**Event to Share Findings from RAND's IMPACT National Beta Test
(Standardized Data Elements; November 27, 2018)
Q&A**

Q: What was this meeting about?
A: The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires that standardized patient assessment data elements (SPADEs) be collected across post-acute care (PAC) providers including Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), Inpatient Rehabilitation Facilities (IRF) and Long Term Care Hospitals (LTCHs). During this presentation, RAND provided updates on and early findings from the National Beta Test, which RAND conducted on behalf of CMS. The presentation also discussed areas of support and key concerns raised by stakeholders during prior engagement activities. Three question and answer periods during the meeting allowed both in-person and teleconference-only attendees to ask questions.

Q: Was this open to the public?
A: Yes, this meeting was open to the public. Individuals were invited to attend in-person at RAND's offices in Arlington, VA, or by teleconference. People interested in attending registered at http://www.rand.org/SPADE.

Q: Who is the contact for more information about the meeting?
A: Questions about this meeting can be directed to SPADEForum@rand.org. General questions about RAND's contract with CMS to develop SPADEs for use in post-acute care (PAC) can be directed to the Project Director, Maria Edelen at: maria_edelen@rand.org.

Q: What was discussed during this event?
A: The discussion included an overview of the National Beta Test and early findings on the cross-setting performance of the standardized patient assessment data elements (SPADE) included in the field test.

Q: What is the National Beta Test?
A: Under contract with CMS, RAND conducted a National Beta Test to evaluate the properties of a set of data elements that were identified as having potential for standardization. This field test ran from fall 2017 to late summer 2018. The goals of the Beta Test were to document the reliability, validity, and ease of use of candidate data elements in the four PAC settings: Home Health Agencies (HHAs), Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs) and Long Term Care Hospitals (LTCHs). Assessment protocols being used in the National Beta Test are available as a download on the IMPACT Act SPADEs web page.

Q: Will there be an opportunity to provide comment on the information being given?
A: In addition to the three Q&A periods during the event, which incorporated questions from both phone and in-person attendees, RAND and CMS invite additional input on the presentation materials to be submitted to SPADEForum@rand.org.

Q: Will meeting materials and/or a recording of the session be made available for people unable to attend the presentation?

A: Yes. Presentation materials were posted to CMS' IMPACT Act webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/-IMPACT-Act-Standardized-Patient-Assessment-Data-Elements.html on 11/27, and a transcript of the presentation, including the Q&A components, is now available for download at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html.

Q: One key takeaway from the Beta test was that results from the repeat assessment on different admission days showed very little variation. What does this mean and why is it important?
A: One of the critical issues in cross-setting standardization is harmonizing the data element assessment windows. Different settings have different reporting requirements and thus different routine approaches to getting assessments completed to meet requirements. This results in settings having different assessment windows, or look back periods, for their assessments. PAC providers from all settings have expressed concerns about how these differences will be affected by standardization. Standardized data is collected at specific points in time (i.e., admission/discharge). Other non-standardized collections may vary in the look back. In the beta test, we evaluated whether answers would change if questions were asked on admission days 3, 5, or 7. We also examined whether chart information changed dramatically among admission days 1, 3, 5 and 7. For both types of evaluations (3-5-7 interview and 1-3-5-7 chart), we found, for the most part, that answers did not change. This result implies some room for flexibility around the data element assessment windows so that the differing reporting requirements need not represent a barrier to standardization.

Q: Kappa statistics are not available for many of the data elements. Is the percent agreement enough to support conclusions about interrater reliability?
A: It is true that for many data elements the distribution of responses was uneven enough that kappa agreement statistics could not be computed. For example, very few patients exhibited any behaviors included in the Behavioral Signs and Symptoms data element (e.g., physical behaviors directed towards others), making the kappa statistic unstable. In these cases, it is standard practice to use a companion metric such as percent agreement. Even though there were very few patients/residents exhibiting these behaviors, when they did occur, paired assessors tended to agree and both were likely to find and record that information in the assessment protocol (agreement for behavioral signs and symptoms ranged from 95-100%). The kappa statistic is considered preferable to percent agreement primarily because it accounts for chance agreement. However, percent agreement is a sufficient representation of reliability in cases where kappa cannot be computed and provides ample evidence to make conclusions about data element performance.

Q: None of the data elements seemed too burdensome when considered individually, but if you add up all these time estimates the total is quite burdensome. How will standardization decisions factor this in?
A: Our goal with the National Beta Test was to identify and test a large number of data elements that could potentially be considered for standardization. We intend to take into consideration the burden associated with the addition of standardized patient assessment data elements for the

purposes of meeting the requirements under the IMPACT Act. We fully recognize the burden on already busy staff of mandated collection of useless information. That is why, in this effort, we have mainatained a clear focus on data elements that represent meaningful collection. That is, we are evaluating the candidate data elements according to four important principles: their potential to improve quality, their validity and reliability, their feasibility of collection and relevance across all four PAC settings, and their potential to contribute to case-mix. These four criteria are continually weighed against the estimated collection burden to ensure that the usefulness of standardized assessment sufficiently offsets burden.

Q: The assessors appear to have provided support for most of the data elements, but their feedback included one or more challeneges or concerns in addition to support. How will these challenges and concerns be considered?
A: The assessor feedback provided extremely valuable information to add to the quantitative results on the performance of the data elements. In addition to their general support for the majority of the data elements, the assessors did raise some challenges and concerns. All of the feedback will be factored into our considerations related to steps taken to modify the post-acute care assessment instruments to include standardized patient assessment data in balance with all feedback received including public comments and technical expert panels held by our contractor. For example, much of the feedback raised the need for better assessor training, more detailed documentation, and/or ongoing assessment support. In this example, we would take steps where feasible to address such concerns, such as to evaluate opportunities to provide better assessor training as suggested.

Q: Why are the findings presented here referred to as 'early' findings, and when will the full results be publicly available?
A: Although the results in this presentation are based on complete data, they are referred to as "early findings" because they are coming ahead of the full published results and are only a subset of the results that will be included in the full report. For example, the full report will include frequencies of resposes to each data element both overall and by setting, and will include other setting-specific results such as reliability and time estimates. The full results will be published in several volumes and made publicly available via the CMS IMPACT Act webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/-IMPACT-Act-Standardized-Patient-Assessment-Data-Elements.html following the close of the contract period.

Q: When will the actual response data be publicly available?
A: The de-identified patient/resident beta data will be made available following the completion of the contract with a target date of early 2020. The 143 participating providers will receive a summary of the results of their individual patient/resident participants at this time as well as the subset of data collected at their facility/agency.

Q: What are the next steps for CMS' implementation of the IMPACT Act?
A: As an extension of the work presented during this meeting, CMS may consider the adoption of the standardized patient assessment data elements in satisfaction of the IMPACT Act.