Electronic Long-Term Services & Supports (eLTSS)

FEDERAL PARTNER WEBINAR

Date: November 4, 2016
Meeting Etiquette

- Remember: If you are not speaking, **please keep your phone on mute**

- Do not put your phone on hold. If you need to take a call, hang up and dial in again when finished with your other call
  
  » Hold = Elevator Music = frustrated speakers and participants

- **This meeting is being recorded**
  
  » Another reason to keep your phone on mute when not speaking

- **Use the “Chat” feature** for questions, comments and items you would like the moderator or other participants to know.
  
  » **Send comments to All Panelists** so they can be addressed publically in the chat, or discussed in the meeting (as appropriate).
<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>Mike Smith (CMS)</td>
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<tr>
<td></td>
<td>Kerry Lida (CMS)</td>
</tr>
<tr>
<td>IMPACT Act of 2014 Data Element Harmonization Overview</td>
<td>Stace Mandl (CMS)</td>
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<td>FASI Overview</td>
<td>Barbara Gage (GWU)</td>
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<td>eLTSS Round 2 Pilot Update</td>
<td>Evelyn Gallego (EMI Advisors LLC)</td>
</tr>
<tr>
<td>Federal Partner Discussion</td>
<td>All</td>
</tr>
<tr>
<td>Next Steps</td>
<td>Evelyn Gallego (EMI Advisors LLC)</td>
</tr>
</tbody>
</table>
Welcome & Introductions
Data Element Uniformity, Assessment Domain Standardization & The IMPACT Act of 2014

Stella Mandl RN, BSN, BSW, PHN
Deputy Division Director for Chronic and Post-Acute Care (DCPAC)
Centers for Medicare & Medicaid Services (CMS)
Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

• Bipartisan bill passed on September 18, 2014 and signed into law by President Obama on October 6, 2014

• Requires Standardized Patient Assessment Data that will enable:
  – Data Element uniformity
  – Quality care and improved outcomes
  – Comparison of quality and data across post-acute care (PAC) settings
  – Improved discharge planning
  – Exchangeability of data
  – Coordinated care
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
Driving Forces of the IMPACT Act

• **Purposes Include:**
  – Improvement of Medicare beneficiary outcomes
  – Provider access to longitudinal information to facilitate coordinated care
  – Enable comparable data and quality across PAC settings
  – Improve hospital discharge planning
  – Research

• **Why the attention on Post-Acute Care:**
  – Escalating costs associated with PAC
  – Lack of data standards/interoperability across PAC settings
  – Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting
Definitions

• Applicable PAC settings and Prospective Payment Systems (PPS):
  – Home health agencies (HHA) under section 1895
  – Skilled nursing facilities (SNF) under section 1888(e)
  – Inpatient rehabilitation facilities (IRF) under section 1886(j)
  – Long-term care hospitals (LTCH) under section 1886(m)
• Applicable PAC assessment instruments
  – **HHA:** Outcome and Assessment Information Set (OASIS) or any successor regulation
  – **SNF:** assessment specified under section 1819(b)(3)
  – **IRF:** any Medicare beneficiary assessment instrument established by the Secretary for purposes of section 1886(j)
  – **LTCH:** any Medicare beneficiary assessment instrument used to collect data elements to calculate quality measures, including for purposes of section 1886(m)(5)(C)
Legislative Background: Data Standardization

• **Benefits Improvement & Protection Act (BIPA) of 2000**
  – Required the Secretary to report to Congress on standardized assessment items across PAC settings

• **Deficit Reduction Act (DRA) of 2005**
  – Required the standardization of assessment items used at discharge from an acute care setting and at admission to a post acute care setting
  – Established the Post-Acute Care Payment Reform Demonstration (PAC-PRD) to harmonize payments for similar settings in PAC settings
  – Resulted in the Continuity Assessment Record and Evaluation (CARE) tool, a component to test the reliability of the standardized items when used in each Medicare setting

• **PAC Reform Demonstration requirement of 2006**
  – Data to meet federal Health Information Technology (HIT) interoperability standards
PAC-PRD & the CARE Tool: Goals and Guiding Principles

**Goals**
- Fosters seamless care transitions
- Measures that can follow the patient
- Evaluation of longitudinal outcomes for patients that traverse settings
- Assessment of quality across settings
- Improved outcomes, and efficiency
- Reduction in provider burden

