

CENTERS FOR MEDICARE & MEDICAID SERVICES
Special Open Door Forum:
Understanding the IMPACT Act-Patient and Family Focused for Informed Decision Making,
Thursday, May 12, 2016
2:00-3:00 pm Eastern Time
Moderator: Jill Darling

Operator: Good afternoon. My name is Sally and I will be your conference facilitator. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum - Understanding the IMPACT Act: Patient and Family Focus for Informed Decision Making.

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 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, press the pound key. Thank you.

I will now turn the call over to Jill Darling.

Jill Darling: Thank you, Sally. Good morning and good afternoon everyone. My name is Jill Darling in the CMS Office of Communication. Thanks for joining us today on this Special Open Door Forum on the IMPACT Act. If you do have the agenda in front of you, there is a link in the middle of the agenda that will have the slides. So, just click on the link and then you'll go down to, I believe, the download section and there's the link to follow along for today's presentation.

One announcement I have is this 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 inquiries, please contact CMS at press@cms.hhs.gov. Thank you.

I will now hand the call over to Cindy Massuda who is the project officer.

Cindy Massuda: Thank you, Jill, and good afternoon and good morning to folks on the west coast. This special open door forum is for Improving Medicare Post-Acute Care Transformation Act of 2014, (effectually) known as the IMPACT Act or the IMPACT Act of 2014. And we are so glad you are able to join us this afternoon because a key part of the IMPACT Act is the focus on patients, families, to the caregivers, the consumers, and we're very fortunate to have a contract with the RAND Corporation to work with that on helping to implement the IMPACT Act. And especially today, we have Barb Gage for the RAND Corporation and Barbara Gage is a co-project director for this contract and we're very fortunate to have her to present at this special open door forum.

So, with that, I'm going to turn it over to Barbara Gage from George Washington University who is working on this RAND contract.

Barbara Gage: OK. Thank you, Cindy, and welcome, everybody. We're really glad that we had so many people join from the beneficiary, consumer and advocacy community. This is a really important national discussion and we're glad to have your input.

So, the goals of the special open door forum are outlined on slide 3. What we'd like to do today is provide you an overview of the IMPACT Act of 2014 and give you a little background on what it says, what will be happening, what CMS will be doing to carry it out, and what role you can play. The consumers, the person's viewpoint, the patient's viewpoint is very important in all of this national policy.

And the purpose of the open door forum is to start bringing you guys to the table. So our goal today is to hear from you, the Medicare beneficiary and consumer community, specifically about the types of information that would

be helpful to you following a discharge from a hospital or other healthcare service that you may use.

So, I'll go through the IMPACT Act and tell you little bit about what it is all about and then bring you back to the issue of what types of information would be really helpful if every Medicare provider that you saw gave it to you either when you're discharged, when you're admitted, et cetera, because that's really what the IMPACT Act is about. It's collecting standard or more uniform information, and in this particular case, getting the information that will be helpful for the patient from the caregivers in the community.

So, what is the IMPACT Act? Slide 4 gives you an overview. It was a bipartisan bill introduced in March 2014. It was introduced in both the House and Senate, passed in September and signed into law by President Obama by October. So, this was a law that had lots of support from both the – both sides of the Congress, the House and Senate, as well as both parties in Congress, the Democrats and the Republicans.

What does it do? It requires a couple of things. It requires standardized patient assessment data that can be used for assessment and quality monitoring in a uniform manner across the post-acute care settings. It requires standardized data to enable quality care and improve outcomes. So, you'll hear a lot of discussion about, "Well, if I only knew that then I wouldn't have – perhaps had this avoidable outcome."

So, standardizing the language that we use to communicate about a person's health condition and functional condition and cognitive condition is really at the core of this. Again, it will allow comparison of quality across the different settings that you might use if you go from an acute hospital, you just had a surgery, you're discharged to a rehab hospital, you're getting some intensive acute rehab therapy, you go home, you have some home healthcare. If we standardize the language that's used to communicate about your condition then all of those providers can be in the same language, which in turn will also

improve discharge planning because everybody will be thinking in the same manner about your condition and about what you need.

