

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act of 2014)
Wednesday February 25, 2015
1:30-2:30 pm Eastern Time
Moderator: Jill Darling

Operator: Good afternoon. My name is (Ryan) 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, Improving Medicare Post-Acute Care Transformation Act of 2014 Special Open Door Forum.

All lines have been placed on mute in order 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 at this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question from the queue, press the pound key.

I would now like to turn our call over to Jill Darling. Please go ahead.

Jill Darling: Thank you, Ryan. Good morning and good afternoon, everyone. My name is Jill Darling in the CMS Office of Communications, and welcome to today's Special Open Door Forum – the IMPACT Act of 2014.

Before we begin, I would just like to say that this Special Open Door Forum is not intended for press. Press should contact press@cms.hhs.gov with any inquiries.

So, we'll begin, and I will hand the call over to Stace Mandl who is the Deputy Director for Division of Chronic and Post-Acute Care.

Stace Mandl: Hi. Thank you. First of all, this is Stace Mandl. I want to thank everybody who has taken the time out to join this call. Hopefully, you're able to grab the slides on the Website that we provided. If not, they'll be up online and we're not intending to take those down anytime soon. I'm also joined by my

colleagues from the Division of Chronic and Post-Acute Care, who can also answer questions related to the measures which will be the main focus of this discussion today.

We're here to really talk about the IMPACT Act of 2014. The Improving Medicare Post-Acute Care Transformation Act or the IMPACT Act of 2014, as you know is transformative. It does stand for transformation. It was a bipartisan bill introduced in March, passed on September 18 and signed into law by the president on October 6.

This fairly massive Act requires standardized patient assessment data for assessment and quality measures, quality of care, improved outcomes, discharge planning, interoperability, and care coordination. What's very unique about this Act, that I wanted to just highlight for a moment and quite obvious to most, is that it really allows for information to follow the person. The data and the use of standardized data enables another sort of chapter in post-acute care, where providers would be able to utilize data for care coordination purposes. In fact, that intent is spelled right out in the Act.

For the purposes of this discussion today, I'm really going to be focusing on the quality measures and touching on the health assessment domains.

So on slide three we have just some simple definition. The post-acute settings that are impacted – I have to say it – by the IMPACT Act are home health agencies, skilled nursing facilities, inpatient rehab facilities, and long-term acute care hospitals. The applicable post-acute assessment instruments that the IMPACT Act spells out as requiring standardized data to be submitted through are: for home health agencies, they currently submit the Outcome and Assessment Information Set, or the OASIS instrument; for skilled nursing facilities, they already submit the resident assessment instrument/minimum data set; for inpatient rehab facilities, they submit data using the inpatient rehab facility patient assessment instrument, and; for LTCHs, they submit the LTCH care data set.

So the Act requires that standardized assessment data be submitted for quality measures as well as for assessment. It requires that providers report data on

resource use and other measures. It requires that data must be standardized and interoperable to allow for the exchange of data using common standards and definitions to facilitate care coordination, which is what I had touched on, and to improve Medicare beneficiary outcomes. The post-acute assessment instruments must be modified over time to enable the submission of standardized data and to be able to compare data across all applicable providers.

I am on slide six. So in the Act, it spells out the data categories for the assessment instruments that must have standardized data within those specific domains; it requires that the assessment data use the instruments that I had just listed, and; that data be submitted with respect to admission and discharge, or more frequently as required. These data categories are functional status, cognitive function and mental status, special services, treatments, and interventions, medical conditions and comorbidities, impairments, and other categories as required by the secretary.

As for using standardized assessment data, the IMPACT Act was very specific about its timing - October 1, 2018 for SNFs, IRFs, and LTCHs and January 1, 2019 for home health agencies. So this is a journey - a marathon, not a sprint. We're all a part of this journey, so we'll definitely be working together over time to develop the data elements for those domains and others (all which will require rigorous research and testing at the national scale.)

On slide seven, the specified quality measures are: functional status, cognitive function and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; the incidence of major falls, and; communicating the existence of and providing for the transfer of health information and care preferences. These five domains are the minimum. I want to point out that they tie directly to the goals and objectives as stated under the National Quality Strategy and CMS' own quality strategy.