**Data Uniformity**
- Reusable
- Informative
- Increases Reliability/validity
- Facilitates patient care coordination

**Interoperability**
- Data that can communicate in the same language across settings
- Data that can be transferable forward and backward to facilitate care coordination
- Follows the individual
Data Elements: Standardization

Uniformity

Data Elements

OASIS-C
HCBS FASI
IRF-PAI
MDS 3.0
LTCH CARE Data Set
What is Standardization?
Standardizing Function at the Item Level

- Inpatient Rehabilitation Facilities – Patient Assessment Instrument (IRF-PAI)
- Skilled Nursing Facilities – Minimum Data Set (MDS)
- Home Health Agencies – Outcome & Assessment Information Set (OASIS)
- Long-Term Care Hospitals – Continuity Assessment Record & Evaluation (CARE) Data Set (LCDS)

- IRF-PAI: Eating
- MDS: Eating
- OASIS: Eating
- LCDS: Eating
Standardized Assessment Data Elements

One Question: Much to Say → 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.

<table>
<thead>
<tr>
<th>CODING:</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Activities may be completed with or without assistive devices.</td>
<td></td>
</tr>
<tr>
<td>06. Independent - Patient completes the activity by him/herself with no assistance from a helper.</td>
<td></td>
</tr>
<tr>
<td>05. Setup or clean-up assistance - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>01. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the task.</td>
<td></td>
</tr>
<tr>
<td>07. Patient refused</td>
<td></td>
</tr>
<tr>
<td>09. Not applicable</td>
<td></td>
</tr>
<tr>
<td>If activity was not attempted, code:</td>
<td></td>
</tr>
<tr>
<td>88. Not attempted due to medical condition or safety concerns</td>
<td></td>
</tr>
</tbody>
</table>

Data Element & Response Code

Care Planning/Decision Support

QI

Quality Reporting

Payment

Care Transitions
## Standardizing Across Settings

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Description</th>
<th>Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) v1.4</th>
<th>Minimum Data Set (MDS) 3.0</th>
<th>Long-Term Care Hospital CARE Data Set v3.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELFCARE GG0130</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Eating</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>B</td>
<td>Oral hygiene</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>C</td>
<td>Toileting hygiene</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>D</td>
<td>Wash upper body</td>
<td>—</td>
<td>—</td>
<td>✓</td>
</tr>
<tr>
<td>E</td>
<td>Shower/bathe self</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>F</td>
<td>Upper body dressing</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>G</td>
<td>Lower body dressing</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>H</td>
<td>Putting on/taking off footwear</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>
Standardizing Across Settings (continued)

<table>
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<tr>
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<th>Long-Term Care Hospital CARE Data Set v3.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Roll left and right</td>
<td>✓</td>
<td>—</td>
<td>✓</td>
</tr>
<tr>
<td>B</td>
<td>Sit to lying</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>C</td>
<td>Lying to sitting on side of bed</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>D</td>
<td>Sit to stand</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>E</td>
<td>Chair/bed-to-chair transfer</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>F</td>
<td>Toilet transfer</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>G</td>
<td>Car transfer</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>I</td>
<td>Walk 10 feet</td>
<td>✓</td>
<td>—</td>
<td>✓</td>
</tr>
<tr>
<td>J</td>
<td>Walk 50 feet with two turns</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>K</td>
<td>Walk 150 feet</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>L</td>
<td>Walking 10 feet on uneven surface</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>M</td>
<td>1 step (curb)</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>N</td>
<td>4 steps</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>O</td>
<td>12 steps</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>P</td>
<td>Picking up object</td>
<td>✓</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>R</td>
<td>Wheel 50 feet with two turns</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>S</td>
<td>Wheel 150 feet</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
IMPACT Act:
Standardized Patient Assessment Data

• Requirements for reporting assessment data:
  – Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions
  – The data must be submitted with respect to admission and discharge for each patient, or more frequently as required

• Data categories:
  • Functional status
  • Cognitive function and mental status
  • Special services, treatments, and interventions
  • Medical conditions and co-morbidities
  • Impairments
  • Other categories required by the Secretary

Use of Standardized Assessment data no later than

SNF: October 1, 2018
IRF: October 1, 2018
LTCH: October 1, 2018
HHA: January 1, 2019
IMPACT Act: Quality Measure Domains & Timelines

1. Functional status, cognitive function, and changes in function and cognitive function
   - SNF: October 1, 2016
   - IRF: October 1, 2016
   - LTCH: October 1, 2018
   - HHA: January 1, 2019

