Interoperability: The IMPACT Act, Post-Acute Care Assessments, & the Data Element Library

Liz Palena Hall, RN, ONC

Beth Connor, RN, CMS

Dr. Terry O'Malley, Partners HealthCare

Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Acronyms in this Presentation

- CMS – Centers for Medicare & Medicaid Services
- DCPAC – Division of Chronic and Post-Acute Care
- DEL – Data Element Library
- HHA – Home Health Agency
- HIS – Hospice Item Set
- HIT – Health Information Technology
- IMPACT – Improving Medicare Post-Acute Care Transformation Act
- IRF – Inpatient Rehabilitation Facility
- IRF-PAI – Inpatient Rehabilitation Facility Patient Assessment Instrument
- LCDS – LTCH CARE Data Set
- LOINC – Logical Observation Identifiers Names and Codes
- LTCH – Long-Term Care Hospital
- MDS – Minimum Data Set
- OASIS – Outcome and Assessment Information Set
- PAC – Post-Acute Care
- SNF – Skilled Nursing Facility
- SNOMED-CT – Systematized Nomenclature of Medicine - Clinical Terms
- SPADEs – Standardized Patient Assessment Data Elements

Agenda

- What is Post-Acute Care?
- The Improving Medicare Post-Acute Care Transformation (IMPACT) Act
- Post Acute Care Assessments
- The Data Element Library
- The Provider's Perspective
- Opportunities/Next Steps

Post-Acute Care

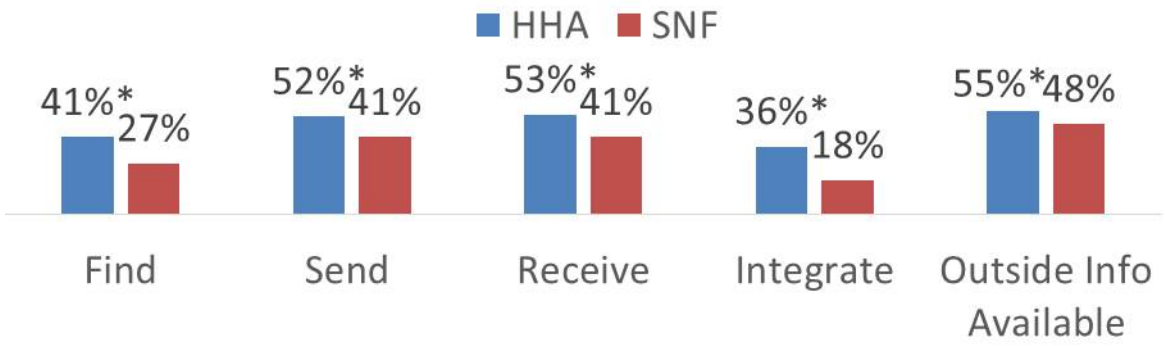
PAC Setting	CMS Assessment
Long-term Care Hospitals (LTCH)	LTCH Continuity Assessment Record & Evaluation (CARE) Data Set (LCDS)
Skilled Nursing Facilities (SNF)	Resident Assessment Instrument (RAI) Minimum Data Set (MDS)
Home Health Agencies (HHA)	Outcome and Assessment Information Set (OASIS)
Inpatient Rehabilitation Facilities (IRF)	IRF Patient Assessment Instrument (IRFPAI)
Hospices	Hospice Item Set (HIS)

- Approximately 33,000 PAC Providers in the U.S.
- Almost 45% of Medicare hospital discharges are followed by PAC use [(1)]

ONC Data Brief: SNF & HHA EHR Adoption and Interoperability in 2017

- EHR adoption rates were higher among HHAs compared to SNFs in 2017

- HHAs are more likely than SNFs to engage in each domain of interoperability.



https://www.healthit.gov/sites/default/files/page/2018-11/Electronic-Health-Record-Adoption-and-Interoperability-among-U.S.-Skilled-Nursing-Facilities-and-Home-Health-Agencies-in-2017.pdf

IMPACT Act of 2014

- Bi-partisan bill passed on September 18, 2014, and signed into law October 6, 2014
- The Act requires *standardized* patient assessment data elements for:
  - LTCHs: LCDS
  - SNFs: MDS
  - HHAs: OASIS
  - IRFs: IRF-PAI
- **The Act specifies that data** "… be **standardized and interoperable** so as to allow for the **exchange of such data among such post-acute care providers and other providers** and the use by such providers of such data that has been so exchanged, including by **using common standards and definitions** in order to provide access to **longitudinal information** for such providers to **facilitate coordinated care** and **improved Medicare beneficiary outcomes**…".

