



# Improving Medicare Post Acute Care Transformation Act of 2014



*Special Open Door  
Forum for  
Consumers*

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# Welcome

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- Centers for Medicare & Medicaid Services, along with its contractor, RAND Corporation, Welcomes You To Join this National Discussion

# Goals of this Special Open Door Forum

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- Provide an Overview of the Improving Medicare Post-Acute Care Transformation Act of 2014.....and what it can mean for you!
- Hear from you, the Medicare beneficiary/consumer community, about the types of information that would be helpful to you following discharge from a hospital or other service you may use

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

- Bi-partisan bill introduced in March, U.S. House & Senate; passed on September 18, 2014 and signed into law by President Obama October 6, 2014
- Requires Standardized Patient Assessment Data that will enable:
  - Assessment and QM uniformity
  - Quality care and improved outcomes
  - Comparison of quality across PAC settings
  - Improve discharge planning
  - Interoperability
  - Facilitate care coordination

# Requirements for Standardized Assessment Data

- **IMPACT Act** added new section 1899(B) to Title XVIII of the Social Security Act (SSA)
- Post-Acute Care (PAC) providers must report:
  - Standardized assessment data
  - Data on quality measures
  - Data on resource use and other measures
- The data must be standardized and interoperable to allow for the:
  - Exchange of data using common standards and definitions
  - Facilitation of care coordination
  - Improvement of Medicare beneficiary outcomes
- PAC assessment instruments must be modified to:
  - Enable the submission of standardized data
  - Compare data across all applicable providers

# Why Post Acute Care?

- Important Part of the Health Care System
  - 42% of Medicare fee for service beneficiaries discharged from hospitals go to at least one PAC:
    - Home health agencies
    - Skilled nursing facilities
    - Inpatient rehabilitation hospitals
    - Long term care hospitals
  - Additional medical and rehabilitation services

# What is an Assessment Tool?

- Set of information collected by your clinical team about your:
  - Medical Status: health conditions, complications (e.g., meds, pressure ulcers, respiratory status, dialysis or ventilator needs)
  - Functional Status: mobility (e.g., ambulation, balance) self-care ability (e.g., bathing, dressing)
  - Cognitive status (e.g., delirium, memory)
  - Social Support (e.g., caregivers, residence)

# Why Standardize Data?

- PAC Assessment Tools Currently Differ Across the Medicare Program
  - HHA: Outcome and Assessment Information Set (OASIS)
  - SNF: Minimum Data Set (MDS)
  - IRF: Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
  - LTCH: Long Term Care Hospital Care Item Set (LTCH-CARE)
- Each tool contains similar items but not the same questions and responses making the information difficult to exchange electronically across providers



# IMPACT Act Identifies Categories that Need to Be Standardized

- 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)

# IMPACT Act Identifies Quality Measures Based On Standardized Assessment Data

Quality measures on which PAC providers must submit standardized patient assessment data

- Functional status, cognitive function, and changes in function and cognitive function.
- Skin integrity and changes in skin integrity.
- Medication reconciliation.
- Incidence of major falls.
- Communicating and providing for the transfer of health information and care preferences of an individual when the individual transitions.

# Why Uniform Assessment Items?

## Potential to Improve Care & Coordination

- Facilitate consistent and reliable identification of the individual's met and unmet needs
- Decrease fragmentation by using common assessment language that can be transferred electronically across caregiving team
- Support care transitions
- Simplify access to programs and supports
- Improve information on quality and health outcomes

# Guiding Principles for Our Work

- Promote Better Care
  - Make care safer and more reliable
  - Effective communication & care coordination
  - Track outcomes
- Person centered processes and items
  - Support care planning focused on optimizing independence & preferences
  - Engage consumers and families in design
- Improve the value of care
- Each care setting will continue to have items specific to the services in that setting

# What do we mean by Person-Centered Care?

- Refers to an approach that reflects the **patients'**
  - Goals in care
  - Strengths to build on for deciding about next steps
  - Needs for understanding post-discharge information
  - Preferences in types of information, access to resources

# Why Are We Having This Open Door Forum?

- Build on the knowledge, experiences, and insights of **consumers, patients, families, and others** in selecting and testing assessment items to meet the goals of the IMPACT Act

# What Do We Hope To Gain Today?

Feedback from you to create better assessment items, responsive to consumer needs

- Gain insight into how consumers and families view standardized assessment –
  - What strengths, weaknesses, ideal outcomes?
- Obtain a wide range of perspectives
- Learn about concerns and preferences of consumers and families
- Ensure that Standardized Assessment supports person-centered principles and protections

# Some Questions to Get us Started

- **What types of information would be useful to you at time of discharge from the hospital, skilled nursing facility, inpatient rehabilitation hospital, or long term care hospital?**
  - Instructions on medications, physician follow-up appointments, contact information for others?
  - Information on the next steps in your recovery?
    - Home Health visits?
    - Doctor office visits?
    - Therapy visits?
  - What do you need to do to prepare for the patient's transition?
  - What resources are available in the community?



# Some Questions to Get us Started

## **What type of information was useful to have when you moved into the next stage?**

- Did your clinical team have all the information they needed from your last caregiving team when they admitted you?
- Were there additional pieces of information that would have been helpful to you in changing locations?
- Did you know who to contact for help after the transition occurred?
  - PAC case manager
  - Your primary care physician
  - Your surgeon (if applicable)
  - Your hospital physician (if applicable)
- Were your care goals incorporated into the process? If not, how could they be better integrated into your care plan?

# Some Questions to Get us Started

- **What types of information would be useful to you when you return home from an inpatient stay at the hospital, skilled nursing facility, inpatient rehabilitation hospital, or long term care hospital?**
  - Who should you call if you “don’t feel right”?
  - How will you get your meds if you live alone?
  - How do you get special equipment, such as hospital beds, shower bars, commodes?
  - Are you expected to change your loved one’s bandages?
  - When should you be worried about your loved one’s:
    - energy levels, appetite, pain
  - What else do you wish you knew or had available when returning home after the hospital?

# Summary

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- Goal is to develop person-centered standardized assessment items for PAC
- We want to identify information consumers need to make easier care transitions
- Stakeholders will be engaged throughout the process
- Future Special Open Door Forums

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THANK YOU

for taking the time to give us your  
input on this important national  
effort!!

# Additional Comments?

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Please send to the CMS IMPACT  
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