joy Sexton: Hi. I'm curious about how you see hospice fitting into this. Because you've got one of the post-acute care providers as home health and I don't know if you're including hospice in that. We're certainly quite different from home health. So, I wondered if you could speak to that.

Charlayne Van: Yes. This is Charlayne again. Thanks for your question. The IMPACT Act – hospice was not included in the IMPACT Act. The IMPACT Act mandates the standardization of quality measures and items for post-acute care facilities

such as IRF, LTAC, SNF and home health agencies. So, hospice is not included in the IMPACT Act.

Female: And this is, again, also (inaudible) under section two, specifically, under the standardization section within the act requiring the modification of the assessment instrument for standardized data. There is a section, section three, that talks about home health and surveys…

(Off-mike)

Joy Sexton: Thank you.

Operator: Your next question comes from the line of Amy Parkinson of Sparrow Home Health Care. Your line is open.

Amy Parkinson: Hello. Thanks for having us. This was very helpful. I just wanted to also – I'm with home health and I understand the meaning of the data items that we're trying to all align. But I am concerned that the outcomes are more impacted by accurate med orders and medications across the continuum of care.

And I am concerned as well with the barriers that are in place between each transition that might be coming even worse with more regulations that have come down the pike with the pre-claim audits, et cetera, for home health that we may have even more problems with outcomes that have nothing to do with the actual (OASIS items) or the IMPACT Act items that we're trying to measure. And I'm just wondering if the government could look more closely at the physician orders transitioning and the medication list transitioning more accurately.

Barbara Gage: Thank you. So you're proposing that there – that the information on the medications and the physician's orders are included in some of the standardization effort?

Amy Parkinson: Yes.

Barbara Gage: Thank you.

Amy Parkinson: Thank you.

Operator: Your next question comes from the line of John Sheridan of the ABILITY Network. Your line is open.

John Sheridan: Thank you. Hello, Barbara. The CCD is unfortunately not shared uniformly. And so, what might actually prove more helpful is if the – and Medicare (culturally) has a repository for this and that would be the utilization of folks sent to nursing homes in the prior 365 days that could be available on a claimed database that was accessible and didn't violate the individual provider or citizenship rights.

And that would prove very helpful, particularly in nursing homes where as oftentimes, you know, residents appear having had multiple hospitalizations in the prior year. Maybe even defined as different episodes but are in a process of the (chronicity) of old age and the progressive changes that appear.

So, you know – so that might be more. The CCD or the Continuity of Care Document or in the discharge summary. I'm connected to the Iowa Health Information Network, there 110 hospitals there. There are about 5 of 110 that can actually execute the connection. And I'm connected to the Cleveland Clinic Foundation. They do a superior job because they employ the doctors and if the doctors don't do their work, they have a little encouragement to do the work. Whereas in the community, it's much harder and doctors are challenged.

So, those are my – that's my question about the prior 365 days of claims. Thanks.

Barbara Gage: Thank you for the question. You raised several important points there. Particularly the (separate) issues. And being a claims and assessment tool researcher, I'm wondering whether you really were asking about transferring the prior 365 days' worth of claims, or whether you are looking for the prior history of being included in part of the documents transfer?

John Sheridan: Well, really, it would be – it would be, Barbara. The CCD, as we've gotten from, you know, major teaching hospitals tends to be much more complete

than from community hospitals. And much more thorough and often includes things in the prior history. Like they got their PNEUMOVAX vaccine three years ago, not in the last 90 days. But, you know, it's good for five years. They got it three years ago.

And – but the fact that they were in the hospital 200 days ago is not included in the CCD, but would be included in the 365 days of claims. And particularly for the nursing home, when you're dealing with families that are 1,000 miles away, trying to deal with what to do with mom and – you know, knowing – and you can't rely on the physicians in the hospital to tell you you got an uncalled doc, you've got a hospital, he's never seen the person before. There's so much discontinuity in the complex patient that all of us as citizens are going to spend $1 million on this person when we might have, with correct knowledge, might have actually been able to do interventions upstream to all these downstream spending. That's just the thought.

Barbara Gage: Thank you.

John Sheridan: Thank you.

Barbara Gage: Yes. Thank you. I understands. And CMS is working towards that. Again, protecting the patient's confidentiality. But as you know in many of the ACO efforts and the bundled payment efforts and the other initiatives coming out of CMMI. They have supported the patient level data being exchanged. Thanks.

John Sheridan: Thanks.

Operator: Your next question comes from the line of Kathy Boyarko of Blue Sky Therapy. Your line is open.

Kathy Boyarko: I'd like to know whether the current changes that we're getting ready to implement on the MDS with section GG, with all of the admission performance and discharge performance statistics that are going to start to become part of the database. If that data is – you're seeing that data going to percolate into some of these tools?

Barbara Gage: Are you asking whether the new items, the section GG function items, are part of these initiatives to standardize measurement?

Kathy Boyarko: Yes or if they'll have – if that data is going to have an influence on some of the items that we have, the ADL items and other coding items that we have in the – for SNF in the MDS already. Is it...

Barbara Gage: I can't speak to the future. We are just doing the research, but the IMPACT Act included language that allowed CMS to the remove redundancies on the tools.

Kathy Boyarko: OK. Well, there are two totally different sets of data so that would not be redundant. So, right now they're not part of the – of the dataflow that you're looking at right now, right?

Barbara Gage: Those items have already been addressed. They – no, the RAND contract is not looking at those items.

Kathy Boyarko: OK. Thank you very much.

Jill Darling: (Aimee), we'll take one more question please.

Operator: Your last question today comes from the line of (Debra LeBaron) of (Haynes). Your line is open.

(Debra LeBaron): Hi, yes. Thank you. I was just wondering, in terms of the recent comment period on the data specifications for the standardized items, is there any plan in terms of giving feedback to the community about their comments?

Barbara Gage: The public comment – thank you if you did write in public comments. There were many good comments on the items and proposed ideas. It was a very helpful set of feedback. The – your question is whether we'll be writing a report on the – what is your question exactly?

(Debra LeBaron): Yes. I was just wondering if there was any plan to kind of summarize what those comments were that you received about the specification. And if that was going to be, you know, kind of closed the information loop, if you will, back to, you know, the world in terms of the comments that you did receive.

Barbara Gage: Yes, we are currently working on a report that, yes, does summarize all of the different comments. And I believe it will be posted either sometime this fall on the CMS website.

(Debra LeBaron): OK. Great. Thanks.

Barbara Gage: You're welcome. Thank you.

Jill Darling: All right. Well, thank you, everyone, for joining today's call. If you are unable to have your question answered, you can send you question to P as Paul, ACQualityInitiative@cms.hhs.gov.

Barbara Gage: And I would also like to bring your attention to the continuing opportunities for stakeholder engagement which you will find out on the CMS website under IMPACT Act and then you click on Standardization and Cross Setting Measures. And then you click on Stakeholder Engagement.

As well as thank you for taking the time to give your input on these issues. And most importantly, on the very last slide you will find the URL to give continuing comments, ideas to the PACQualityInitiative@cms.hhs.gov. Thank you. Thank you for joining us.

Operator: And this concludes today's conference call, you may now disconnect.

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