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

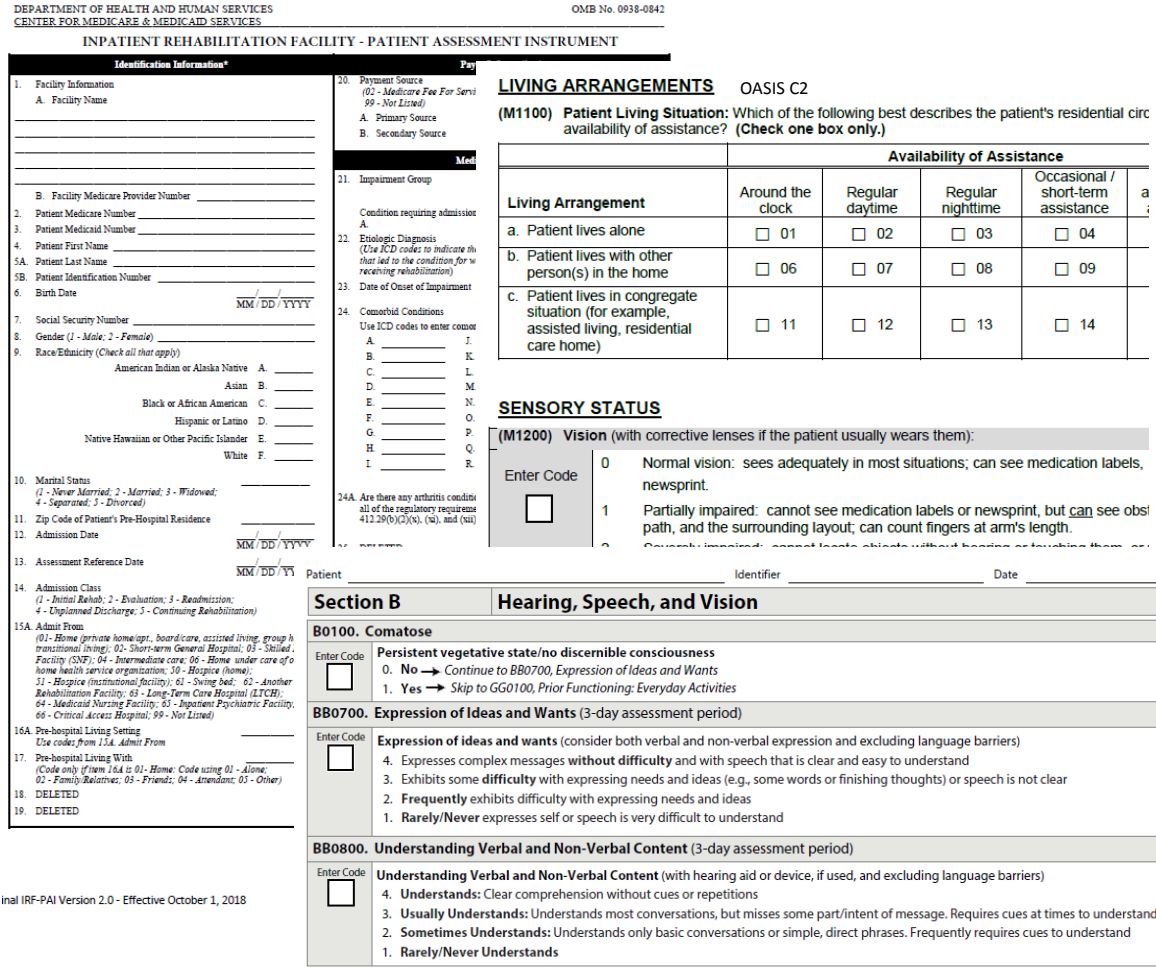
PAC IMPACT Act Requirements

- **Data Must be Interoperable**

- **Quality Measures**
  - Functional Status
  - Skin Integrity
  - Medication Reconciliation
  - Incidence of Major Falls
  - Transfer of Health Information
  - Medicare Spending per Beneficiary
  - Discharge to Community
  - Potentially Preventable Hospital Readmissions

- **Standardized Data Submission**
  - Admission and Discharge
  - Functional status
  - Cognitive function and mental status
  - Special services, treatments, and interventions
  - Medical conditions and co-morbidities
  - Impairments
  - Other categories required by the Secretary