On slide eight, we list the resource use and other measure data coming in from those four providers. At the least, these domains include: the total estimated Medicare spending for beneficiary; discharge to community, and; measures to

reflect all-condition risk-adjusted potentially preventable hospital readmission rates.

The statute also is very clear on the stages and phases of the implementation of the measures and the sort of major milestones that go with them. The first measure implementation phase requires that we number one, specify the measures. So we have an entire process. We call this the blueprint that we engage in for measure development, which includes expert panel review of the measures, data collection and analysis. We do that through our contractor contracting experts. We have a period of time where we seek public input. We also go through the measures application partnership, the MAP process. Then we go through rule making, where we propose measures that have gone through the other processes, and do or don't finalize such measures. Those steps are all required under the IMPACT Act. And then, as part of the first phase, is actually the data collection, or we say data submissions.

The second phase is one year following the implementation of the data coming to CMS. We are required to provide to the providers private and confidential feedback reports. And then one year following that is the third implementation phase which includes public reporting of post-acute provider's performance with an opportunity to correct. We also have to provide a review period prior to public reporting.

Just a couple of other activities to note. We are required to use measures that are consensus-based entity endorsed. We currently do that through the National Quality Forum. However, there is an exception if we don't have any measures that are currently endorsed. We are also required to utilize the pre-rulemaking process, the MAP. We can do that through an ad hoc process or through the regular process.

Actually, the statute also allows us an exception if we simply cannot manage to do all of this in time for rule making. However, this year [we utilized the MAP] and we hope to continue to use that process. It's extremely important to us in our efforts to be transparent and to get feedback. We just are about to complete the ad hoc process for the upcoming rule cycle.

So I'm going on to slide 10. One other rather major implementation requirement is – under the IMPACT Act – the establishment of the skilled nursing facility quality reporting program. It is, for the most part, very similar to the other post-acute quality reporting programs. SNFs that fail to submit the required data are subject to a two percent annual payment update reduction. It's a penalty for failure to report, and the reduction only applies to the payment year involved. So that's a little bit about the IMPACT Act as it pertains to the standardized data and the quality measures, the resource and other measures, and the assessment domains.

I want to dial back in time to give a little bit of footprint leading up to this incredibly important legislation. The use of standardized data dates way back. In fact, we've been collecting standardized data by setting for nearly two decades for nursing homes. What's a little different about this [legislation] is the use of standardized data across programs.

Back in 2000, the Benefits Improvement and Protection Act required that standardized items be applied across the Medicare program, to supersede current items. That was followed in 2005 by the Deficit Reduction Act, or the DRA, which required the use of standardized assessments across acute and post-acute settings. [The DRA] also established the Post-Acute Care Payment Reform Demonstration, or the PAC-PRD, which included a component testing for the reliability of standardized items when used in each Medicare setting. So in other words, the same data element, same question, and same response code options were tested out across settings. [Testing] was done for multiple purposes, but there were several important things that they were trying to (gleam) at that time. One was, can you use a uniform questionnaire response code and apply it with good, healthy interrelator reliability and validity across settings? Can you capture patient complexity in varying levels across facilities and within facilities?

And in 2006, the PAC-PRD had a requirement that the data meet federal HIT interoperability standard. So as you can see, there was a little bit of groundwork laid down over the last 15 years getting to this point. In PAC-PRD, the CARE tool, the CARE item set, was the item set that was used for across setting testing and the testing occurred from acute care hospitals,

LTCHs, IRFs, SNFs and home health agencies. But what's important to touch on here is the relationship of the information from the PAC-PRD and the CARE tool or the CARE item set and the intent of standardized data that supports interoperability. This whole concept of data following the person or information following the person to help with care coordination.

Basically, if assessment data is uniform, reusable and informative, it can help achieve data that can communicate in the same language across settings and it can ensure data transferability. In summary, basically, data uniformity and standardization increases reliability and validity. It allows information and data to follow the person and that, of course, facilitates patient centered care and care coordination.

And this reaches our goals: fostering seamless care transitions; having data that can follow the person for improved outcome; be able to evaluate longitudinal outcomes; really see how folks are doing in the long haul; assessment of quality across settings; improved outcomes and efficiency, and; reduction in provider burden.