Interoperability, one of the goals that the federal government has going on right now is to be able to exchange healthcare data. And how many times I've heard people say, "Well, what do you mean my doctor does not know what my medication list is?" Well, that's because the physician – the pharmacist has the most recent one. If we have interoperable systems or systems that allow my Mac to speak to your PC then we can make sure that data that the provider is writing can be transferred to the next caregiver in your system. And most importantly, all of these activities will facilitate care coordination, which we expect will then improve outcomes.

So, on slide 5, you see what the IMPACT Act actually did. It added a whole new section to the Social Security Act. Now, all of the post-acute care providers, including the rehab hospitals, the long-term acute care hospital, the skilled nursing facilities, the home health agencies, they all have to report standardized assessment data. They're all reporting assessment data right now, but it – because of the history- it is not standardized, they all have to report data so that the quality of care can be monitored and they also have to report data on resource use and other measures specified by the Medicare program.

The law also calls for the data to be standardized and interoperable, again, exchangeable between different types of I.T. systems to allow for the exchange of data using common standards and definitions or common terminology, common response scales, and allow for the facilitation of that care coordination to then improve the outcome.

But the current post-acute care assessment instruments, the ones that the skilled nursing facilities currently use and the home health agencies and the long-term care hospitals and the rehab hospitals, need to be modified in order to enable the submission of the standardized data and to be able to compare data across all applicable providers. So, basically, the IMPACT Act took the

existing world where everybody was collecting assessment data and is calling for this to be modified so that the assessment items are standard and can be exchanged across all of the caregivers in the patient's episode of care.

So, slide 6 asked why post-acute care, why is the IMPACT Act targeting these providers. Well, 42 percent of all Medicare beneficiaries in the traditional Medicare fee-for-service program are discharged from the hospital and go on to at least one post-acute care setting. These are numbers from the Medicare Payment Advisory Commission.

So, 42 percent of everyone that's hospitalized in the Medicare fee-for-service program are going to either home health when they leave or they're being discharged to a skilled nursing facility or to an inpatient rehab hospital or long-term care hospital for additional medical and/or rehab services. So that's a high number of people who's been hospitalized showing that that's not the end of their care and we really need to improve the communication across care.

So, slide 7 asked the question what is an assessment tool. We're talking about standardizing assessment items. Well, for set of information that's collected by your clinical team when you're admitted to a hospital or when you're admitted to a nursing facility or when you're admitted to home health, any of these settings, when – upon admission, a nurse or other clinician is going to come in and put together information on your medical status. They'll be noting what your health conditions are including your primary conditions, any complication you have, what meds you're on, whether you have pressure ulcers, trouble breathing, are you a dialysis user, are you on a ventilator.

They're also collecting information about your functional status, how mobile are you, are you able to walk down the hall, do you have good balance, what kind of self-care ability do you have, are you able to bathe yourself, just yourself, what's your cognitive status like, do you have delirium, do you have short-term memory problems, do you have long-term memory problems, what kind of social support do you have. When they're getting ready to discharge

you, they need to know, do you live alone, do you live in your own house, do you have caregivers that come in, are they paid, are they unpaid.

So, each time you're admitted to healthcare, particularly post-acute care levels of care, somebody is collecting these types of information and they're all collecting basically the same information, but each of the assessment tools are currently different.

So, slide 8 kind of lays out the issues. As I mentioned, each of the assessment tools at each level of care are different. So, if you're discharged to home health, the nurse or the physical therapist will come in and they'll be running through a set of items that are in the outcome and assessment information set or the OASIS. That's noting your diagnosis, your comorbidities, all of that type of information.

If you're discharged to a skilled nursing facility, they'll be completing the MDS, which collects similar types of information but doesn't ask the questions in the same way. So, for example, if you're having difficulty walking after your surgery, you may be coded as being more impaired on one scale in the OASIS than you are on the scale in the MDS. And the goal is really to standardize what items are used so that everybody recognizes you at the level of impairment or health condition that you're at.

As you can see on slide 8, the inpatient rehab hospital has a separate tool, the IRF-PAI and the long-term care hospital has the LTCH-CARE tool. So, each of the four tools contain similar items but not the same questions and responses, which then makes it difficult not only to compare a person's condition but to exchange that data electronically across providers.

So, slide 9 identified what the IMPACT Act called for. It literally called out certain categories of information that should be standardized across the post-acute care providers in the Medicare program, function; the ability to care for oneself, eating that sort of thing; mobility, the ability to walk or to use a wheelchair; cognitive function, how well can you express yourself and

understand ideas, things like this are particularly important after somebody has had a stroke or a head injury; mental status, such as depression and dementia.