Post-Acute Care Assessments



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

OMB No. 0938-0842

INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT

Identification Information*

1. Facility Information
   A. Facility Name
   B. Facility Medicare Provider Number
2. Patient Medicare Number
3. Patient Medicaid Number
4. Patient First Name
5A. Patient Last Name
5B. Patient Identification Number
6. Birth Date — MM / DD / YYYY
7. Social Security Number
8. Gender (*1 - Male; 2 - Female*)
9. Race/Ethnicity (*Check all that apply*)
   American Indian or Alaska Native A.
   Asian B.
   Black or African American C.
   Hispanic or Latino D.
   Native Hawaiian or Other Pacific Islander E.
   White F.
10. Marital Status (*1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced*)
11. Zip Code of Patient's Pre-Hospital Residence
12. Admission Date — MM / DD / YYYY
13. Assessment Reference Date — MM / DD / YY
14. Admission Class (*1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation*)
15A. Admit From (*01- Home (private home/apt., board/care, assisted living, group h transitional living); 02- Short-term General Hospital; 03 - Skilled Facility (SNF); 04 - Intermediate care; 06 - Home under care of o home health service organization; 50 - Hospice (home); 51 - Hospice (institutional facility); 61 - Swing bed; 62 - Another Rehabilitation Facility; 63 - Long-Term Care Hospital (LTCH); 64 - Medicaid Nursing Facility; 65 - Inpatient Psychiatric Facility, 66 - Critical Access Hospital; 99 - Not Listed*)
16A. Pre-hospital Living Setting (*Use codes from 15A. Admit From*)
17. Pre-hospital Living With (*Code only if item 16A is 01- Home: Code using 01 - Alone; 02 - Family/Relatives; 03 - Friends; 04 - Attendant; 05 - Other*)
18. DELETED
19. DELETED

20. Payment Source (*02 - Medicare Fee For Servi 99 - Not Listed*)
   A. Primary Source
   B. Secondary Source
21. Impairment Group
   Condition requiring admissio A.
22. Etiologic Diagnosis (*Use ICD codes to indicate th that led to the condition for w receiving rehabilitation*)
23. Date of Onset of Impairment
24. Comorbid Conditions
   Use ICD codes to enter comor
   A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R.
24A. Are there any arthritis conditi all of the regulatory requirem 412.29(b)(2)(x), (xi), and (xii)

LIVING ARRANGEMENTS OASIS C2

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circ availability of assistance? **(Check one box only.)**

Living Arrangement	Availability of Assistance: Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	a
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	
c. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	

SENSORY STATUS

(M1200) Vision (with corrective lenses if the patient usually wears them):

Enter Code ☐

0 Normal vision: sees adequately in most situations; can see medication labels, newsprint.

1 Partially impaired: cannot see medication labels or newsprint, but can see obs path, and the surrounding layout; can count fingers at arm's length.

Resident _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0100. Appliances

↓ Check all that apply

- ☐ **A. Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
- ☐ **B. External catheter**
- ☐ **C. Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ **D. Intermittent catheterization**
- ☐ **Z. None of the above**

H0200. Urinary Toileting Program

Enter Code ☐ **A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training)** been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?
0. **No** → Skip to H0300, Urinary Continence
1. **Yes** → Continue to H0200B, Response
9. **Unable to determine** → Skip to H0200C, Current toileting program or trial

Enter Code ☐ **B. Response** - What was the resident's response to the trial program?
0. **No improvement**
1. **Decreased wetness**
2. **Completely dry** (continent)
9. **Unable to determine** or trial in progress

Enter Code ☐ **C. Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?
0. **No**
1. **Yes**

H0300. Urinary Continence

Enter Code ☐ **Urinary continence** - Select the one category that best describes the resident
0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

H0400. Bowel Continence

Enter Code ☐ **Bowel continence** - Select the one category that best describes the resident
0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

0500. Bowel Toileting Program

Enter Code ☐ **Is a toileting program currently being used to manage the resident's bowel continence?**
0. **No**
1. **Yes**

0600. Bowel Patterns

Enter Code ☐ **Constipation present?**
0. **No**
1. **Yes**

Patient _____ Identifier _____ Date _____

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐ **Persistent vegetative state/no discernible consciousness**
0. **No** → *Continue to BB0700, Expression of Ideas and Wants*
1. **Yes** → *Skip to GG0100, Prior Functioning: Everyday Activities*

BB0700. Expression of Ideas and Wants (3-day assessment period)

Enter Code ☐ **Expression of ideas and wants** (consider both verbal and non-verbal expression and excluding language barriers)
4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas
1. **Rarely/Never** expresses self or speech is very difficult to understand

BB0800. Understanding Verbal and Non-Verbal Content (3-day assessment period)

Enter Code ☐ **Understanding Verbal and Non-Verbal Content** (with hearing aid or device, if used, and excluding language barriers)
4. **Understands:** Clear comprehension without cues or repetitions
3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
1. **Rarely/Never Understands**

inal IRF-PAI Version 2.0 - Effective October 1, 2018

)S 3.0 Nursing Home Comprehensive (NC) Version 1.16.0R Effective 10/01/2018 DRAFT