On slide 13, there is an important link. If you want to learn more about the CARE tools, the testing, the PAC-PRD, and so forth, there is a link that you can go through to get that information.

Slide 14 is an example of when we talk about standardized data and use of one slice of information for multiple purposes; get once, reuse many times. This is an example of questions on the right side of the slide (three questions) and then there are response codes that the clinicians provide into those boxes - and it actually was done electronically. We get our data electronically through the QIES ASAP system. And what's important to note too is that we don't just have these assessment instruments. They are part and parcel with very detailed manuals that instruct on how to code, and we also provide trainings.

On slide 15, when we talk about get once and use many times, the data element and response code that come to CMS are used for multiple purposes – the quality reporting, payments, and other uses. But also at the local level, they're used for quality improvement, care planning, decision support, and

also care transition. The data elements are being used, at least in pilot but not in real time, for the purposes of transitions in care. So this is where the IMPACT Act brings to life – I don't know what color that is, kind of pinkish color at the end – care transition. That's a very critical feature of the IMPACT Act.

Slide 16 is one of my favorite pictures because it's very colorful. But in the center, while all of these assessment instruments are going to have to have very unique assessment, questions and response codes for those settings, where the information is necessary across the settings is where you get the sweet spot of uniformity. And we know that there are going to be unique needs in an LTCH perhaps versus home health assessment needs. But where you're looking for health information that can be transferred should be transferable or that simply is necessary for quality measures across settings, in the center is where the uniformity needs to happen.

Slide 17 is really just about the ideal state and looking towards this ideal state; not just what's happening today, and not even necessarily what's happening in two years from now, but really reaching the ideal state which I think we all want. A convergence in language where we can communicate about a person's need no matter where they go, even outside of the settings and into the community; where data elements used are clinically relevant; where care is coordinated using meaningful information that is spoken and understood by all; where measures evaluate quality across settings and evaluate intermittent and long term outcomes; where the measures and the information can follow the person, and; where the incorporation of needs beyond the healthcare system can be achieved.

Slide 18 shows where it all comes together. CMS developed six measures pertaining to function. Function, as we all know, is one of the most important indicators of long-term outcomes. Improving function, maintaining function or simply reducing decline in function touches on all of the priorities of CMS quality strategy and the goals and priorities of the National Quality Strategy.

The data elements used to develop the function measures come from the CARE item set. That section of the CARE item set tested well enough to

develop these measures after years of rigor and testing. [Through] CMS and its contractor, six measures were developed [and] allow for items that have been tested across the spectrum.

So what we'll get into now are the measure domains and the measures under consideration right now. As I stated previously, we have the option to utilize an ad hoc MAP and we opted to utilize and apply that ad hoc MAP process. We have a tremendous amount of gratitude for the folks that served or are serving on the workgroup, the folks at NQF and our colleagues here that made this happen...as well as our sister agencies who went through clearance with us.

On February 9th, the NQF held the first ad hoc workgroup meeting for these measures under consideration. The measures were posted on the www.qualityforum.org website and public comments were opened on February 11th. The second workgroup MAP coordinating meeting will be meeting this Friday, where they will finalize recommendations on these (off-cycle) measures.

So what I'll do right now is to simply state the domain again under the IMPACT Act and the measure that was on the MUC list. The first domain is functional status, cognitive function and changes in function and cognitive function. And the [corresponding] measure is Percent of patients or residents with an admission and discharge functional assessment and a care plan that addresses function.

The second category – and I'm on slide 19 – is skin integrity and changes in skin integrity. The measure under consideration is NQF-endorsed #0678, Percent of Residents or Patients with Pressure Ulcers that are New or Worsened.

And the third category is Incidence of major falls and the measure under consideration is Percent of Residents Experiencing One or More Falls with Major Injury. That is NQF-endorsed #0674.

The other measures on the measures under consideration list are applied to measures to reflect all condition, risk-adjusted potentially preventable hospital

readmission rates. And therefore, I'm going to combine two together. For the IRF and the LTCH setting, it's the All-Cause, Unplanned Readmission Measure for 30 Days Post Discharge from the Inpatient Rehab Facility or from the LTCH. And those NQF numbers are #2502 for the IRF setting and #2512 for the LTCH setting.