The IMPACT Act also called for standardizing special services, treatments and interventions. Obviously, it's important for the physician if you're on chemotherapy. But if that information isn't transferred in a consistent way, then it can't be electronically sent to the next setting. Medical conditions and co-morbidities were also called out. While we have a common language about what our health condition is, how we record it on each of these tools differs.

So, some of these changes are pretty minimal impact but important for improving outcomes. Impairments, the IMPACT Act pointed out that certain key impairments would be good to be tracking consistently, for example, incontinence, how we measure incontinence differs by setting, one's ability to hear or to see or to swallow.

The IMPACT Act also called for not only standardizing data but developing quality measures and these are outlined on slide 10. So, a quality measure monitors the outcome. So, what the patient experienced in a setting. And it's different than just the data elements because it actually has – it's more of a measure of something. It's a – it has a numerator and a denominator. It applies to certain populations. For example, you might say, what percent of the residents or the patients had a fall during a certain period.

So, these quality measures are also called out in the IMPACT Act and they call for measures of functional status, cognitive function, and changes in function and cognitive function. They call for measures of skin integrity problems at the provider level as well as changes in skin integrity problems. They call for a measure or measures in medication reconciliation, a key piece in the prevention of many adverse events. They call for a measure on the incidence of major falls and something on communicating and providing for

the transfer of health information and care preferences of an individual when the individual transitions.

So, this is a critical point because you can see how the patient care preferences are being moved front and center and it's one of the reasons that we wanted to have this open door forum today. This project is not working on the quality measures, but it is working on identifying the standardized data elements that will possibly go into quality measures in the future.

So, slide 11, why uniform assessment items? Because they create the potential to improve care and coordination. And the types of coordination are listed on slide 11. They facilitate consistent and reliable identification of the individual's met and unmet needs. They decrease fragmentation by using common language that can be transferred electronically across the care giving team out of an organization on to the organization. They support care transition. They simplify access to programs and support. And they improve the information on health and outcome.

So, slide 12 kind of outlines the guiding principles of the RAND project. The goal of the standardized elements that we are asking for your input on will be to promote better care, making care safer and more reliable, creating effective communication and care coordination, tracking outcomes. It will focus on person-centered processes and items, and this is a big deal. One of the things that has happened through several pieces of legislation over the last few years is the recognition that the patients and the family are part of the -- should be partners in the care of the person.

So, this person-centered processes and items, we're focusing on supporting care planning, focused on optimizing independence and patient preferences, focusing on engaging consumers and families in design and that's part of this work today, focusing on improving the value of care. It's all very nice if somebody wants to offer you services that could improve your ability to walk, but you actually are more interested in working on different area of function. This is the opportunity to bring your voice into the care.

So, slide 13 highlights what we mean by person-centered care. It refers to an approach that reflects the patients, not clinicians, or in complement to the clinician, that reflects the patient's goals of care, the patient's strengths to build on for deciding about next steps, the patient's needs for understanding post-discharge information, and the patient's preferences and the types of information and access to resources that would make your consequent experience better.

So, why are we having this open door forum? As we note on slide 14, it is to build on the knowledge, the experience, and insight of consumers, patients, families and others in selecting and testing assessment items that will meet the goals of the IMPACT Act. So, again, our goal today is to hear from yourself, the consumers, the patients, and the families about items that will make your care better.

Slide 15 outlines what we hope to gain today. We're looking for feedback from you to create better assessment items that respond to the consumer needs. We want to gain insight into how the consumers and families view standardized assessment, pull in a wide range of perspectives, learn about concerns and preferences of consumers and family when you're thinking about what information you needed when you went home from the hospital. That's the type of thing we want to hear from you today. That's the type of information that can be transferred consistently across settings including into the homes so that the standardized assessment supports person-centered principles and protections.

So, we've outlined a few questions to get us started and I'm going to walk us through them and then I want to turn the floor over to yourselves because our goal of today is really to hear from you about the types of information that you think would be helpful to have available in a standardized way when you're discharged from hospital. And standardized kind of sounds like a scary word, but it really just means what – we want to ask the question in the

same way so that we can also send it across the electronic layers, to yourself, to your next provider, to your physician, et cetera.