Page 24 of 50

Final LTCH CARE Data Set Version 4.00, Admission - Effective July 1, 2018

PAC Assessment Content

- **Administrative Content**
  - Patient Name
  - Date of Birth
  - Race/Ethnicity
  - Marital status
  - Admission/Discharge dates
  - Admit from/Discharged to locations
  - Reason for admission
  - Provider NPI, CCN, Medicaid Provider #
- **"SPADEs"**
  - Function (e.g., self care and mobility)
  - Cognitive function (e.g., express & understand ideas; mental status, such as depression and dementia)
  - Special services, treatments & interventions (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
  - Medical conditions and co-morbidities (e.g., diabetes, heart failure, and pressure ulcers)
  - Impairments (e.g., incontinence; impaired ability to hear, see, or swallow)
  - Other categories
- **Clinical Content**
  - Diagnosis/medical conditions
  - Mental/Cognitive Status (memory, orientation, consciousness, delirium, mood, behavior)
  - Communication (express needs, understanding verbal/non-verbal content, hearing and vision)
  - Functional Status (Self-care/ADLs, Mobility, Use of assistive devices)
  - Bladder and Bowel continence
  - Falls
  - Pressure ulcers and other skin conditions
  - Surgery
  - Nutritional and swallowing status
  - Medication information
  - Special treatments, procedures & programs
  - Height and Weight
  - Patient preferences and goals of treatment
  - Pain
  - Vaccinations
  - Therapy- PT, OT, SLT
  - Living arrangements/support availability
  - Care planning

Data Elements: Standardization
One Question → One Response: Many Uses

GG0160. Functional Mobility
(Complete during the 3-day assessment period.)

Code the patient's usual performance using the 6-point scale below.

CODING:
Safety and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

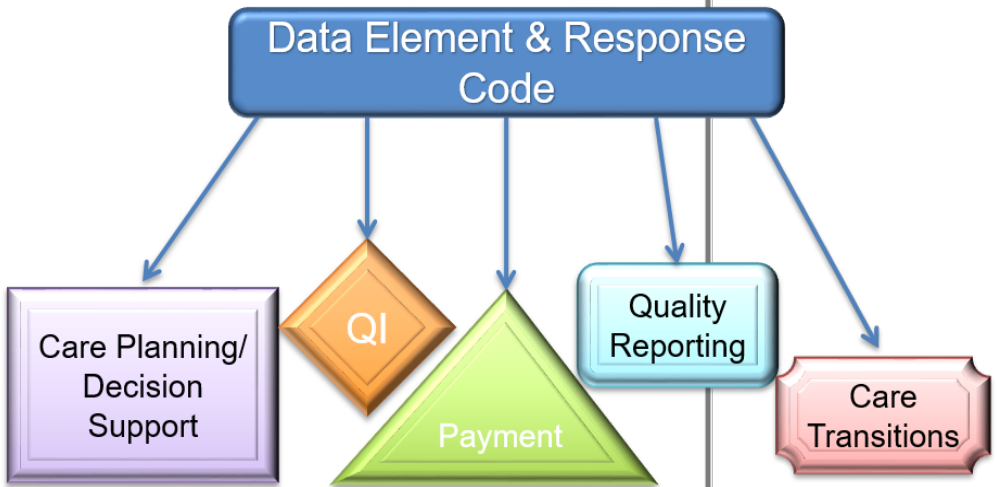
06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the task.