The third measure is the Skilled Nursing Facility 30-Day All Cause Readmission Measure, NQF 2510, and then Home Health services, NQF #2380, Re-hospitalization During the first 30 Days of Home Health.

So what I would like to do now on slide 21 is provide a little bit of insight as to why these measures and to also stress that we're approaching the IMPACT Act as a marathon and not a sprint. We are looking at the totality of measures considered for use for the purposes of meeting the requirements of the IMPACT Act and knowing that this evolve over time in a phased approach.

To meet the statutorily required fiscal year and calendar year 2017 timelines, our review and consideration was given to metrics that: number one, address a current area for improvement, and; number two, consider measures in place in post-acute care quality reporting programs that are already endorsed, , finalized for use in the program, already previewed by the MAP with support and minimize burden.

Slide 22 is simply a place where you can see more information pertaining to this discussion. At CMS, it's our quality initiative post-acute care website.

Also, you can email your comments and questions to:

PACQualityInitiative@cms.hhs.gov mailbox. And I'm going to turn it back over for questions.

Jill Darling: Ryan, we'll take our – we'll have our Q&A session now please.

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

Your first question comes from the line of Cynthia Golden from Bon Secour.
Your line is open.

Female: Identify yourself.

(Judy Campbell): Yes. This is (Judy Campbell) and I'm with Bon Secour with Cynthia Golden.

Stace Mandl: Yes. Go ahead.

(Judy Campbell): I have a question for home care. Why can't occupational therapist do admissions?

Stace Mandl: I think that that question may need to be handled through a different forum. I would suggest submitting to the Help Desk. OASIS answers.

(Judy Campbell): OK. Thank you.

Stace Mandl: Sure.

(Judy Campbell): Thank you.

Operator: Your next question comes from the line of Cynthia Morton from MASL.
Your line is open.

Cynthia Morton: Thanks for the presentation today. Does CMS need to go through formal rule making on particular quality measures after they've been through the NQF process?

Stace Mandl: There are no requirements on the sequence, but we do have to go through rulemaking to adopt measures into the quality referring programs.

Cynthia Morton: So in other words, the quality measures, for example, the couple of ones you showed on those couple of slides, will need to go to formal rule making?

Stace Mandl: Yes. For the purposes of implementing measures, these measures in the programs to satisfy the IMPACT Act, yes. They do. They do go through rule making.

Cynthia Morton: Thank you.

Operator: Your next question comes from the line of Kate Stimeford from America Academy. Your line is open.

Kate Stimeford: Hi. I just have a question in – with regard to how the quality measures would sort of interface with other medical necessity measures. What I'm thinking of in particular is the 30-day readmission, let's say, from an IRF and there are conditions that IRFs can treat. They have the, you know, medical capabilities of doing it, but the patient may not be able to participate in the three hours of therapy while they're being treated. How do you reconcile those two things?

Joel Andress: This is Joel Andress. The IRF readmission measures are agnostic to that particular issue. They apply to whether or not a patient has been – in the case of the IRF and LTCH measures – whether or not a patient been discharged from the care of the setting in question and if there is a return to an acute care setting or a long term care hospital within 30 days following that discharge.

Kate Stimeford: So basically, if you have a patient that gets sick in IRF, you can't win. If you transfer them back, you got the 30 days. If you don't transfer them back, you got lack of medical necessity.

Joel Andress: I'm not sure I'm understanding the question. I mean – are you saying if a patient is discharged – gets sick within the LTCH and then is transferred to a hospital for care? Is that what you're referring to?

Kate Stimeford: Well, I'm talking more of an IRF. That's what I'm more familiar with. So I'm saying if a patient is admitted to an IRF, they're getting rehab, they're doing whatever, may get sick then the IRF has two alternatives. They can treat them there but the patient may not be able to participate in therapy during the treatment or they can transfer them to an acute care hospital. And it seems like either choice is going to result in a bad effect.

Joel Andress: OK. So to clarify. Patients who are discharged from an LTCH and go to acute care hospital the day of the discharge or the day following are not counted as a readmission. Those are treated as transfers. And so the facility would not be penalized for that action.

