

**HIT Policy Committee
Quality Measures Workgroup
Transcript
March 7, 2014**

Presentation

Operator

All lines bridged with the public.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you; good afternoon everyone. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Quality Measures Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Helen Burstin? Terry Cullen?

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Present.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi Terry. Ahmed Calvo? Aldo Tinoco?

Aldo Tinoco, MD, MPH – Physician Informaticist – National Committee for Quality Assurance

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi Aldo. Alexander Turchin? Cheryl Damberg? Chris Boone? Daniel Green? David Kendrick? David Lansky? Eva Powell? Westley Clark? Heather Johnson-Skrivanek?

Heather Johnson-Skrivanek, MS – Centers for Medicare and Medicaid Services

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi Heather.

Heather Johnson-Skrivanek, MS – Centers for Medicare and Medicaid Services

Hi.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Marc Overhage?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Present.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi Marc. Jim Walker?

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi Jim.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Hi.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

John White? Kate Goodrich? Kathleen Blake? Letha Fisher? Mark Weiner? Michael Rapp?

Michael T. Rapp, MD, JD, FACEP – Office of Clinical Standards and Quality – Centers for Disease and Medicare & Medicaid Services

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi Michael. Norma Lang? Olivier Bodenreider?

Olivier Bodenreider, MD, PhD – Staff Scientist – National Library of Medicine

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hello. Paul Tang? Russ Branzell? Sarah Scholle? Saul Kravitz? Steve Brown? Tripp Bradd? And are there any ONC staff members on the line?

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Kevin Larsen.

Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology

Lauren Wu.

Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology

Elise Anthony.

Elizabeth Palena-Hall – Office of the National Coordinator for Health Information Technology

Liz Palena-Hall.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

And with that I will turn it back to you Terry.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Michelle?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Oh, is there one more?

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Michelle there also a couple of CMS staff on the call do you want them to identify?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Sure.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yes.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Hi it's Stace Mandl.

Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

And this is Jennie Harvell from ASPE.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Hi Jennie.

Ellen M. Berry, PT – Technical Director, Center for Clinical Quality & Standards(CCSQ) – Centers for Medicare & Medicaid Services

Ellen Berry with CMS.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Anyone else from CMS on the phone? Okay.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

No –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

With that I will turn it back to you Terry.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Again, this is Stace –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

I'm sorry?

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Do you have Barb Gage as well? Do we have Barb Gage?

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Yes, Barbara Gage from Brookings is on.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Okay.

Lauren Wu – Policy Analyst – Office of the National Coordinator for Health Information Technology

We have a slide shortly where we'll ask each SME to be introduced.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yeah.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Thank you.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

So, we'll go around. Okay, well welcome everybody Friday afternoon after a long snowy week in DC. I appreciate you're being on and I believe Helen will be joining us soon. So, if we could go to the next slide which is the agenda slide and we're going to just briefly talk with you today about what we're trying to do.

We want to discuss and provide recommendations on quality measurement in the long-term post-acute care setting. This was an ask that was given to us through other parts of the working groups and so our goal today was really to convene subject matter experts and like we mentioned we will be sharing with you who the subject matter experts are asking them to present a little, give you some background information on the long-term post-acute care assessment and reporting, and then propose a series of questions to you that we are trying to get some responses on so we believe that the majority of this call will hopefully focus on a dialogue and a discussion to try to get us the answers to some of the asks that have been given to us.

So, with that and obviously we're going to try to adjourn by 4:30, with that we're going to go to the next slide which has a list of the LTPAC subject matters that have been convened here and if we could just run this list and you could introduce yourself, tell us a little bit about yourself and your knowledge in this area and then we will open it up for a dialogue hopefully informed predominantly by you about where we should be going here. So, with that why don't we have Craig, is Craig on?

Craig Behm, MBA – Executive Director - MedChi Network Services

Yes, hi there.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Hi Craig.

Craig Behm, MBA – Executive Director - MedChi Network Services

I'll –

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Do you want to just introduce yourself a little and tell us about you?

Craig Behm, MBA – Executive Director - MedChi Network Services

Sure, I'm with MecChi Network Services, we're a subsidiary of the Maryland State Medical Society, we own and operate three Medicare Shared Savings Program Advance Payment ACOs. So, I really come from a more vast background and am incredibly interested in the discussion about how long-term care and standards, and interoperability can help support a lot of the work that we're doing both in terms of Medicare and then also dual eligibles.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Great, thank you. Ellen Berry?

Ellen M. Berry, PT – Technical Director, Center for Clinical Quality & Standards(CCSQ) – Centers for Medicare & Medicaid Services

Yes, I'm Ellen Berry I'm with CMS, I work over the assessments that we collect for patient level data from nursing homes, home health, long-term care hospitals, inpatient rehab facilities and soon to be hospices. So, I ensure that the data specifications are correct and that the system, the QIES system which we collect the data in is functional and available.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

And before we go into our dialogue we will be getting a presentation from a few people to give us some more background. John Derr?

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Hello, this is John Derr, I'm on the Standards Committee and on NQFs HITECH Committee, I represent long-term and post-acute care which is not only a skilled nursing facilities, nursing facilities, assisted living, home care, hospice care and independent care, IRFs and LTACHs and that.

And I've been in this since 2004 when Secretary Thompson released the first Executive Order by President Bush and Secretary Thompson then asked me to coordinate long-term care, so after that I founded what is now called LTPAC HIT Collaborative which has our 10th IT Summit in June, we're the only group that has all the stakeholders in LTPAC.

At that time I was a COO of American Health Care Association in the National Center for Assisted Living and then I became the CIO and the CTO of Golden Living which is a 3 billion dollar long-term post-acute care corporation which has over 300 nursing homes, 40 assisted living, 7000 therapists, pharmacy and home and hospice care. And we have actually over 63,000 people under our care at any one point in time.

And I'm very interested in all of the certification and that so we can be part of the community of healthcare and establish a trust, and also security and privacy throughout the spectrum of care as we go to person centric care. I'm a pharmacist also I guess I should say, but I think I would not be very good behind the counter anymore.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Thanks for that insight. Okay, Barb Cage? Gage, sorry.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

That's okay. This is Barbara Gage I'm a Fellow at the Brookings Institution and have been working in this area for most of my professional life. I've worked over the years with Stace and Jennie, and everyone else, particularly with the CCSQ crew in examining the items in the MDS/OASIS and IRF PAI for different policy pieces of work for the different units within CMS and I led the development of the standardized care items to bring some consistency across the three different settings and now four different settings as the long-term hospitals are also collecting the standardized items.