07. **Patient refused**
09. **Not applicable**

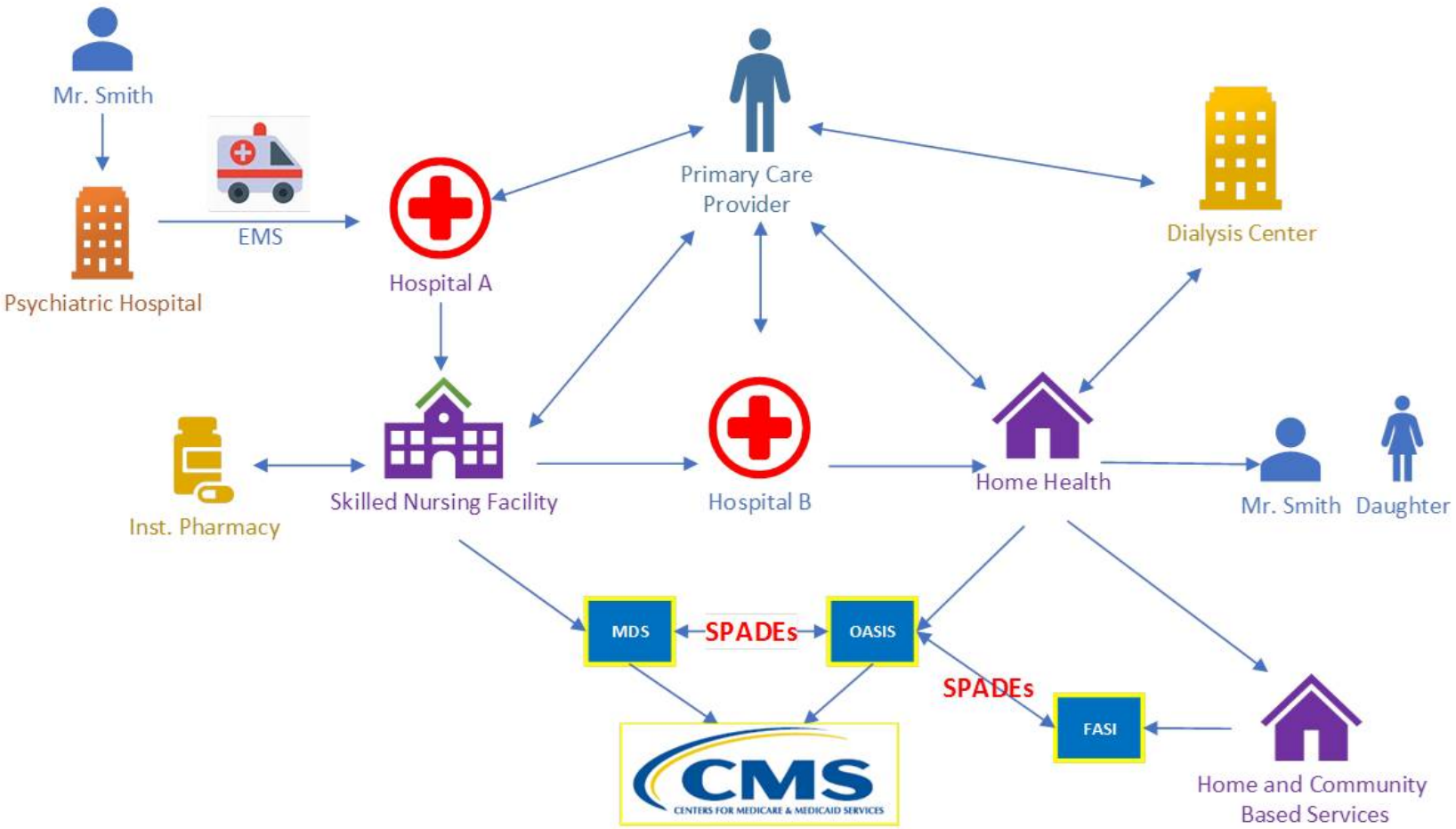
If activity was not attempted, code:
88. Not attempted due to **medical condition or safety concerns**

↓ **Enter Codes in Boxes**

☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.