2. Skin integrity and changes in skin integrity
   - SNF: October 1, 2016
   - IRF: October 1, 2016
   - LTCH: October 1, 2016
   - HHA: January 1, 2017

3. Medication Reconciliation
   - HHA: January 1, 2017
   - SNF: October 1, 2018
   - IRF: October 1, 2018
   - LTCH: October 1, 2018
IMPACT Act: Quality Measure Domains & Timelines (continued)

4. Incidence of Major Falls
   - SNF: October 1, 2016
   - IRF: October 1, 2016
   - LTCH: October 1, 2016
   - HHA: January 1, 2019

5. Communicating the existence of and providing for the transfer of health information and care preferences
   - SNF: October 1, 2018
   - IRF: October 1, 2018
   - LTCH: October 1, 2018
   - HHA: January 1, 2019

Resource use and other measures will be specified for reporting:
- Total estimated Medicare spending per beneficiary
- Discharge to community
- Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates

SNF: October 1, 2016
IRF: October 1, 2016
LTCH: October 1, 2016
HH: January 1, 2017
The strategy is to concurrently pursue three aims:

**Better Care**
- Improve overall quality by making health care more patient-centered, reliable, accessible, and safe

**Healthy People / Healthy Communities**
- Improve population health by supporting proven interventions to address behavioral, social and environmental determinants of health, in addition to delivering higher-quality care

**Affordable Care**
- Reduce the cost of quality healthcare for individuals, families, employers and government
NQS Promotes Better Health, Better Healthcare, and Lower Costs Through:

Six Priorities

- Make care safer by reducing harm caused in the delivery of care
- Ensure that each person and family are engaged as partners in their care
- Promote effective communication and coordination of care
- Promote effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- Work with communities to promote wide use of best practices to enable healthy living
- Make quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models
The Six Priorities Have Become the Goals for the CMS Quality Strategy

- Making Care Safer
- Strengthen person & family engagement
- Promote effective communication & coordination of care
- Promote effective prevention & treatment
- Work with communities to promote best practices of healthy living
- Make care affordable
Measures should be patient-centered and outcome-oriented whenever possible.

Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures.
Addressing Critical Gaps
IMPACT Act & Opportunity

The Act provides an opportunity to address all goals within the CMS Quality Strategy:

- Strengthen person and family engagement as partners in their care
- Promote effective communication and coordination of care
- Promote effective prevention and treatment of chronic disease
IMPACT Act: Measurement Implementation Phases

1) Measurement Implementation Phases

   (A) Initial Implementation Phase –
       (i) Measure specification
       (ii) Data collection

   (B) Second Implementation Phase –
       Feedback reports to PAC providers

   (C) Third Implementation Phase –
       Public reporting of PAC providers' performance

2) Consensus-based Entity Endorsement Evaluation

3) Treatment of Application of Pre-Rulemaking Process
IMPACT Act: Standardized Patient Assessment Data

- **Requirements for reporting assessment data:**
  - Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions
  - The data must be submitted with respect to admission and discharge for each patient, or more frequently as required

- **Data categories:**
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Use of Standardized Assessment data no later than:

SNF: October 1, 2018
IRF: October 1, 2018
LTCH: October 1, 2018
HHA: January 1, 2019
Overarching Principles

The Mission: To transform and modernize the health care system; promoting effective, efficient, high quality care for beneficiaries, through the use of standardized, reusable data so as to:

- Facilitate rapid, accurate exchange of critical patient information to reduce errors, prevent adverse events and improve care
- Allow for the measurement and reporting of comparable quality across providers and provider types
- Enable person-centered decision making using comparable data
- Enable payment reform
Guiding Principles I

We believe that certain principles should be applied in the work related to data standardization and that the data should:

• Allow for reusable data:
  – Data to serve multiple purposes: collect once, use multiple times

• Create a common spoken and IT language
  – Enable Interoperability
  – Facilitate care coordination through standardized communication

• Be usable across the continuum of care, and beyond the healthcare system
Guiding Principles II

Assessment instrument item development shall take into account these essential principles:

- The data elements selected for use shall reside in the public domain
- Item development shall occur through a consensus-based development process
- Application of current science
- Adherence to the statutory requirements under the IMPACT Act of 2014
Please Pass the Legos:

- Standardized
- Detailed
- Reusable
Standardization: Ideal State

Person-centered care: Prevention, Mitigation, Risk Reduction, Continuity of Care & Care Coordination