Kate Stimeford: Oh, OK. Thank you.

Joel Andress: I'm sorry. It took me a second to understand what you're asking.

Operator: Your next question comes from the line of Miram Blankeneiller from Marshall Homecare. Your line is open.

Miram Blankeneiller: Yes. Hi. This is (Miriam). I have a question about – question about the data collection process. Is it going to be through like for home care the current OASIS data or is it going to be a separate questionnaire and how will it be published like to a public website since this is considered improvement for transitions in care? Are different organizations going to be able to access it if they take the patient up or the patient is transferred to skilled nursing? Would they have access to the information that was acquired through home care?

Stace Mandl: Thank you. This is Stace. So the statute actually dials back to the original assessment instrument for home health, which is the OASIS instrument. Any updates to that instrument will be exactly how they've always been done. Data exchange between providers is a business decision that you engage in. Having standardized data simply enables or helps facilitate that process.

Miram Blankeneiller: OK. It seems like that process is already in place. And so I'm not sure why this needs to go to a federal level then or beyond that. I mean it sounds like through our OASIS data, which is already collected, how is – what you're doing with IMPACT is going to change what we're already currently doing.

Stace Mandl: The IMPACT Act requires specific measure domains to have data submitted from the OASIS instrument and it requires certain domains to be standardized across the settings. Those are some key – potentially some key – differences I think.

Miram Blankeneiller: OK. Thank you.

Stace Mandl: Sure.

Operator: Your next question comes from the line of Crystal Darnell from Mohun Health Care. Your line is open.

Crystal Darnell: Yes. Thank you. I was wondering if you could repeat what other measures you combined with IRF setting. You said you combined two and I was interrupted and I missed it.

Joel Andress: Yes. This is Joel. So (what I think) she was referring to that we developed two measures for readmission for the long-term care hospital and inpatient rehabilitation facilities in tandem. Those are both readmission measures. One applies to readmission following discharge from an IRF. The other applies to readmissions following discharge from an LTCH.

Crystal Darnell: And what number was the LTCH? Was it 2502? I mean 2501?

Joel Andress: I believe it's –

Male: (Inaudible).

Joel Andress: Is it 2512?

Crystal Darnell: The LTCH is 2512 and the IRF is 2502.

Joel Andress: OK.

Crystal Darnell: OK. I just missed it. Thank you so much. That's OK. Sure. And the slides are there.

Operator: Your next question comes from the line of Janine Sollom from St. Joseph Home Care. Your line is open.

Janine Sollom: Thank you. My question is in regard to the 30-day readmission to acute care from home health in the first 30 days of home health and whether their questions are going to change in order to discern whether it was discharge planning issues or patient failure in the home health setting. Is there going to be some changes in the OASIS? We've just changed to OASIS-C1. Are we projecting additional changes to that data set?

Joel Andress: OK. So there's a lot ...I'm going to try to make sure I catch everything. If I don't hit on something that you want to know about, just follow up and let me know. First of all, the measures are claims based. Second of all, because of the timeline we're operating under to get the MUC list put together, we presented the readmission measures that we currently have available for each of these four settings. What we're going to be doing over the course of the next year is making modifications to them, so that they are potentially preventable. Their current forms are not.

The other issue that we'll be addressing that I think touches directly to your question is the timeframe that we'll be including for the IMPACT Act. The current home health readmission measure as it stands is a measure that assesses readmissions within the first 30 days of home health following a discharge from an acute care hospital. The measures that we will be implementing for the purposes of meeting the statutory requirements of the IMPACT Act will for each of the settings be addressing readmissions within the 30 days following discharge from those particular settings.

So for home health, we'll actually be developing a new measure that addresses a new timeframe. Our expectation is that we'll be moving to cover both. In all the settings eventually, we want to be covering both the 30 days following acute care hospital discharge and the 30 days following discharge from those post-acute care setting. But for the IMPACT Act, we would want to be developing measures of the latter.

I realize that is a lot to take in. So if you have any follow-up, some more questions or needed clarifications, please throw them at me.

Janine Sollom: OK. I just want clarification. So according to this NQF 2380, the re-hospitalization during the first 30 days is the measure domain that's under consideration. But you're saying that in addition to that you're going to be looking at readmission to the home health agency within 30 days of discharge from the home health agency.