So, I've been both a quality measure developer for CMS as well as an item developer and led psychometric analysis of the items, etcetera as well the eSpecification of the items that CMS has been – I haven't led the eSpecification but I've worked with the Regenstrief Institute and others to identify LOINC codes for the standardized items.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Great, thank you. Jennie Harvell?

Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

Hi, my name is Jennie Harvell I work in the Department of Health and Human Services in the Office of the Assistant Secretary for Planning and Evaluation. And I've worked in the area of long-term and post-acute care nursing homes, home health, inpatient rehab facilities, long-term care hospitals, hospice providers in terms of payment, quality and eligibility policy for more than the last 25 years or so and since 2000 have worked on identifying Health IT standards and health information exchange supporting health information exchange in the area of long-term and post-acute care.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Great. Crystal Kallem?

Crystal Kallem, RHI, CPHQ – Executive Director, Analysis & Policy – Lantana Consulting Group

Yes, thank you. My name is Crystal Kallem and I'm Executive Director of Analysis and Policy at Lantana Consulting Group. I also serve as Co-Chair of the HL7 Clinical Quality Information Workgroup. Lantana actually provides services and software for standards-based health information exchange.

So, my comments today will focus on those areas of particular relevance to our expertise with the HL7 clinical document architecture and the data and interoperability standards that support both electronic clinical quality measure reporting standards and eMeasures themselves. We have several contracts with a variety of public and private agencies and we've done quite a bit of work with CMS and ASPE in the long-term and post-acute care space.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Great, thank you. Stace Mandl?

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Sure, hi, I'm Stace Mandl I am a Technical Advisor in the Division of Chronic and Post-Acute Care in CCSQ. I'm a nurse by trade. In our specific division we oversee and develop quality measures for all of the post-acute settings that Ellen had touched on long-term acute care hospitals, inpatient rehab facilities, nursing facilities, skilled nursing facilities, home health agencies, hospices as well as ESRD and we are delighted to be here to provide some background information on our standardized assessments moving forward into the future and look forward to the discussion.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Great, thank you, thanks everybody for joining us. Next slide.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

And Terry, this is Helen Burstin, I wanted to let you know I joined late, my apologies.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Oh, great, hey Helen, the Co-Chair.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Thank you for leading.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

No worries, so we're – Helen everybody just introduced themselves and now we're going to go through the background and the ask.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Yes.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

And –

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

I've been listening intently.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yeah, in the middle have CMS and Brookings present.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Great, thanks.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

So, I think ONC want to talk about this slide?

W

Sure.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Someone want to tee this up?

W

–

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

This is Kevin I can do it quickly which is that ONC is looking at the possibility of certification for long-term and post-acute care settings and specifically they've charged this Quality Measure Workgroup with thinking about quality measurement in the context of that kind of certification.

So, the discussion here is a little bit to get a frame around how things are the same and different, what opportunities exist for an early stage of long-term post-acute care certification both at the kind of infrastructure kind of function feature level but more importantly at the specific kind of measure detail level.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Great, so we can go to the next slide then. So, I think here what you'll see is where we know there were certification efforts that what came out of the hearing and then the proposed measures for certification and you can see the charge which is in the last column to us was to discuss clinical quality measures and provide recommendations about the potential clinical quality measures for EHR certification in this domain. So, you guys can read that I think you've probably seen most of that before. Next slide.

And I think with this Stace and Ellen you were going to go first with your presentation I don't know which of you is doing the presentation. The slides were sent out but I also think we may be projecting them is that accurate? I think so, okay.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Yes.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Hopefully, this is the right deck for you guys.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

I hope so, we're good. We can wing it if it's not quite it. So, this is Stace Mandl and again thank you. We really believe that this background information is really important to your discussions and providing information about post-acute and it's sort of uniqueness in how it requires the data that is submitted and how it is submitted. So, I'm going to just walk through some initial slides, I'm going to pass the baton to Ellen and then also I will introduce Barb Gage just before her couple of slides.

So, in post-acute care we received the minimum data set through law for skilled nursing facilities and nursing facilities. We also received the inpatient rehab facility patient assessment instrument, the IRF PAI for the 1200 IRFs that exist and let me just back up.

Skilled nursing facilities, nursing facilities, there are 16,000 of them in total. We also received the outcome and assessment information set the OASIS tool for the home health patients, the long-term care continuity assessment record and evaluation data set, the LTCH CARE data set for the LTCHs and to be sent in, I believe that's July of 2014 is the hospice item set for the 3600 hospices.

What's important to mention is that these assessment tools are assessment, other than the HIS, which is actually data abstraction but for the other settings these are assessment-based tools therefore we require, at the atomic level, specificity and the information that's being provided for us.

So, each of these assessment tools are released with a very specified manual for data collection or assessment information and the minimum data set for example is used specifically for not only data submission to CMS for measure calculation by us but also by the providers per law for care planning, the same information is used for payment as well as for survey and certification purposes.

So, that's a little bit of background on the assessment tools that are submitted now. It's also important to touch on the CARE tool. CARE stands for the Continuity Assessment Record and Evaluation Tool. The CARE tool was birthed in the mid-2000s, it came from a combination of the Benefits Improvement and Protection Act as well as the Deficit Reduction Act and Barb Gage can speak much more fluently to this than I, but the CARE tool was an assessment-based instrument that was used as part of the Post-Acute Care Payment Reform Demonstration which included a component of testing for the reliability of the standardized items when used in the Medicare setting. So, they tested this instrument for inter rate of reliability and validity across the settings and at the discharge time from hospitals. And we can go to the next slide.

The PAC PRD and the CARE tool really solidified some concepts for us, it gave us some guiding principles and goals, it gave us the goals that assessment data can be standardized, can be reusable and be informative with the principles that communicating the same language across settings is really critical and to ensure that data transferability forward and backward allows for interoperability.

It gave us the goals related to the importance of standardization reducing provider burden allows for the increasing reliability and validity to offer meaningful application to providers and to facilitate patient centered care, care coordination and improved outcomes and efficiency with additional priorities fostering seamless care transitions, evaluating outcomes for patients that traverse the settings and assist them and beyond assist them actually allowing for measures to follow the patient which is a very important concept and also the ability to assess quality across settings and inform payment modeling.

So, in that spirit we are currently seeking building sort of the future state and moving towards the use of uniform data elements and standardized items across the settings where we're able to and we have taken active steps in harmonizing measures in post-acute care at the data element level and we have been actually able to expand three quality measures across settings from LTCHs, IRFs and skilled nursing facilities.