Information Follows the Person

Long Term Care
Institutional and Home and Community-Based Services (HCBS)
### PAC QRP IRF Estimated Timelines/Milestones to Meet the IMPACT Act of 2014 Timeline Requirements

<table>
<thead>
<tr>
<th>Year</th>
<th>Milestone Description</th>
<th>Narrative</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>1/1/15 - 8/1/15 Meas. dev.</td>
<td>Requires six months to two years and includes public input, stakeholder input, and the MAP process</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>Rulemaking FY 2016</td>
<td>IMPACT Act measure domains are defined in legend #1 above</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>Rulemaking FY 2017</td>
<td>IMPACT Act assessment domains are defined in legend #2 above</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>Rulemaking FY 2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>Aug - Jan MAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>Aug - Jan MAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>Aug - Jan MAP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Legend #1: IMPACT Act Measure Domains
- A. Functional status
- B. Cognitive function and mental status
- C. Special services, treatments, and interventions
- D. Medical conditions and co-morbidities
- E. Impairments

#### Legend #2: Standardized Assessment Domains
- 1. Functional status
- 2. Cognitive function and mental status
- 3. Special services, treatments, and interventions
- 4. Medical conditions and co-morbidities
- 5. Impairments

---

1. Quality measure development requires six months to two years and includes public input, stakeholder input, and the MAP process
2. IMPACT Act measure domains are defined in legend #1 above
3. IMPACT Act assessment domains are defined in legend #2 above
4. Provider feedback and preview reports and publicly reported data are refreshed at regular intervals after starting
PAC QRP LTCH Estimated Timelines/Milestones to Meet the IMPACT Act of 2014 Timeline Requirements

1. Quality measure development requires six months to two years and includes public input, stakeholder input, and the MAP process.

2. IMPACT Act measure domains are defined in legend #1 above.

3. IMPACT Act assessment domains are defined in legend #2 above.

4. Provider feedback and preview reports and publicly reported data are refreshed at regular intervals after starting.
Estimated Timelines/Milestones to Meet the IMPACT Act of 2014 Timeline Requirements

### Key Timeline Events

**2015**
- 1/1/15 - 8/1/15: Measure development

**2016**
- 8/2/16 - 4/1/17: Measure development
- Rulemaking FY 2016

**2017**
- Aug - Jan: Measure Applications Partnership (MAP)
- Rulemaking FY 2017

**2018**
- Aug - Jan: MAP

**2019**
- Aug - Jan: MAP

**2020**
- Aug - Jan: MAP

**2021**
- Aug - Jan: MAP

### Milestones

**10/1/16**
- Begin 2% reduction for SNF failure to report quality and resource use measure data

**10/1/17**
- Confidential feedback reports to SNF providers

**10/1/18**
- SNF providers begin reporting quality measure data specified by the Secretary (C, E)²

**10/1/19**
- Confidential feedback reports to SNF providers (A, B, C, D, E, F, G, H)²

**Jul 2018**
- Preview Reports - SNF provider opportunity to review (A, B, D, F, G, H)²

**10/1/18**
- Public reporting of provider-previewed individual performance (A, B, F, G, H)²

**10/1/18**
- Assessment domains standardized³

**10/1/20**
- Public reporting of provider-previewed individual performance (A, E, C, D, E, F, G, H)²

### Legend #1: IMPACT Act Measure Domains
- A. Functional status, cognitive function, and changes in function and cognitive function
- B. Skin integrity and changes in skin integrity
- C. Medication reconciliation
- D. Incidence of major falls
- E. Transfer of health information and care preferences when an individual transitions
- F. Resource use measures, including total estimated Medicare spending per beneficiary
- G. Discharge to community
- H. All-condition risk-adjusted potentially preventable hospital readmission rates

### Legend #2: Standardized Assessment Domains
- Functional status
- Cognitive function and mental status
- Special services, treatments, and interventions
- Medical conditions and co-morbidities
- Impairments

---

1. Quality measure development requires six months to two years and includes public input, stakeholder input, and the MAP process
2. IMPACT Act measure domains are defined in legend #1 above
3. IMPACT Act assessment domains are defined in legend #2 above
4. Provider feedback and preview reports and publicly reported data are refreshed at regular intervals after starting
### PAC QRP HHA Estimated Timelines/Milestones to Meet the IMPACT Act of 2014 Timeline Requirements

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1/1/15 - 8/1/15</td>
<td>8/2/15 - 6/1/17</td>
<td>Rulemaking CY 2016</td>
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#### 2. IMPACT Act measure domains are defined in legend #1 above