So, some questions to get us started on slide 16. What types of information would be useful to you at time of discharge from the hospital or the skilled nursing facility or the rehab hospital or the long-term care hospital? A few examples might include instructions on medications, physician follow-up appointment information, contact information for others that perhaps you're to reach out to once you're back in the community.

Another area might be information on the next steps of your – in your recovery, are you expecting to have home health visits, doctor's office visits, therapy visits. Another area might be what you need to do to prepare for the patient transition. Perhaps you're a caregiver and you're about to take your loved one home from the hospital, but nobody gave you key information, what kind of information is that. Another area might be what resources are available in the community. Often people are going home and they don't know how to reach out to a home health aide if they need some short-term assistance in the home or assistance to the doctors, et cetera.

Slide 17 shows a slightly different set of questions, what type of information was useful to have when you moved into the next stage. So, now, we're not just thinking about transitions, but did the clinical team have all the information they needed from your care giving team when they admitted you or when you went to the doctor's office did they ask for your med list and you didn't think to bring it.

Were there additional pieces of information that would have been helpful to you in changing locations? Did you know who to contact for help after the transition occurred? Do you have a case manager from the discharging organization, your primary care physician? Did they know that you had been in the hospital, talk to your surgeon? Are they communicating with your hospital physician? Were your care goals incorporated into the process? And if not, how could they be better integrated into your care plan? We often hear

this comment that, “Well, nobody asked me.” What types of things is it important to know and to make sure is being asked when you’re being discharged?

Slide 18 is the last set of questions I’m going to read off to you. What types of information would be useful to you when you return home? So, not just leaving the organization, but now you’re going home. Things like who should you call if you do not feel right, not quite sure if that’s normal for your condition and you think you might perhaps check. How will you get your meds if you live alone? How do you get special equipment such as a shower bar so that you can safely take a shower even though it might be the week following surgery? Are you expected to change your loved ones’ bandages and what do you need to know about that? When should you be worried about your loved ones’ energy levels or their appetite or their pain? So, we’re interested in the viewpoint of the patient and also the caregiver. Lastly, what else do you wish you knew or had had available when returning home after the hospital? Your input today can help make other people's experiences much safer and easier.

So, again, on slide 19, I’m just going to summarize what we’re looking for from yourselves today. Our goal is to develop person-centered standardized items for post-acute care. We want to identify information that consumers need to make easier care transitions. And just looking forward, we expect that stakeholders such as yourselves will be engaged throughout this process, including invited to future special open door forums. But for today, we’re really focusing on that second bullet and would love to hear from you about the types of information you would like to see be made available consistently during your healthcare process.

Jill Darling: Thank you, Cindy, and thank you, Barb. Into our Q&A please.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question 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 press star one again to rejoin the queue.

And your first question comes from the line of (Kristin Finley) with Desert Star Home Health. Your line is open.

(Kristin Finley): Hello. This is (Kristin Finley) and thank you so much for taking my call. I am calling from a home health agency, but I am calling on behalf of quite a few of our patients who have had this question. We are concerned about how we are taken out of their insurance by (inaudible) and – which interferes with, you know, our practice of care and weakens those outcomes that, you know, we're moving towards a payment on outcomes and we've had quite a few patients being taken out and we're in the middle of the care period and (these deals) that they are not, you know, part of that process.

So, the question is at what point or when do the HMOs are being pulled into this wonderful direction that we're moving with health care with the uniformity and the standardization and the communication and improving the care and coordination and that's my question.

Barbara Gage: Thank you. That is an excellent question. As you know from working with the HMOs, they are required to provide the beneficiaries with all of the benefits in the traditional program so and many of them are involved in advancing their IT systems, but this law particularly is directed at the providers participating in the Medicare Program so to the extent that the HMOs are using Medicare-certified providers they will be pulled in to the standardization process.

(Kristin Finley): OK. Thank you.

Operator: And your next question comes from the line of (Rosebio Santos) with the VeriraView Medical. Your line is open.

Racibio Santos: Yes. Good morning. It's Racibio Santos. Thank you so much.

Yes, we were just actually thinking. We are talking about standardized assessment tools, but it seems like for the data that we are - that we need to collect anyway that the system is already in place, should we be using and revising the same form or you know or a standard form because it seems like there would be actually more optimal way of collecting the data for any entity or more so actually with CMS if we have a specific standardized form, a standard form actually that would be distributed, you know, to each, you know, specific facility for example a specific standard data for SNF, specific, you know, form for IRF and so forth.