Joel Andress: Right. You are correct. That measure does not exist yet and we'll be [developing] this over the course of the next year.

Janine Sollom: OK.

Joel Andress: We ...aren't able to present it now.

Janine Sollom: Right.

Joel Andress: So #2380 is in place. It is something of a place holder but ...it is going to form some of the basis for our work in developing the new measure. The other issue – well, I think that touches everything. If it didn't, please let me know.

Janine Sollom: Well, I hate – I'm sorry. I don't mean to keep persisting. I guess my question really boils down to whether the re-hospitalization in the first 30 days is going to be evaluated from the perspective of whether the discharge may have been inappropriate, premature, or whether the home health agency had some issues with providing adequate care?

Joel Andress: So because these are claims-based measures, we don't really have the capacity to dig into that. The answer is that some readmissions will be a combination of both factors. Some will be largely the responsibility of one provider or another. And the claims data don't have the sensitivity to allow us to grapple with that. Instead, what we have opted to do is to implement readmission measures that are applicable at both ends of the handoff. So the hospital is responsible for readmissions that occur after they send a patient for care at a home health agency and the home health agency is responsible for readmissions that occur after they receive that patient in the handoff.

And as a consequence of that, both providers involved in that transition of care are responsible in some ways to the quality ...whether or not that patient is readmitted. The idea is to create a shared accountability for excessive rates of readmissions so that both providers are motivated to work with one another to enhance the coordination of care during those transitions.

Janine Sollom: Very good. Thank you.

Operator: Your next question comes from the line of Robert Latz from Trinity Rehab Services. Your line is open.

- Robert Latz: Thank you. And thank you very much for the presentation, great information. My question comes related to the functional status measurement that you're looking at and it's a process item at this point. And I guess my question is at what point – since we're looking at a marathon, when are you looking at that moving to an actual quality measure with data elements and I ask about that in part because we're supposed to submit first information 19 months basically 19 months per Monday is what we're looking at and so the timeframe we need to be ready is getting shorter every. When are you looking at it changing from a process element?
- Stace Mandl: I'm trying to understand the process element? So there are data elements that are used in this measure, and they've been posted on our CMS site. If we adopt and finalize the measure, we will provide the submission specifications of successful implementation, just like we always do. But as far as taking a process measure and then turning it into an outcome measure, I don't think we quite – we're quite there yet to answer that question.
- Robert Latz: OK and I guess part of what I'm saying is it's a process measure you're looking at now. Are you – so for 2016 are we going to need to be submitting outcome measures and if so the data elements for those we need to know as soon as possible, I guess is what I'm suggesting and is there any guess as to when they might be available? Thank you.
- Tara McMullen: This Tara McMullen from CMS. Thank you for your question. So as it stands today, we are proposing a process-based measure. You're correct about that. The data elements for this process-based measure will be posted on the post-acute care quality initiative webpage, so you'll be able to review and scan what elements facilities will be collecting on. Development of outcome measures are very important to us. We know outcome measures are top priority, as we move through this iterative process of phasing in quality measures. We will be testing and looking into developing outcome measures that are appropriate for each setting and that are standardized across all settings.

Stace Mandl: Thank you Tara very much for that. Just to clarify, we have to go through the rulemaking process, but before anything is definitive we always do provide for you (the providers of post acute care) the submission specifications necessary for you to make system changes. Any of these that require - we would [ensure you] have the time to allow for that, in the same manner as has always happened. Which I think is what your concern is.

Robert Latz: Yes, thank you very much.

Operator: Your next question comes from the Roshunda Dye from APTA your line is open.

Roshunda Dye: Yes, thank you for the great presentation as well. Just a couple of quick questions, as you implement these measures into the respective assessment tools, (Oasis) NDS and our patient assessment instrument, I assume that there's also going to be a process to eliminate any kind of duplicative measures that already exist within those tools that would be duplicative of the measures that you're going to implement for purposes of the standardized assessment, and then secondly can you just speak a little bit more to the resource use measures and how that information will be collected?