Use Case: The Patient Story

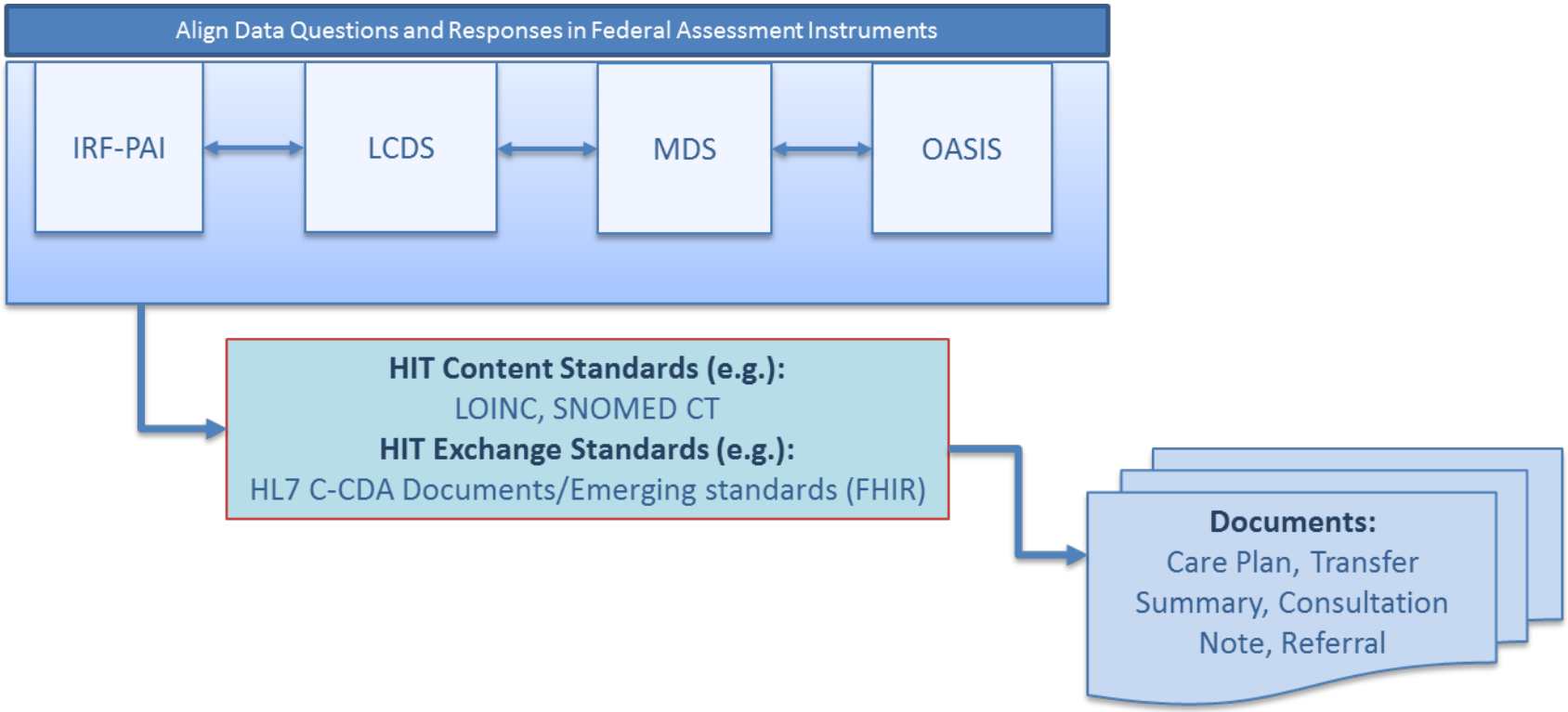


The Data Element Library

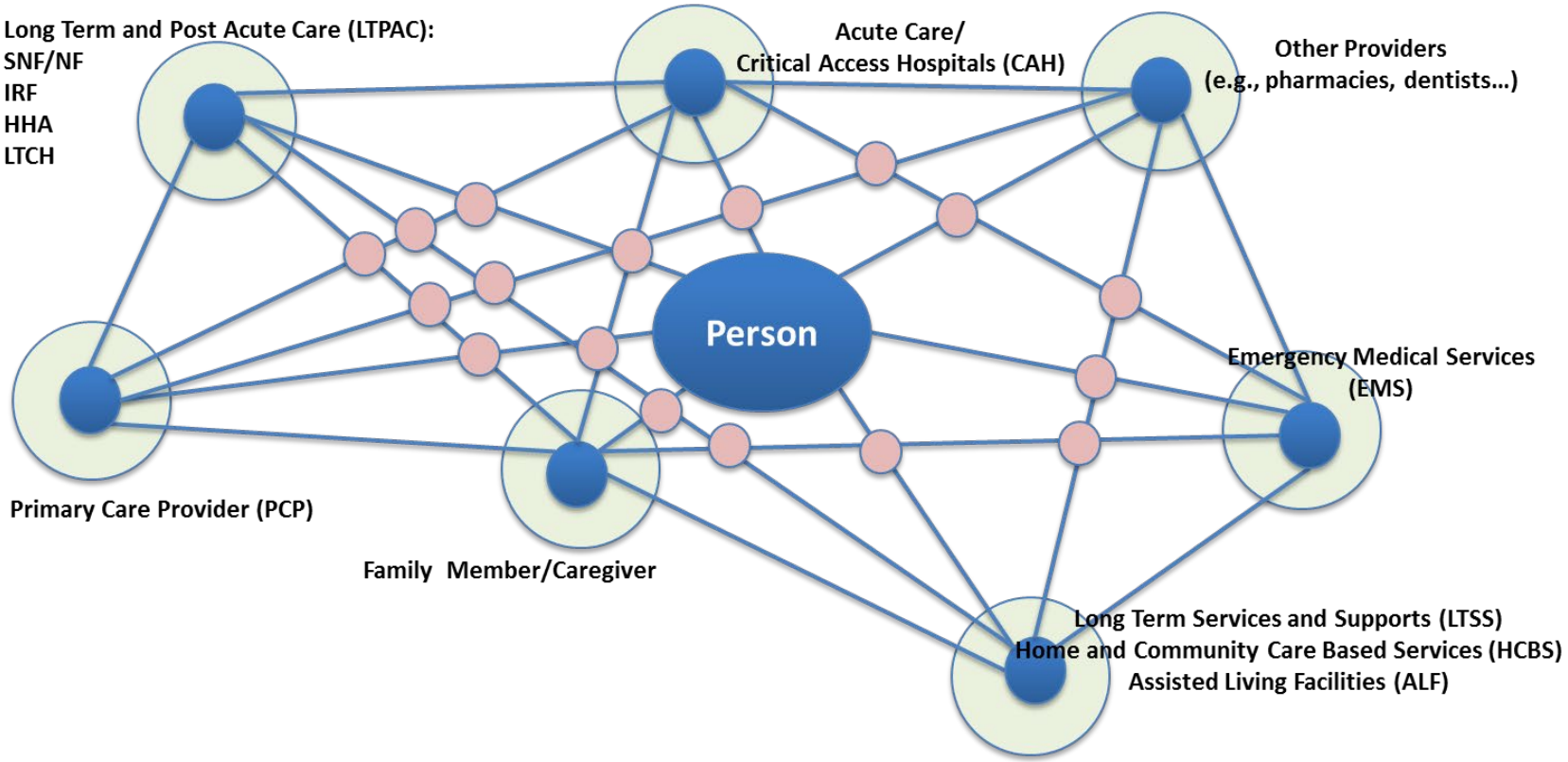
- The (DEL) is a centralized resource for CMS assessment data elements (e.g. questions and response options), and their associated mappings to nationally accepted health information technology (IT) standards.
- Use is encouraged to:
  - Support provider exchange of electronic health information for better care coordination
  - Enable more seamless/less costly health information exchange
  - Reduce overall provider burden through use and exchange of health care data
  - Promote high quality, personalized, efficient health care
  - Support real-time, data driven, clinical decision making
- Search and generate reports (assessment questions & response options, their attributes, and linked HIT standards)
- No patient data