We believe that in a future state it was important for providers and vendors to have access to standards and that data elements be easily available with national standards to support post-acute healthcare information technology and care communication and that transfer of care documents be able to be incorporated in uniform data elements for use in post-acute settings if desired and importantly in the future state that our measures can follow the person.

And in the world that we live in we work on the future state, the current state, the future state and sort of the ideal state all at once and in the ideal state that facilities be able to transmit electronic and interoperable documents and data elements and that's really where data uniformity becomes so critical and that data uniformity in the ideal state really would allow us to provide convergence and that those data elements that are uniform are also very clinically relevant and that they carry meaningful information in a way that can be spoken and understood by all.

And again that the measures follow the person and that the information electronically can support needs actually beyond the healthcare system. So, that's a little bit of background, a little bit of future and I'm going to next hand the baton over to my colleague, Ellen Berry, who is not only a technical director in her division but also a physical therapist by trade who will present on the QIES assessment data information.

Ellen M. Berry, PT – Technical Director, Center for Clinical Quality & Standards(CCSQ) – Centers for Medicare & Medicaid Services

Hi everybody this is Ellen Berry, unfortunately I'm not able to follow on line so I'm going to do the best I can with regard to the slides. For those who are not aware QIES is a national database where we house, CMS houses, all the patient level data as well as all the surveys that are conducted throughout the US in the various settings.

As I mentioned earlier we collect data from four of the post-acute settings that is patient level. We will be, as Stace mentioned, collecting hospice patient level data beginning July 1 of this year. So, on that first slide of the diagram we also are responsible for providing free CMS software for all of those settings and those are mentioned as HART, LASER, jHAVEN, jRAVEN and jIRVEN.

All that data, which we process 3.3 million records a month are collected. We do put those assessments through a reliability standard so that they meet the data specifications for CMS to make sure that at least certain data is accurate.

On slide nine our contractors are responsible for the software development. We support the assessment and payment initiatives within CMS as well as the quality initiatives. On slide 10, as I mentioned, those are the providers that we will – that we collect data from and will be collecting data from nursing homes, which are your skilled nursing facilities as well as your nursing facilities and your swing bed, providers that are non-critical access hospitals, home health agencies, inpatient rehab facilities those that are freestanding as well as those that are units within an acute care and then long-term care hospitals. Hospices currently we collect facility level data but we will be collecting patient level data as I mentioned earlier.

On slide 11 those are just many of the processes that we support and that we actually, under my contractor, develop which is the item set for the MDS, the data specifications are for all the user tools and all the data substitutions that vendors or software developers would use to ensure that their products meet our standards.

We provide error messages and reports to all the providers. We have a validation utility tool for each of the provider settings to assist vendors to ensure that their software again meets our data specifications and if one of their users submits an assessment or a record that it will be accepted into our QIES system.

We support the payment groupers and actually develop some of the groupers for some of the settings. In some areas such as home health and nursing homes we support the care planning. We provide the data for publically frequency report as well as quality reporting programs.

We do create, on slide 12, user guide manuals, we host vendor calls for each of the settings when we release new data specifications once we finalize data specifications and as needed throughout. We provide help desk support and mailboxes for vendors or software developers to submit their questions.

On slide 13 the MDS is used by numerous stakeholders not just CMS but also for the state, it's also used for payment and the A/B MAC, we provide software for them so that they can conduct medical review easier when looking at the MDS.

Assessment and payment initiatives, OASIS, we support survey and certification requirements, so payment as well as an extract for the RHHI. For IRF we assist with the rehab eligibility report for the A/B MAC, the grouper, there is an IRF viewer and we are conducting claims allegation now with the IRF PAI and IRF provider claims.

There are numerous quality initiatives that we support throughout survey and cert, nursing home compare the five star program, home health compare, home health agency pay for reporting and also the CAHPS we interact and provide them data through our QIES system.

And a recent area that we began supporting is ACA 3004 which is for LTCHs, IRFs and hospices to submit data to CMS as well as two settings submit data to CDC. So, we do exchange data and receive data from the CDC on a monthly and quarterly basis.

Slide 17 is just a repeat of the beginning of my presentation and it just shows you the complexity of all the data that we have and all the capabilities that our system has for providers and other stakeholders.

The last diagram that we provided is just to show you a high level of how the data is moved throughout our system that it begins with the provider who submits data to the ASAP database, they do receive a feedback report for their submission as well as a feedback report within 24 hours of whether those records within the submission were accepted or rejected and if there were any errors within an accepted or rejected record.

We do provide some of the data to the states depending on the setting and so we do have a feed down to them at a CMS server within the states. So, that concludes my presentation.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Ellen, thanks, this is Stace, I'd like to take a moment to introduce Dr. Barb Gage who is a Fellow and Managing Director at the Brookings Institution Engleberg Center for Healthcare Reform. And prior to joining Brookings Dr. Gage was the Director of Post-Acute Care Research at RTI where she led CMS's efforts to develop standardized assessment items for use across LTCHs, IRFs, SNFs and home health populations.

These standardized items were then used in CMS's post-acute care payment reform demonstration and under Dr. Gage's direction to examine differences in the populations admitted to each of the post-acute settings and differences in Medicare cost and patient outcome for similar patients using alternative PAC settings.

Dr. Gage then worked with Regenstrief Institute under a third CMS project the CARE Prototype to have Regenstrief institute develop LOINC codes or identify SNOMED codes for new assessment items not formally in the MDS or OASIS and actually IRF probably has never had the LOINC codes assigned not yet. This work was used by CMS in several subsequent projects with Lantana and by partners in the ONC Grant and now I defer to Dr. Gage.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Okay, thank you. So, I think that Ellen and Stace have clearly shown the extent, the huge number of data elements that the Medicare Program relies on for these quality programs and the payment work that is done to pay all of the Medicare participating providers in the country in the post-acute care arena. We didn't even mention the hospitals or the physicians, the focus here is on the post-acute care.

So, if you look at the slide 19 I'm going to talk a little bit about the quality measure development because one thing I've learned in the more recent years as I've heard about the physician quality measures is that not all quality measures are as intensely defined.

In the post-acute care world there are – each of the assessments have specific items measuring concepts and the providers are literally – all the SNFs are completing the same items, all the home health agencies are completing the same items, all of the rehab hospitals are completing the same items and the reason the CARE standardization was so important was because they were concepts, they were all measuring the same concepts of medical complexity, functional complexity, cognitive complexity and social support but they were using different items.