Stace Mandl: Those measures are currently under development. Joel was just highlighting one of the resource use and other measure domains, which is a readmissions measure which is claims based. The other measures are really in the early phases of development, so we're looking at possibly claims based measures also, but that's about as much as I can describe right now (because they're in the early formative stage.)

Roshunda Dye: And referring to resource use measures?

Stace Mandl: What's that? I'm sorry. Say that one more time.

Roshunda Dye: Which measures are you referring to?

Stace Mandl: The resource use.

Roshunda Dye: OK.

Stace Mandl: That's what you asked about, yes.

Roshunda Dye: Yes, and the other piece about kind of assessing to make sure that measures are not duplicated with current measures, is that going to be a part of the process as well?

Stace Mandl: Yes.

Roshunda Dye: Thank you.

Stace Mandl: We would definitely be aware of not duplicating measures and we would also... One of the considerations was minimizing provider burden. Thank you.

Operator: Your next question comes from the line of Maria Avers from Stillwater Medical, your line is open.

Maria Avers: Yes, I have concerns related to the planned readmissions when they come home from the hospital and then they're planned for a second surgery or a take down or some of those kinds of things, so that's going to elevate this rates? Do you all have any idea what rates you're looking for to achieve because there's always going to be some of those rehospitalization rates that are not preventable?

Joel Andress: Thank you for your question, this is Joel. So in terms of what rates we're looking for, the answer is that the measures are designed so that we're not looking for a particular rate. Rather, we're comparing all of the facilities in a particular – of a particular setting type – to one another. So it's a measure of relative performance. Essentially, we are at a point where we know that some percentage of readmissions should not be occurring but there isn't a clear standard of how many readmissions should be occurring. It is also a bit of a sticky wicket for CMS to be saying that these readmissions should occur at any given time, given all that goes into that kind of a decision. The planned readmission exclusions are in place in the measures so that we are specifically not counting readmissions for those that we have very good reason to believe are not an indication of a failure in care.

I mean the key to a readmission we want to count is that it should indicate that there is a failure in care, a failure in coordination of care somewhere along the line for the patient. So when we exclude a planned readmission, we're doing that because we have looked at it not only with our own expert but also with the assistance of technical expert panels and public comment and we have excluded essentially claims code that suggest to us that a patient is highly unlikely to have been readmitted for a failure of care. Therefore we exclude it for the readmission or we exclude it from the readmission measure.

The difference with the measures we'll be implementing for the IMPACT Act is that they are also potentially preventable, which is not exactly clearly defined at this time. That's a big part of the work that we're going to be undertaking in the next year for all of these settings – to be able to define exactly what potentially preventable means as it applies to the readmission measures that we'll seek to implement.

Maria Avers: The third piece or the second point I wanted to make is while we're all working very hard to prevent rehospitalizations recognizing that a large cost of the healthcare dollars are because of rehospitalizations and that would save all of this across the board as tax payers, I think that there's a missing caveat to this approach and the patient engagement. No where do we make the patient responsible for following through with any of the education that's been provided in any of the settings and they're the ones that actually when you get into the home and you're seeing them three times a week for three hours total, the other hours of the day rely on the patient following through with what they've been educated about so or their planned medication regimen or any of the other treatment plans. So my other thought is that we need to do something to hold the patient accountable for their engagement and their healthcare choices and that's just I know probably not part of the IMPACT Act but until we address that we're never going to get to where we want to be.

Joel Andress: So I think the answer isn't necessarily through the readmission measures, but certainly we're highlighting CMS patient engagement measures. While you can't necessarily measure very easily the extent to which a patient is taking responsibility simply because of limitations and data collection, I think we can all agree that there should be some limitations in that regard.

I think certainly encouraging patient engagement by the facility can only – can only benefit the decision making that the patient makes and I think that you have to look at the readmission measures as they interact with other domains of quality measures as well. So I also would go on record on saying that I agree patient engagement certainly should be a focus of quality improvement.

Maria Avers: Thank you very much for your time.

Operator: Your next question comes from the line of Susan Bowen from Shepherd Center, your line is open.