Visit the DEL here: https://del.cms.gov

Making PAC Assessment Data Elements Standardized/Aligned and Interoperable

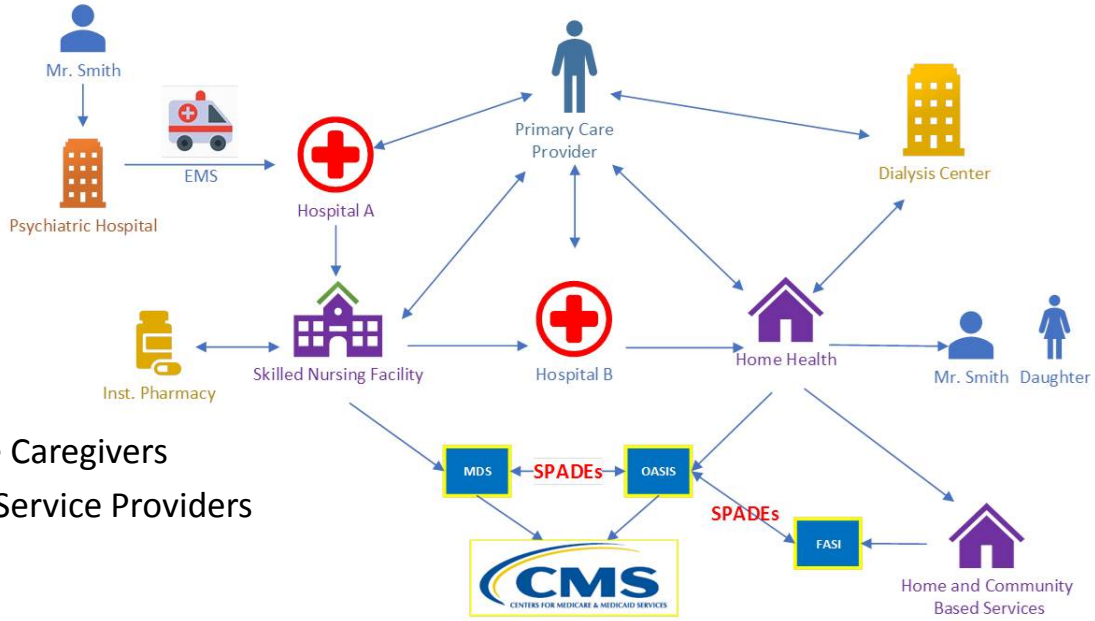


Data Follows the Person



The Provider's Perspective

- **Medical Stakeholders:**
  - Primary/Principal Care Physician
  - SNF (and other PAC Facilities)
  - Home Health Agency
  - Dialysis Center
  - Acute Care Hospital
- **Other Stakeholders**
  - Case Manager
  - EMS
  - Pharmacy
- **Non-Medical Stakeholders:**
  - Patient and Family/Immediate Caregivers
  - Home and Community Based Service Providers



Who Needs PAC Assessment Content?