So, when the quality measures are developed they are very specifically identified with a specific numerator, a specific denominator, the populations that are included or excluded are specified in the development of the quality measures and then they have to be submitted to the National Quality Forum where they go through a very extensive vetting process. The data specifications literally cite the exact items that are posted on the web as Ellen referred to back in the earlier slides when she said her contractor puts all of the data specifications out.

Slide 20 talks a little bit about that endorsement process and Helen I don't mean to make this sound overwhelming but it is a pretty intensive process. Before a measure can be endorsed by NQF which is the preferred approach before a measure becomes a CMS quality measure it has to meet five qualities. The concept has to be important to measure and that's true across all of the programs but the measure has to have scientifically reliable properties and that takes you back to those elements in the assessments.

The measures research is done that measures the reliability of the items if two different people are assessing the same patient would you both code that patient as being equally impaired or equally severely impaired in a respiratory condition.

The level of scientific reliability is very important before a measure goes into a federally mandated reporting program that could lead to a provider being negatively rated or being highly rated. So, you want to make sure that the items are reliable and that whole assessment process, the development of the items that go into the assessment goes through a very extensive reliability testing process.

Thirdly, before a quality measure can be endorsed it has to be feasible, it has to be feasible to collect the measure under the current data practices and this is much more familiar to all of yourselves who many times were working from what is in the field trying to build up a policy that introduces the least amount of burden.

The usability and the use, the information has to be useful. I am sure all of you have been working on the Meaningful Use activities and the related and competing measures this is work that I give Jennie Harvell credit for in the early days of trying to align measures across the home health field, the nursing facility field, the rehab field.

So, that if you think about it conceptually there is agreement on – well, take a pressure ulcer as a simple item, everybody uses the same language to assess how bad somebody's pressure ulcer is, you can then transfer that data. There is consistent agreement about it.

In the current field before – well, before the pressure ulcer item was one of those items that Stace mentioned is now consistent across the SNF, the IRF and the LTCH assessment, but prior to that a patient would be discharged from the hospital, say a rehab hospital to a skilled nursing facility, the rehab hospital was using the push item to define that pressure ulcer and the skilled nursing facility was using an item developed by the National Pressure Ulcer Advisory Panel.

So, you have the nurse from the nursing facility trying to understand the level of severity of that pressure ulcer on the patient coming at them and the language of the discharging facility was different than what they were used to. So, it created some real barriers in coordinating care and moving towards care improvement.

So, slide 21 kind of drives home where CMS has been going. The point is if you collect that element once you can use it multiple times, it minimizes the burden on the providers, it increases the integrity of the data, it allows for exchangeability cross between providers and more importantly I think one way that the post-acute care assessment tools are different than some of the other registries and other quality measurement sources in the Medicare Program is that they have very specific items in each of the tools and those items then feed into the payment group.

So, if you're in a skilled nursing facility, if you are a skilled nursing facility provider you want to make sure that you are coding that patient in the same way as CMS thinks you are coding that patient so that you get paid the rate that will cover the cost of that patient.

So, specificity in the data elements is critically important in these assessments and all of them are used in the Medicare payment rate, the MDS is used in the SNF payment rates, the OASIS in the home health payment rates and the IRF PAI in the IRF payment rates.

So, just as I noted with the quality measures exact specification of the data elements is key to the Medicare regulations in both payment and quality. That's all I have.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Well, thanks a lot you guys, this is Terry, does anybody – so if we could go to the next slide, because the next slide has what we're going to talk about today but does anybody have any overarching questions that they want to ask any of the presenters before we go into this?

Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

This is Jennie Harvell and I was wondering, I think it was Ellen Berry who was talking about how the long-term care hospitals and inpatient rehab facility data was, I think transmitted to CDC, I was wondering if you could talk a little bit more about that transmission and the type of information I guess that's being exchanged or made available to CDC?

Ellen M. Berry, PT – Technical Director, Center for Clinical Quality & Standards(CCSQ) – Centers for Medicare & Medicaid Services

Right, actually what we exchange with them is we send them a finder file for those provider settings first and LTCH so that they can send to us the specific hospital acquired infection data that they are required to submit to the NHSM which is supported by this, which owned by the CDC. So, we do not receive patient level data it's facility aggregate data that's used for the ACA 3004 QRP reporting. Does that answer it enough Jennie?

Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

That's enough for now thanks.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

This is Terry, I had one question and it was related to I think the last presenter there was a discussion about the mapping of the standard data sets that you're collecting to LOINC and/or SNOMED and/or just some other endorsed data set and then I got lost whether that was done or not done or is it in process?

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Sure, this is Barbara Gage, I can start it off and then our colleagues from Lantana can probably speak more completely, but all of the items that are in the assessments in the MDS and the OASIS Jennie had actually had Regenstrief identify LOINC codes for those existing items.

As we built the standardized CARE items which were not a fourth set of items they were instead based on a consensus across all the different clinical communities about what are the best ways of measuring these items given their different historical development of their tools. The CARE items were then also given to Regenstrief to have LOINC codes assigned.

So, as Stace mentioned earlier the IRF PAI has no LOINC codes at this time but the MDS, the OASIS and the CARE items are all LOINC'd or SNOMEDed and Lantana has since been using them to develop eSpecifications. Lantana do you want to add?

Crystal Kallem, RHI, CPHQ – Executive Director, Analysis & Policy – Lantana Consulting Group

This is Crystal and I believe that you're probably referring to the CDA implementation guide for long-term post-acute care summary and there is – this particular implementation guide does include a subset of elements from both the MDS and the OASIS and mappings to the quality data model.

And so I included that in my particular slide presentation and felt that this might be informative for the purposes of this discussion to actually support the alignment of the MDS and OASIS data sets with EHR reporting and EHR standards that are used for Meaningful Use.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

And this is Stace thanks Crystal that's helpful, can I just jump in as well, we're actually having to walk through and scrub what it is that we have currently because the item sets have not been stagnant.

We actually have releases in all the settings in 2014 which means that there have been changes or editions to the item sets, so we have to make sure that other specifications or the standards that we have are not changed, so I just want to throw that in there.

Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

Yeah and this is Jennie Harvell and so in terms of the long-term post-acute care assessment summary a clinically relevant subset of the MDS and OASIS that existed at that time had been identified through conversations with clinicians and for those data elements LOINC codes and SNOMED codes that had previously been linked or were paired and that the patient assessment summary document was represented in a Health IT standard document, the CCD, and Stace is exactly correct that as CMS evolves its assessment instruments work is needed to evolve re-uses of that data such as in the patient assessment summary document.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay, thanks, so I think with that, because it sounds like we may be answering some of the questions as we have this dialogue why don't we just relook at the slide that we have here, which was what the asks were.