Barbara Gage: Thank you. That is part of the goals of the implementation of the IMPACT Act is to standardize the forms that the - standardize the items on the forms that the providers currently use.

The question today is really what additional information is important to the consumers and the beneficiary communities in addition to that, which the clinical efforts are standardizing i.e. How we refer to the medical conditions, how we refer to the functional impairments and how we refer to cognitive issues, but what other pieces of information are the beneficiaries interested in having provided.

Racibio Santos: OK. Thank you for that. So I'm so sorry. Just to follow up so we would be still probably using our own form in revising it. We were just talking about it actually in a separate, you know, session, you know, just with our group that if ever for it to be more standardized, it would be like if I'm referring to Page 3 then the other person collecting data would also be looking for Page 3, but probably we're looking at it, you know, a little bit more, you know, specific, you know or some sort.

Barbara Gage: Exactly. If you are seeking from a beneficiary community or an advocacy group and you were designing a form about the information that your community thinks is important, please do share what types of information you think that is. CMS's goal is then to be able to incorporate the input that they

hear from this community into these standardized forms that the providers submit and the last slide in the slide (deck) gives you the CMS IMPACT mailbox address where you're welcome to send the copy of your form. It is PACQualityInitiative, one word, @cms.hhs.gov. We'd love to be working with you because you're right, nationally if everybody uses the same set of items it will be much easier to communicate across organizations.

Racibio Santos: All right. Well thank you so much. While we don't have that specific form, we'll just have to make sure then that all of the important items are actually included in our form, but hopefully one day we'll have that so it will be really standardized. Thank you.

Barbara Gage: Ok. Please do send in the types of items that you think are important to have in that form as a - as a patient or a caregiver.

Arcadio Santos: Yes ma'am. Thank you so much.

Barbara Gage: You're welcome.

Operator: And your next question comes from the line of (Brock Eichenhofer) with (JEVS). Your line is open.

(Brock Eichenhofer), your line is open. If you're on mute, please unmute.

(Brock Eichenhofer): Hi. Can you hear me? Hello.

Barbara Gage: Yes. Go ahead.

(Brock Eichenhofer): Oh sorry about that. Yes, I work with nursing home transitions and I'm on a committee that's kind of looking at hospital discharges and one of the questions that we- or one of the concerns -we have is that a lot of the people that get discharged have problems getting to that first doctor's appointment after their discharge from the hospital and one of the things I think about all the time is a couple of things, transportation issues or having someone to take

a person to a doctor's appointment and some of the considerations we've - we've given is like doctors that make house visits or there's some things that you can do like online with monitoring people like TeleMed and things like that and I'm wondering it's such an important thing to get the people to that doctor's appointment for follow-up and it's not happening in many cases and in fact can be addressed either through really looking at transportation needs of people or other ways of getting the person to be seen because they can't get to the doctor for whatever reason medically or transportation wise.

Barbara Gage: Thank you for your comments. So as a take-home suggestion then are you thinking it would be useful to ask the patient whether they have a ride to their next - to their follow-up physician's appointment and whether they know ...

(Brock Eichenhofer): Yes.

Barbara Gage: ... the physician's ...

(Brock Eichenhofer) Yes.

Barbara Gage: ... follow-up.

(Brock Eichenhofer): Yes and not even - not only if they have a ride or if they could even use a ride because some people are just physically unable to get there for whatever reason. Like I work with people that are morbidly obese or they have some other thing going on where they can't even get out of the house, I mean that is a consideration too.

Barbara Gage: Thank you.

(Brock Eichenhofer): Sure.

Operator: Your next question comes from the line of Cathy Dale from the Los Angeles Jewish Health. Your line is open.

Cathy Dale: Hi. Good morning. Our question here is when we're looking at all of these forms (that you have) laid out in front of me, I have the (ARCS) Assessment, I have the OASIS Assessment, I have the MDS Assessment and I have the New Section GG. When we talk about the people who complete these assessments, you have mastered prepared therapists, you have LPNs maybe in home health with one year, you have MDS coordinators who are RNs two years possibly a bachelor's degree and then you have CNAs with six months of education. We do not all speak the same language.