	Non-Medical		Medical				
Stakeholders / **Clinical Content**	Patient and Family	HCBS	Home Health	SNF, IRF, LTCH	Dialysis Center	Acute Care Hospital	Primary Care
Diagnosis/medical conditions	x	x	x	x	x	x	x
Mental/Cognitive Status	x	x	x	x	x	x	x
Communication	-	x	x	x	x	x	x
Functional Status	-	x	x	x	-	x	x
Bladder and Bowel continence	-	x	x	x	x	x	x
Falls	x	x	x	x	x	x	x
Pressure ulcers and other skin conditions	x	x	x	x	x	x	x
Surgery	-	-	x	x	-	x	x
Nutritional and swallowing status	x	x	x	x	-	x	x
Medication information	x	-	x	x	x	x	x
Special treatments, procedures & programs	-	-	x	x	x	x	x
Height and Weight	x	x	x	x	x	x	x
Patient preferences and goals of treatment	x	x	x	x	x	x	x
Pain	x	x	x	x	x	x	x
Vaccinations	x	-	x	x	-	x	x
Therapy- PT, OT, SLT	-	-	x	x	-	x	x
Living arrangements/support availability	-	x	x	x	x	x	x
Care planning	x	x	x	x	x	x	x

Who Needs PAC Assessment Content?

	Other		
Stakeholders	Case Manager	Community Pharmacist	EMS
Clinical Content			
Diagnosis/medical conditions	x	x	x
Mental/Cognitive Status	x	x	x
Communication	x	x	x
Functional Status	x	-	-
Bladder and Bowel continence	x	-	-
Falls	x	-	-
Pressure ulcers and other skin conditions	x	-	x
Surgery	x	-	x
Nutritional and swallowing status	x	x	-
Medication information	x	x	x
Special treatments, procedures & programs	x	-	-
Height and Weight	x	x	x
Patient preferences and goals of treatment	x	-	x
Pain	x	-	-
Vaccinations	x	-	-
Therapy- PT, OT, SLT	x	-	-
Living arrangements/support availability	x	x	-
Care planning	x	-	-

Opportunities/Next Steps

- DEL Surveys
  - New Feedback Button- coming soon
- DEL Contractors (NIC, Telligen, RTI, and MITRE)
  - Landscape Analysis of PAC Interoperability
  - Participation in Roundtable Discussions
  - FHIR APIs- Implementation Guide Development, Connect-a-thon
    - Open to all providers who exchange data with PACs

Industry Expert Roundtable on CMS Data Element Library

- Provided feedback on how the CMS Data Element Library (DEL) can be used to:
  - Inform healthcare policies
  - Advance interoperability
  - Support transfer of care, coordination of care, quality measurement, and research

Medicaid Technology Financing to Support Health Information Exchange Activities

CMS Incentive through State Medicaid Director Letter (#16-003)

Medicaid HITECH funds are now available to support states in their initiatives to expand interoperability and data sharing related to connecting professionals and hospitals that are eligible for Medicaid EHR Incentive Payments to other Medicaid providers, including behavioral health, long-term care providers (including nursing facilities), home health providers, and other Medicaid providers, including community-based Medicaid providers.

- **This funding is in place until 2021** and is a 90/10 Federal State match. The state is still responsible for providing the 10%.
- The funding is for HIE and interoperability **only**, not to provide EHRs.
- The funding is for implementation **only**, it is not for operational costs.
- The funding still must be cost allocated if other entities than the state Medicaid agency benefit
- **All providers or systems supported by this funding must connect to Medicaid Eligible Providers**

For more information:
https://www.medicaid.gov/federalpolicyguidance/downloads/smd16003.pdf

Resources

- For more information on the IMPACT Act, visit the **IMPACT Act** webpage

- For more information on Post-Acute Care Quality Reporting Programs, visit:
  - **Home Health Agencies**
  - **Hospice Agencies**
  - **Inpatient Rehab Facilities**
  - **Long-term Care Hospitals**
  - **Skilled Nursing Facilities**

- For DEL updates, sign up for the listserv **here**
- For DEL feedback or questions, contact: **DELHelp@cms.hhs.gov**

Elizabeth.PalenaHall@hhs.gov
Beth.Connor@cms.hhs.gov
TOMalley@mgh.Harvard.edu