Susan Bowen: Thank you very much and thank you for the presentation. I'd like to address slide 14. As an LTCH for a rehab LTCH, we use functional independence measures FIM score, and we collect that data. We submit that data through a vendor and the vendor forwards that data to CMS for reimbursement and we don't stand alone in that. My concern is, is that the FIM measure that we use is slightly different than what you're using for functional measure in slide 14 and so my question would be in order to eliminate redundancy of work and are you aware of this, are you addressing this inconsistency to ensure a standardization and since it's all CMS, it seems like it should be quite simple to remedy.

Stace Mandl: This is Stace Mandl. Dr. Tara McMullen and I will sort of tag team this. Yes, we're aware and this – we actually don't refer to these as measures, these are the data elements within an assessment instrument and we are aware of what you're describing as far as a double – I think it's a burden question. The data elements used in the measures come from the CARE item set and I'll turn it over to Tara.

Tara McMullen: Yes, just to follow-up on what Stace was saying, we're very – we're acutely aware of these issues, particularly issues of burden. We absolutely understand that the job of the IMPACT Act is not to increase burden, but to increase the efficiency of information flow across providers and really help providers understand what is going on with the person as they traverse the care continuum.

So we understand and we hear you. We have had many of these same comments as well in the past from public comment periods, and we are working to create an efficient system for data collection purposes.

Susan Bowen: I appreciate your response because I think that it would be quite imperative to have that clarified before we start any data submission, not for obvious reasons. Our submission through our other mechanisms is for actually for reimbursement.

Tara McMullen: Right.

Susan Bowen: And so it would – I mean just muddy the water.

Tara McMullen: Yes, we absolutely understand that and like Stace illuminated in her presentation, we have a lot of mechanisms for communicating with stakeholders and we also provide trainings for the providers. So for any type of revision to any assessment instrument and how the data is collected, we provide training so that the data can be collected in an efficient way.

Susan Bowen: All right, thank you very much.

Jill Darling: And Ryan, we'll take two more questions.

Operator: Your next question comes from the line of Danielle Breaux from West Jefferson Medical, your line is open.

Danielle Breaux: Hi, thank you for the great presentation. My question is you know with the transition to more share accountability between providers like home health and acute care hospitals, what direction can be given to hospitals if higher readmission rates are identified to be associated with a select group of home health agencies in our community, you know when we are bound by the patient's choice condition on participation?

Joel Andress: Yes, so I think on the one hand, we don't want to be prescriptive in terms of how you operate your business. On the other hand, I think our encouragement would be that communication with those home health agencies should certainly be increased.

The main thing to encourage in home health agencies, especially when they're becoming responsible for these kinds of quality indicators, is to demonstrate to them that you know there's a consequence if they choose not to engage in coordination of care with the hospital.

I mean that really is kind of the focus of shared accountability; that if they fail to coordinate care appropriately for their patients, then their readmission rates will increase and while that may have some impact on the hospitals readmission rate, it is most heavily going to affect the home health agency's readmission rate. It's reported and is publicly available information and that's the purpose of the quality reporting program in the first place. Does that answer your question?

Danielle Breaux: Yes, thank you very much.

Operator: Your last question comes from the line of (Lee Gendering) from Baptist Health, your line is open.

(Lee Gendering): I'm sorry they've already answered my question. Thank you.

Jill Darling: And I'll hand the call back over to Stace for closing remarks.

Stace Mandl: Great, thank you Jill. I want to first of all thank everyone who took the time to join today. This, the IMPACT Act, is really an opportunity. It's really an opportunity to bring a more seamless and safer healthcare environment with care coordination and support. Just the sort of the many, many factors that the IMPACT Act addresses relating, or opportunity that I should say for quality improvement in areas that we know are gaps - care coordination, which Jill has been touching on, is one very important one.

If I take off my CMS hat and put on my nurse hat, my wife hat, my mother hat, my daughter hat, I will tell you how we all know how important this – the Act is and what the opportunity is for anyone in the nation as they utilize and traverse the healthcare system and into the community, especially for those who are frail and vulnerable. Thank you every one.

Jill Darling: Thank you everyone for joining today's special open door forum and to all of our speakers, if you are interested in taking a look at the transcript and audio recording it will be posted on the special open door forum website which the link is on the announcement just be on the look out for that, so thanks everyone for joining.

Operator: This concludes today's conference call you may now disconnect.

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