How will the IMPACT Act uniform that because when you look at all of these assessments now the scales go from zero to six, six being on totally dependent to from one to six, six being on Section GG independent and one being dependent. There's no consistency, continuity and again you got people speaking different languages so we're wondering how you're going to unify all of this so that we all speak the same language and at the lowest level of education.

Barbara Gage: Thank you Cathy. That's an excellent question and it's really the heart of the IMPACT Act.

As you noticed, those differences are the current state of affairs in the four different federal tools just because of historical reasons so a great deal of work has been going on over the last 5 or 10 years to reach consensus across the different clinical communities, identify the most important pieces of information from the clinician's perspective that are needed to be able to identify differences in care needs as well as be able to think about outcomes and to work across the clinical communities to reach a consensus about the best language for collecting that information. So that work is underway and Section GG shows the results of some of that as it is being moved into each of the assessment tools to have a standard way to ask about mobility or to ask about self-care items.

The question today is really about information that's important to the consumer that they would like to have available in order to improve

transitions of care so beyond the immediate clinical information that's captured on the assessment tools what information are the consumers or the patients, the caregivers, the advocates wishing they had in order to have a better health care experience.

Cathy Dale: Well (some of the work) to that would be again going back to the consumer's transition, again they would need to be able to understand the language of the information about themselves presented, but also you know leaving the hospital out of there, how they transfer through that hospital stay to this other the IRFs, the SNFs, the home health, the hospice having that language for all of the people, their family members, the patient has been solving, understanding where somebody thinks they really are at and then Section GG when you -- when you have Section GG and then you have Section G at the MDS where there are two separate different categories all in the same form that don't speak the same language just in the one, the scales are the opposite.

This is really challenging consumers, the people that are taking care of them, the information that comes from the hospital. This is such a - such a huge challenge. It's obviously a great need because we do not even as we sit down in meetings and we transition people through all these levels of care.

Barbara Gage: Yes thanks. Well thank you Cathy. You've underscored the importance of the IMPACT Act and we're happy to discuss further, but we take your point very seriously about making sure that the language of the information given to consumers is at an appropriate level for even the least health literate person.

Thank you. We're - We're running short on time I fear. Is there another question?

Operator: Yes. We have a question from the line of Diana Puckett with Caris Healthcare. Your line is open.

Diana Puckett: Thank you. I wanted to (expand there) as far as the language of the standardized tool that we're using if there'll be any I guess recognition that

the patient has had some kind of previous hospice or that they're currently on it. (all of the times) we found the patients may be under service and maybe their (own) family member rushed them out to the hospital and once they get there the staff there doesn't realize that they are on hospice or if they'll be any information provided to consumers so that they know the comfort care and palliative care options that will be available to them.

Barbara Gage: Excellent suggestion. That's a good point. That having an awareness of the patient status as being on hospice when they're coming in to the hospitals would be very useful. It's certainly been an issue in the hospice program and this is a great opportunity as we develop exchangeable interoperable data for the hospital to actually see immediately that this patient is on hospice and the information about alternatives is a - it sounds like you're suggesting that there should be something, some type of consumer education piece that informs the patients of all of their choices similar to what's in the hospice program, but more widely used.

Diana Puckett: Yes.

Barbara Gage: Thank you.

Operator: And your next question comes from the line of (Dorothy Winningham) with VHQC. Your line is open.

(Dorothy Winningham): Hi. My name is (Dorothy Winningham) and again I am calling or my question is from the patient experience in the facility. I think that the patient should be given additional information prior to the release from not the hospital, but from a previous nursing facility to another nursing facility and the reason I make that statement is because I have experienced it as an advocate for my brother. He was given like one day to find another location and so how, you know, my question is the information should be given to the patient or to the advocate and plenty of time for them to help them make that decision.

Barbara Gage: Thank you (Dorothy) and what type of information would be helpful to have?

(Dorothy Winningham): Well the case that I'm talking about is that at the time that I was notified that he had 24 hours to get out of the facility, their concern was he did not fulfill the requirement such as therapy and I did not know that until that event and I was - I was like kept (abreast) of the situation that was going on. Does that help you?

Barbara Gage: OK. So it sounds like what would be useful is as the organization, the case manager, the physician, whoever is in charge of the patient should be given enough information for them to understand if their benefits are about to run out as well as perhaps the next steps in terms of options to continue their - their health improvement.