I personally think that there is a lot of interdependencies in these asks and I think we can accommodate a free flowing conversation, we have about probably 35 minutes where we can ask you to, because you are SMEs, to help answer these questions and we can probably tolerate some indirect conversation to try to get to them.

So, identify infrastructure needed to support the quality measurement there, what are the capabilities and functions for this system, the EHR systems in these settings. We did just finish out the Accountable Care Quality Measure Subgroup so we are attentive and want to help inform the accountable care service delivery environment as other potentially transformed service delivery environment so if we could get some insight from you on whether you think that changes it or not, what the needs would be, whether there is certification of minimal data elements and that's actually, I think I was jumping ahead of myself asking that question about LOINC and SNOMED, is there ongoing work and we've heard, Jennie from you, especially right at the end that there may still be some ongoing work in terms of keeping things up-to-date and then gaps needed to be addressed or barriers that need to be removed to support EQM construction and reporting.

So, with that I think we'll just turn it over to the SMEs and the Workgroup members on the call and ask you for your insights into these questions.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

This is Barbara Gage, one concern that we've had all along as we're developing concurrent efforts those of the electronic health records along with the content refinement in the assessment tools and along with the assessment refinements the refinement of the quality reporting requirements and the payment models.

One concern is a fear that a similar concept may be exchanged and submitted into CMS for reporting, to meet a reporting requirement but it won't be the exact element that was in the assessment tool and as I noted earlier that could lead to a provider having a payment that is much lower than they expected or conversely higher. So, it's really critical to have the exact assessment items in the infrastructure in the coding.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

And this is Kevin Larsen from ONC, I just want to point out, because we're using a number of terms here like data elements that, and correct me Barbara or Crystal if I'm getting this wrong, but for the purposes of long-term post-acute care a data element really equals a standardized survey instrument question with its standardized responses is that correct?

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Correct.

Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

This is Jennie, I just hope – I think we, all of us on the call hopefully, will try to – I think we need to pay attention to the words that we're using like standardized, you know, at least for me standardized means, you know, Health IT standards LOINC, SNOMED have been applied to data elements versus making items uniform consistent across various assessment instruments. So, just – I sometimes get confused as to what people are – what concepts people actually are referring to.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

So, Jennie, this is Terry, to follow-up on that then because we do have a specific question here, are there standards for data elements and Kevin thank you for getting clarification on that, so when we talk about data elements and standards we're talking about the standards survey instrument question and the response.

Jennie, when we use standards you're right in the Quality Measure Workgroup we're really talking about Health IT endorsed standards and/or is there a void where there isn't a Health IT endorsed standard and there should be related to the data elements.

So, I did hear obviously reference to LOINC and SNOMED for most of the elements, some of the elements?

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

The CARE items all have LOINC or SNOMED codes associated with them and I believe that the MDS 3.0 and the OASIS fee do also –

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Yes.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Where IRF PAI does not.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Yeah, this is Stace, I want to just jump in to also clarify definitions and maybe we can have a working order of definitions, maybe that would be helpful, we actually use assessment, user assessment instruments and tools not necessarily survey. I'm not exactly sure what the difference is but I think I have to stress assessment because we get information at the atomic level, we specify exactly what the practitioner is to be collecting and when.

And the assessments are actually part of the medical record, they are a primary source for skilled nursing facilities and nursing facilities as well as the OASIS and the IRF PAI.

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

Terry, this is Joe Francis from VA.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yeah, go ahead Joe?

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

So, just to tell you about our environment and I'll mention by the way that I began my VA career as a VA Nursing Home Medical Director and we were actually one of the first sites in VA to implement VistA back in the days before it had a GUI.

So, we use, you know, a fully functional EHR in the long-term care environment but in terms of the assessment such as the MDS 3.0, which we recently moved to, that's a separate system it's not integrated into VistA and we have to go through a separate data intermediary to develop composite reports and benchmarking and tracking and I have staff that actually published some of that data for the purposes of quality review.

I can imagine it would be extremely complicated to try to combine the assessment tools into the clinical electronic health record, at least in our environment, where, you know, the change that happened moving from MDS 2 to MDS 3 was very, very substantial and I don't think we would have been as nimble if we had to build it all along into the EHR.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Doesn't that increase your workload on the – oh, no VA doesn't have to submit, okay, never mind.

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

Well, it doesn't necessarily increase the workflow from the stand-point of a clinical workflow because there is normally an MDS coordinator that's responsible for collecting and reviewing the assessments. And I noted the earlier confusion between assessment and survey. Assessment is often done by a clinically trained person after reviewing all the available information including patient and family, and medical documents.

So, it's – whereas a survey is generally, you know, a patient reported state. So, those differences are quite important and in fact in clinical settings I worry about rushed assessments where people can click on buttons, it works better if you have a dedicated person doing the assessment that's not necessarily the person that has to, you know, quickly put a patient in a bed, get them assessed, get them a meal and all that. So, it's a little bit of time for completing these things thoughtfully makes sense.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Joe, this is Kevin Larsen, does that data then that you collect flow into your EHR and if not how could certification help it to do that?

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

Well, I'm not sure certification makes anything easier for our EHR it just means more struggling to get it done. But it does not flow in it is available through our reporting system, so, you know, we have, you know, a very robust measurement and reporting environment that's accessible essentially to all staff, you'd have to pull up a different screen, a different window but generally the staff that are doing the day to day work, you know, documenting things like patient status or, you know, how their skin condition is, are different than the staff who are actually monitoring the quality and, you know, doing the sort of population health stuff.

You know even my doctors in primary care don't have time to pull up, you know, composite reports of performance such as, you know, pop health generates, they're seeing the patients in real-time and it's a very – you know, some of these things are wishful from the perspective of people like ourselves but it's generally a care manager that's spending time with the composite reports.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

So, Joe, let me touch on that a little because so we have pressure ulcers, because we heard about pressure ulcers and we heard about very specific standards being assigned to them –

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

Yes.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

And my guess is those aren't the standards we're using in current EHR systems? Maybe we are but –

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

Well, we're trying to capture that information and as you know Terry this ties into some of the nursing documentation package issues.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Right.

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

But one of the things that we've observed empirically is that if you take a busy nurse and you ask them to document pressure ulcer status they often get it wrong and that's one of the biggest problems with data quality and in fact the hospital acquired pressure ulcer group in VA, which I'm part of, their recommendation is actually to have, you know, a certified wound and ostomy trained nurses actually do those assessments and do the documentation because it's – you know, again even with education it's very hard to get people to do this well.

You know in my prior life as a health services researcher when I was using assessment forms and surveys in clinical studies, you know, we found that the best person to administer the assessment or the survey was often a non-clinical person because they actually could do this, they were trainable whereas the clinician often just moves very, very quickly and pencil whips stuff.

And I think that's a reality, just because you put it into the system and you make it easy for clinicians to do it in the flow of the EHR doesn't mean you'll get good data and I think a lot of it has to do just with, you know, workflow, production pressure, biases, some conscious biases, you sometimes don't want the patients to have those conditions and, you know, we see that for instance when we integrate things like the Audit C or for alcohol screening into clinical workflow.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

That's a nice point and CMS really invests a lot in the training so that each – because the providers have to, in the Medicare Program, the providers have to submit the specific elements in order to get paid or to meet their quality requirements, they run – Stace how often do you run the – you run training all over the country for the different PPS coordinators and the thousands of providers, is that annually? Twice a year?

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Whenever there is a new release there is an assessment training.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Yeah and they have extensive manuals on how to code the different things they're seeing.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

This is John Derr –

Multiple voices

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

You have to understand the difference here, in a nursing home 95+ percent of the actual clinical care is not being delivered by the people completing those assessments.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Correct.

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

You will have a nurse for one nursing home 120 beds trained in doing that and they invest in that one person, that's the same model that I talked about with assessment of pressure ulcers, besides the –

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

That's correct, yes.

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

So, you're not giving it to every clinician to do.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

No understood but you are –

W

Yes.

W

– I'm sorry –

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

This is John Derr, I wanted to get – I want to get in here a little bit –

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Yeah.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Because one I don't want us to confuse the civilian with the VA because I know I got involved with that once before and the Vista problem there, but I think we have to realize we are talking about, as far as I know, certification and it's mainly pointed to the transitions of care not to the EMR which is inside the nursing home and one of the big problems we have in any nursing home or the 40%, the 60% that go to home care nursing homes is that they – we get a care plan from the hospital on an episodic-basis of a hip replacement and we have to convert that almost all the time into a longitudinal chronic care with co-morbidities type of care plan.

And in the future as I understand what we're trying to achieve is longitudinal person centric care and the quality measures tend to be disease specific and once you get into a nursing home and they are – the software companies now – there are reports out there, you know, state that what the state of the art is out in a nursing homes and most of the nursing homes, because they don't have the funding are not upgraded to the new EMRs that are out there which are kind of robust and in many cases the MDS and the OASIS are byproducts of a good clinical system and I know they're all working on this longitudinal-based because we're the first care giver to look at a patient longitudinally after an episodic issue.

And when we get to these quality measures, if we're dealing with the EMR and inside the facility for quality measures I'm not sure that's what our charge was, at least when I sit in on the other one we've sort of come to the certification part is only addressing transitions of care and making sure they have volunteer certifications and not getting into the specific things inside the facility itself, although with that said, we have to do this sooner or later because we have to get chronic care type of quality measures and not just disease state quality measures.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

John, this is Kevin Larsen, just a little – I'd love to explore this a little bit more with you, what opportunities do you see that's really what we're trying to queue up here, what are these first level opportunities that help with this longitudinal patient at the center, data follow the patient?

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

And Kevin, if I could just piggyback onto that question before John answers, this is Helen, it also just feels like we're being very grounded in the now and we know when we're grounded in the now we don't really get very – it's very hard to be thoughtful about what could be, so thank you for asking that question, because I think it gives John a chance to be more prospective about how we could build this such that it actually adds value and helps improve transitions, coordination and patient care. John?

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

John?

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Sorry, I was on mute. We have to get – first off we have to get electronic transitions of care where we get good information and not just get paper or a phone call at 4:30 on a Friday afternoon when the hospital doesn't want to count for a length of stay. And once we get all of that – I was talking at the American Society of Hospital Pharmacist meeting, I was talking to a software vendor who said that there was – they had some epidemic type software in the hospital where they tracked the type of hospital epidemic or that and I said "of course you put that in your EHR, your transitions of care, so the nursing home would know that" and he said "no we don't do that."

And so it's more complete information maybe we haven't been that good in telling you what we need although we did do that up in Minnesota and that, so once we get it – then the other is understanding that the assessments that we do are sometimes, and I guess you'll fight me on this, but a little bit on the static side when we're really looking at the dynamic side and as we move from an episodic to predictive, which is where a lot of the nursing homes are now predicting re-hospitalization, we want to get to the preventive side and then get the patient home as quickly as we can. Once we're in that preventive side we've got to look at quality measures a little bit more in the chronic care.

So, the opportunity I think is getting a doctor involved immediately when we get somebody, get the physician and AMDA, American Medical Directors Association, is doing that right now some of the nursing homes are putting physicians in the nursing homes and then that first 48 hours, as you all know, is crucial in wound care and in a lot of the other types of things, especially when you're in chronic care.

So, the opportunity is getting started, I've even advocated a lot for people to get the Blue Button Plus for people that are being admitted to the hospital, I mean to the nursing home so they get a good three year start on some of those people and our guy is working on that now.

So, one opportunity is a quick start and also it's from the time and effort, and efficiency right now a lot of times we don't get a full medical medications list and then somebody sits on the telephone to try to get that from the hospital. So, that's one benefit of this thing.

Another benefit is when we have to send somebody to a hospital and re-hospitalization, which we hate to do, but we don't want to get to a point where we are afraid to send somebody back, as far as I know now there is not much being done on hospitals receiving electronic information.

I think those are the biggest things and then also as I mentioned before that people trust us and our data that we send back to the hospital or to the next care setting.

You know I applaud Jennie on what she has done with LTCHs, the nursing homes, the home care, to possibly hospice care, but the way I understand the assessment of a wound within a hospital is different than what we get in a nursing home and that's where the harmony has to take place, it's a funny thing, but we always say that the pressure ulcer was formed in the ambulance coming from the hospital to the nursing home, so we've got to add those and fill those gaps in. Did I ramble too much or –

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

This is Stace from CMS I just want to thank you.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Yeah, that was great thanks John, yeah.

Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

This is Jennie, in addition to the transitions of care that John described as being important possible areas to focus on I wonder if – I think there's a need to think about how to extend QRDA quality measure reporting in this space. I think it's a challenge because, you know, we heard from Stace and Ellen about the multiple quality reporting activities and systems that CMS has and so there is – so CMS has a huge infrastructure here that's very important for various CMS and quality activities.