(Dorothy Winningham): That's correct.

Barbara Gage: Thank you.

(Dorothy Winningham): And enough notice for you to make a better decision instead of just finding a place to house them until the advocate can find a better location. (You're welcome).

Operator: Your next question comes from the line of Kim Evansoski with Care Manager LLC. Your line is open.

Kim Evansoski: Thank you very much. This is Kim Evansoski with Care Manage for all and my question really relates to transitions programs and long-term care. For patients we see that hospitalists are serving them and giving them medications and issuing more medications upon discharge than they have had previously and for the next day or the following week, they go to their primary care physician, (a doctor) and they change those medications or they take those medications away and we're seeing tremendous amount of cost to patients and I don't know how we can kind of collaborate on this because this is a very big burden to family so I'm kind of just putting it out there, you know, do we need

to relook at some of, you know, the medication issues and you know can we look at highlighting medication changes or when medication changes come do the - do the physician coordinate because it really, really is a burden on these families.

Barbara Gage: Thank you. Medication reconciliation is one of the key areas that comes up time and again and again we are interested in your suggestions about the types of information that would be helpful to your patients and consumers.

Operator: And your next question comes from the line of (Peg Ram) with (Qua). Your line is open.

(Peg Ram): Hi. First, I'd like to thank the people on this call and to the presenters. If 10 years ago someone had told me that a call like this would ever happen I wouldn't have believed it so thank you to everybody and the work they've done to get us this far.

On building on the question, the prior question on transportation, have you thought about the whole issue of community-based social supports in the growing thankfully growing trend of connecting people prior to discharge and perhaps including the case manager name and phone number on the form, I have a feeling that that might be a growing area of informational need.

Barbara Gage: Thank you. That is an excellent suggestion (Peg). One of the questions that does come up is who to call, you know, who is the case manager once the person is discharged from the organization, do they call back to the case manager at the organization, is there somebody else associated with their insurer, et cetera so having a name right there in the patient's materials and perhaps their contact info sounds like a great suggestion.

(Peg Graham): And if I may I know that we can ask one question and then perhaps a follow-up comment. I just had a friend who is an RN who was just discharged from a major academic medical center and her caregiver was a friend, also an RN and they were sharing with me the fact that their discharge plan was 17 pages long

and that these are both RNs, it took them a while to figure out how to organize the data so that they divided it up into three categories. I forget what they were, but it took them a while to figure that out so there is that.

And then another friend who was very active in the AIDS community and health policy and help create health homes and what have you, she's been on In-Care for some intensive chemotherapy and in her discharge plan, which I saw personally there were five pages on smoking cessation. She has never smoked a day in her life. So I think that, you know, there is in addition to finding common elements, I think it might be an organization and length challenge.

Barbara Gage: Thank you and you also gave us a suggestion, kind of a discreet suggestion that while these items can become interoperable, one could use that to also reduce the number - the pieces of information that are then actually given based on the individual patient circumstances so for example knowing that the patient didn't smoke, you don't need to include those pages of the form of the information and interoperability and Peg Graham having electronic data empowers these types of changes so thank you.

(Peg Graham): Right and again as I go - as we and - as I and my connection with you today, I want to thank a work that has preceded this I'm sure it was not always fun.

Barbara Gage: Thank you very much.

Operator: Your next question comes from the line of Silvia Yee with DREDF. Your line is open.

Silvia Yee: Hello. I just want to - I would like to thank you for the presentation. I have two questions and just a brief comment. I'll give the questions all at once and you can decide how you want to address them.

The first is up I'm curious how this effort is aligning with the dual's projects and the dual Medicaid eligibility. Those - Those projects that are going on

around the country as assessment tools, uniform assessment tool and one that actually combined addressing acute care needs and long-term services and support needs are I think a large part of those demonstration projects so I was wondering how the two interacted or if there was an interaction.

Second in terms of the information that people need or could be useful to those or discharge. I was thinking about peer support and in particular while I do think it's - it's critical for those who are being discharged from the hospital to have information about other options and especially home and community-based options, I think for new for - especially for older people who are acquiring - who are acquiring (disability) for the first time, there is really not understanding what it means to be at home and to work through a permanent chronic condition or new disability or work through a temporary one and the idea of a peer support and especially connections with people who have had disabilities for a long time, people who have maybe the same level of functional impairment, but who are functioning with that in the community, connections to independent living centers, connections to aging and disability resource networks that that information can be very critical to those who are going home for them and for their families.