So, I'm trying to say, you know, strategically I think there is some need to focus strategically on moving towards QRDA reporting in long-term post-acute care and I wonder if possibly towards that end thinking about perhaps ToC, transitions of care, measurement might be one opportunity.

Alternatively or in addition maybe the work on or related to the work on immunization reporting or hospital acquired infections might be other opportunities and the reason I call those out is perhaps and I don't know this area well enough but perhaps those are opportunities that are already being advanced for hospitals or physicians and might be kind of opportunistic to piggyback on in this sector as well.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

That's a very interesting idea, this is Helen again, and in some ways catheter associated UTI might be an interesting example to kind of walk through almost as a prototype of a clear issue for both nursing homes as well as hospitals.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

This is John Derr again, you know, I don't want to pull out Barbara and all that because I worked with her on the CARE assessment and one of the things – because I got five of our nursing homes when I was with Golden to be in that demo we thought that might – and also if we really went longitudinal stop having the MDS coordinator coordinate that all that in a true clinical EMR system that's robust and really doesn't just do therapy as an individual silo within an EMR or dietary, or medications but they are really doing analytics within there that eventually we wouldn't have that one person that looks at it and does it, sort of what we call the MDS coordinator, in fact at times I've thought, you know, with the CARE and some of these other types of harmonizing quality measures and not just piling them on that we would not have to have a MDS coordinator who is usually a nurse and that person could go back to direct care.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

That's right John that is how the rehab hospitals, the long-term care hospitals and the home health agencies use their respective forms, they are actually collecting it during their usual workflow and using the information in – well in the rehab hospital they kick out weekly reports on function based on that information.

So it is – and they are starting – this is the type of information that the ACOs are looking at when they're thinking about the complexity of the case and the likelihood of a re-admission or the expected improvement if they go to one setting versus another.

But right now all those hospitals are kind of developing their own little systems and kind of waiting. The time is right for the uniform items to go out and the standards to be published with them. So, it's like it's ready to be folded into what you guys do.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

So –

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

And that's very important because otherwise there is a lot of work and effort being spent to do things right because there aren't standards that a lot of that work is going to be wasted.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

So, this is Terry, let me ask a really pointed question though, when you – because of the transitions of care and the continuum of care and so there is this data, there are these standard data elements that are being collected some of which are mapped to the standards that the acute care facilities are using and the patients are going between them.

So, does it make sense that we continue with that, that we continue with standards that are specific for the LTPAC settings or should the goal be that there are standards that traverse the continuum of care?

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

I'll take a crack at that because I know that Mark McClellan addressed this in one of the recent MAP meetings over at NQF. The question came up about measuring function in the physician, the clinician measurement group and he pointed out that it makes sense to build on what comes out of the post-acute function because those specialists had already thought about those measures and yes they should carry over to the rest of the clinical community, you should be using, you know, there is no reason to measure a condition with five different scales if you're all looking at the severity of a condition. So, yes –

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

So what we've said before, this is John again, is somebody could be normal in one setting and abnormal in another setting that's just –

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

This is Kevin, I wanted another sort of question, one of the opportunities here is let's say a patient has a Stage 3 pressure ulcer and they go from long-term care to home care and then back to the hospital and then to acute rehab, wouldn't it be ideal if that data element with its staging could move in the transition of care document and populate in a place for people to see and confirm as opposed to people having to read it or not even find it and re-document it.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Yes, exactly Kevin.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Yeah, this is Stace, can I just jump in real quick?

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Yeah, well somebody, because I don't really know – maybe Barbara or CMS but I think the group should know how often we do an assessment, you know, if the patient changes, you know, one on admit, because one of the things I've gotten involved a little bit is people sometimes think the assessments are doing on a continuous day-to-day basis and there really are specific times and the other thing is don't forget that's how we get paid. I mean, I don't think other quality assessments have as much of a pay importance as the ones we do in LTPAC.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

I want to just jump in and I appreciate your thoughts on that John and that is absolutely spot on and I just want to highlight a couple of things. There is, for informational purposes, there is no requirement from CMS that there be an MDS coordinator, in fact the purpose, part of the purpose of the 3.0 version was to actually integrate not only the entire team for providing assessment information to the MDS but also the voice of the resident.

And I want to echo also a little bit about what you had said Barbara, the functional assessment items that are included in the care tool that were tested in all of these settings including the hospitals at the time of discharge has led to the development of six function measures that are currently publically posted and they are right now have been developed for the IRF and the LTCH settings and they use the same data elements.

Our team is also working to develop functional outcome measures for SNFs and home health and hopefully as well hospitals, all crafted from the same data elements. So, when I think of uniformity in the future state I think of uniformity that is uniform across a setting.

So, if all settings are using and post-acute are using the same information that they use the same data element that's not to preclude the settings from having additional necessary information that they have to collect that's unique to their setting but if you're going to ask for pressure ulcers, if you're going to require an assessment for pressure ulcers ask it the same way and we've just done that.

If you're going to have population health related questions or assessment questions about immunization ask them the same way that information could then be transferred its all the use and re-use concept and that is a big priority for us here at CMS.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Stace, this is Terry –

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

This is John and you're harmony with ONCs program then too right? Because, I think what you're doing in a future state is great but is it using the same standards and all that that ONC is or that?

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

That actually would be my question as we push on the standards for data elements and we know we have ONC endorsed standards. We also know we have things like the ICF, International Classification Function, out there that's not an ONC endorsed standard but at least from an acute care setting would give us a ton of information we need for functionality and visibility. Are there –

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

We –

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

And I know Jennie I think has done some of this, that crosswalk back to the ONC endorsed standards and where is the delta?

Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

I'm sorry Terry what was your question?

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

So the question is we know we have ONC endorsed standards which I'm sure you guys are familiar with, you know, and they're mostly endorsed through the SDOs and through Doug Fridsma's shop, but what's the delta, what isn't in there that long-term care needs to have addressed either by an SDO or already thinks it's addressed and should be endorsed and/or are there already something like ICF that could be endorsed and would meet a lot of the need and then there wouldn't need to be additional development of data elements.

Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

I think most of the data elements that and – well, many of the data elements needed in long-term post-acute care have already been represented or linked to LOINC and SNOMED which are the primary vocabularies that ONC has endorsed that is applicable in this situation.