And finally just a quick comment on transportation and I certainly support the earlier commenter who made that comment that understanding transportation , how they can get not only to their first appointment, but subsequent appointments, the barriers that they may encounter and what they can do about those barriers is very, very important. Thank you and this is Silvia Yee of DREDF.

Barbara Gage: Thank you for the - for the insightful questions Silvia. As you - As you know, there's a great deal of many initiatives happening across the Centers for Medicare & Medicaid Services and much alignment across the different initiatives including the dual's projects as well as another piece that I know I'm working on with the home and community-based waiver projects under the TEFT grant so and that's just to mention a couple so there are many efforts where coordinating care for Medicare beneficiaries or Medicaid

beneficiaries is underway. It really all comes out of the ACA and the goal to improve the nation's health so thank you and thank you for your suggestions on asking about barriers to transportation and providing information on some of the community-based services as well as the medical services so it's an important point especially for people new to their disability.

Jill Darling: Sally we'll have one more question please.

Operator: All right. Your next question comes from the line of (Sharon Solomon) with Belmont Hospice. Your line is open.

(Sharon Solomon): Yes. I just have three quick comments. I think one of the things that we find challenging for patients is when they leave the inpatient setting they don't have their C2 scripts so they're not able to quickly obtain their medications for pain if they're not on hospice prior to leaving the hospital or if they're going to a home care situation.

The second thing is that often this acute care or sub-acute plan of care including the medications might not be formulary for the patient when they leave the hospital and they could be unaffordable for the patients and their families so knowing what their medication coverage, insurance pays for in a home setting is pretty critical and the third thing and one of the other callers mentioned this is that families sometimes or patients are choosing a sub-acute level of care due to perhaps not having the ability to pay for room and board coverage and I don't know if that was the case with the prior comment, but in an assisted living or a skilled nursing home so the patients are going to sub-acute, they're not being successful and then they are either going back into the hospital or sometimes they are very late referral to hospice and I think it's not being talked about enough that many families cannot afford to pay for caregivers in their homes. They are working and they cannot afford the room and board coverage in a facility.

That's all I have. Thank you.

Barbara Gage: Thank you for your comments. If you have ideas about how to incorporate the formulary questions and the - it sounds like you're thinking about some type of question asking about their - their coverage or using some of the information like on their prescription drug plan, or the COMPARE Web sites that would identify whether a drug was on their coverage benefits so that when they are discharged they know if they have to pay out of pocket. Good suggestion.

Are there any closing remarks?

(Laughter)

Barbara Gage: Well I might add that I think this has been a very helpful discussion. The beneficiaries, the patient really is at the heart of treatment. It is their outcomes that everybody is working towards and so this is very helpful.

We will continue to look for comments. As you turnaround and you go home and you are talking to others, or say gee I wish I had this information when I was discharged, please share the website, the CMS IMPACT mailbox site with your friends and neighbors. No idea is too small or too big. They can just submit it via Web to PACQualityInitiative@cms.hhs.gov as shown on the last slide of the slide (deck), slide 21.

So we'd like to thank you for coming today. Your input was invaluable.

Operator: Thank you.

Cindy Massuda: And this is Cindy Massuda and I also on behalf of CMS wanted to thank you. The kinds of discussions with the patients, the families, the caregivers and those working with the patients in the settings, the different post-acute care settings have been extraordinarily insightful and we really, really appreciate it on behalf of CMS, on behalf of the RAND Corporation for this contract.

I can tell you in order to move this work forward, we need the input from patients, families and caregivers so I can't stress enough in order for us to reach the goals of the IMPACT Act, your input is highly, highly important and critical. We welcome it and can't stress that enough on behalf of the Centers for Medicare and Medicaid Services and also the RAND Corporation who has the contract related to the work we're discussing today.

So as Barb Gage was describing then as questions you have or you want to keep bringing comments, the mailbox that we have -- the PACQualityInitiative@cms.hhs.gov. Please use it. As we respond to all questions that come in. It is actively monitored and actively responded to so we highly appreciate your input and your being on the call today. Thank you very much.

Operator: Thank you ladies and gentlemen for your participation. This concludes today's conference call. You may now disconnect.

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