I think the concern about the ICF is that it's a classification scheme and generally not granular enough and so there has been some I guess, I don't know if resistance is the right word, but, you know, the utility of the ICF in this setting has not been articulated I guess clearly enough for people to proceed with that work.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Jennie, do you want me to speak to the issues with ICF? We looked at it in our initial work with the CARE standardization of the existing commonly assessed items, we looked at the ICF because the world was moving towards that approach for measuring disability and we thought it would be very useful for all the therapy recipients under the Medicare Program.

The issue with the ICF, as Jennie mentioned, it's a classification system and so in – again this goes back to if you're developing a payment group or you're specifying a quality measure you need the data elements to be uni-dimensional.

The ICF elements contain, some of them, contain more than one concept in an item. So, for example I'm going to make this example up, but suppose a patient was asked – suppose the item was measuring whether a patient could sit and wheel their wheelchair that would measure their ability to access, you know, to be mobile if you will, but it also represents two different types of impairments, it represents the physical impairment of sitting which is probably more lower body as well as the upper body strength of rolling the chair and so we couldn't bring those items into the assessments because you couldn't build a payment or a quality metric off it because you wouldn't know whether the lower or higher rating was due to the upper body impairment or the lower body, you wouldn't know the patient could change on average between the two and look like no change at all rather than just measuring one dimension.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay, I want to be attentive to the time and I acknowledge that, so what do you do in place of that, what data standard set are you using in place of that?

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Stace, do you want to speak to that? Those are the assessment items. All of the CARE –

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Are you asking what CMS collects?

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

No, I think I'm trying –

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Or is it standards –

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Yeah, I'm trying to get at this second question are there standards for data elements or I guess the question is does CMS believe or do people on the phone believe that what you're currently collecting gives you adequate data elements that are standardized and so there is not a need to do additional work in this area?

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

To have more refined information? I guess I'm trying to – I'm trying to wrap –

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Are there additional standards that you need? So, because you guys have standardized – you've developed your data elements and they're standardized, right? So, are there any additional standards or work that needs to be done for the LTPAC community to get to be able track information to help produce quality measures?

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

So, we – so let me – I'm not quite – I'm trying to follow you, so I may not answer you correctly, so just – but here's what we do, we have our data elements or assessment items, that's what we call it, they are standardized to the setting, we get the information as Ellen explained through the QIES system and then we calculate our measures and we have – you know, a plethora of measures in post-acute that we use that come directly from our assessments and their patient level.

When we have our measures, you know, part of our measure maintenance and part of our steward responsibility for not just our measures but our payment models and so forth is to evaluate, you know, over time look at the assessment information that we collect to see whether it's sufficient, a gold standard, so to speak, up-to-date, you know, current science and then as we go through that sort of process evaluate whether we need to update an assessment item, retest it, you know, perform national testing and then from there –

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Stace, this is Kevin, let me take a stab at this.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Okay.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

I think that the standards that exist are fantastic for ensuring that consistent data is collected and sent to CMS. I don't think that we have standards that, but someone correct me if I'm wrong, for sharing that data between different organizations.

So, I think we're very close because the data is so standardized for getting sent to CMS but because it's not being shared back and forth I don't think we know how that would happen or what the standards would be used.

Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

But, Kevin that's not completely accurate.

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Yes.

Jennie Harvell PhD – Senior Policy Analyst – Office of Disability Aging & Long-Term Care Policy

For example, in terms of the long-term post-acute care assessment summary document that there are standards, Health IT standards that have been applied to the assessment content, that assessment content, those data elements, those data elements have been represented in a continuity of care document, a CCD standard, and those CCDs are being exchanged to receiving providers.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

And that's under the –

Stella Mandl, RN (Stace) – Technical Advisor/Nurse – Centers for Medicare & Medicaid Services

Yeah, I would add that there is some work that's been done as Jennie and I mentioned with the HL7 standards and the alignment with CDA and Meaningful Use requirements, and there are some providers who are testing that exchange of information. There is more to be done I think with regard to governance and harmonization and versioning of data elements I think that's critical.

And probably some prototypes or pilots that need to be implemented to really assess whether or not these particular standards are meeting the needs, whether or not they need to be enhanced and whether or not there are opportunities to leverage other standards such as QRDA and the HAI reporting tools.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay, so this is Terry and I hate to cut off this dialogue but we have to be attentive to time because we have to open it up. Do I have to open it up for public policy, for public comment? I do right?

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Yes.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

ONC?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Terry, we do, I mean, we could go a few minutes over but not much and it is Friday afternoon, so –

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Okay, so why don't we do that. I think that we have – we're going to as the committee, we're going to regroup and get back to you because I don't know that we answered all these questions yet and we may need at least to reach out to you and/or reconvene and we are so appreciative of your time and your willingness to engage with us and help us figure this out. So with that why don't we open it up for public comment really quickly?

Public Comment

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Operator can we please open the lines?

Caitlin Collins – Project Coordinator – Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have a comment.

Darryl W. Roberts, RN, MS, PhD – Senior Policy Fellow, Health IT & Quality – American Nurses Association

Hi, this is Darryl Roberts, I'm actually calling on behalf of Norma Lang who couldn't attend the meeting today. I would like to make a comment regarding some of the statements and comments that were made around nursing data capture of clinical quality metric measures most particularly quality of care around pressure ulcers and other nursing sensitive measures.

And what I would like to say is that in the presence of excellent clinical decision support systems in combination with thoughtful data elements that do not take the nurse away from the point of care but actually maximize the use of data entered in the normal provision of care into the EHR, along with a nurse working at the top of his or her license, you would have a much increased likelihood of capturing reliable, valid and effective data reporting from all people in the LTPAC community, such a combination would increase also the speed and efficiency of quality improvements at the point of care as well as improving the exchange of data and the continuity of care among facilities and providers for these patients under long-term and continuing care.

The use of electronic data quality measures that actually are capturing standardized language and possibly even using such artificial intelligence types of mechanisms that would be able to capture key words and key phrases out of text, particularly in the LTPAC community where the implementation of EHRs is somewhat limited and compared to hospitals somewhat rudimentary, would be very effective in making sure that these quality metrics are captured in a useful and adequate way. Thank you very much for your time.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Thank you for your comment. Operator, are there any other comments?

Caitlin Collins – Project Coordinator – Altarum Institute

We have no additional comment at this time.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

Great, okay, thanks everybody for your time, this was a great discussion and like I said I think we have lots to think about and we all will be doing some follow-up with you. So, have a great weekend everybody.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

You too.

W

Thanks.

W

Bye.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Thank you.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Thanks.

Barbara J. Gage, PhD, MPA – Fellow, Managing Director – Brookings Institute

Thank you.