#### 3. IMPACT Act assessment domains are defined in legend #2 above

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### Legend #1: IMPACT Act Measure Domains

- Functional status
- Cognitive function and mental status
- Skin integrity and changes in skin integrity
- Medication reconciliation
- Incidence of major falls
- Transfer of health information and care preferences when an individual transitions
- Resource use measures, including total estimated Medicare and Medicaid spending per beneficiary
- Discharge to community
- All-cause risk-adjusted potentially preventable hospital readmission rates

### Legend #2: Standardized Assessment Domains

- Functional status
- Cognitive function and mental status
- Special services, treatments, and interventions
- Medical conditions and co-morbidities
- Impairments
Home and Community Based Services
Testing Experience Function Tools (TEFT)
Functional Assessment Standardized Items (FASI)

Barbara Gage, PhD
Co-Director for IMPACT Act & FASI Task Lead
George Washington University, Contractor to CMS
TEFT COMPONENTS

**CROSS-DISABILITY EXPERIENCE OF CARE (EoC) SURVEY**
* Field Test: 2014-2015
* Grantee implementation: 2016-2018
* Submission for CAHPS Trademark: 2015
* NQF submission for endorsement of EoC-derived measures: 2016

**FUNCTIONAL ASSESSMENT STANDARDIZED ITEMS (FASI)**
* Field Test: 2016
* Grantee implementation: 2017-2018
* NQF submission for endorsement of FASI measures: 2017

**eLTSS PLAN STANDARD**
* Participation in solution plan development & consensus activities with ONC: 2014-2015
* Phase I Pilot execution: 2015-2016
* Phase II Pilot execution: 2016-2017

**PERSONAL HEALTH RECORD (PHR)**
* Grantee implementation: 2016–2018
WHAT IS FASI?

Person-centered measures of functional ability and need for caregiver assistance

Aligned with Federally standardized items (ADL & Mobility) with additional items (IADLs, Caregiver assistance needs)

Identifies personal goals related to functioning and caregiver assistance
5 HCBS POPULATIONS

- Individuals who are Frail Elderly (FE)
- Individuals with Brain Injury (BI)
- Individuals with Intellectual or Developmental Disabilities (ID/DD)
- Individuals with Physical Disabilities (PD)
- Individuals with Severe Mental Illness (SMI)

* These 5 population groups are participating in FASI Round 1 data collection.
OVERVIEW OF FASI ITEM DOMAINS

- Self-Care such as eating, dressing.
- Mobility activities such as bed mobility and transfers, ambulation, wheelchair use.
- Instrumental Activities of Daily Living (IADLs) such as making a light meal, answering the telephone.
- Use or need for assistive devices
- Living arrangements and presence of paid/unpaid assistance
- Personal goals for each area
### Section B: Functional Abilities and Goals

#### Self-Care

**Form Instructions:**
Code the person’s usual performance during the past 3 days using the 6-point scale in Column A. If the person’s performance changed during the past month, also code their most dependent performance in Column B. If the person’s self-care performance was unchanged during the past month, column B should be coded the same as column A. If the activity was not attempted, code the reason.

Please complete the Self-Care Priorities section at the bottom of this page.

#### CODING:

<table>
<thead>
<tr>
<th>Safety and Quality of Performance</th>
<th>Performance Level</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A Usual</td>
<td>B Most Dependent</td>
</tr>
<tr>
<td>Safety and Quality of Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06. Independent – Person completes the activity by him/herself with no assistance from a helper.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>05. Setup or cleanup assistance – Helper SETS UP or CLEANS UP; person completes activity. Helper assists only prior to or following the activity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>04. Supervision or touching assistance – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as person completes activity. Assistance may be provided throughout the activity or intermittently.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02. Substantial/maximal assistance – Helper does MORE THAN HALF the effort.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Performance Level:

| 6a. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. |   |
| 6b. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and place dentures from and to the mouth, and manage equipment for soaking and rinsing them.] |   |
| 6c. Toileting hygiene: The ability to maintain perineal/feminine hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment. |   |
| 6d. Wash upper body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed. |   |

---

**TEFT FASI OVERVIEW**
<table>
<thead>
<tr>
<th>Self-Care Priorities: Please indicate your top two priorities in the area of self-care for the next six months.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
</tbody>
</table>
FASI GOALS

1. Align and standardize core HCBS functional assessment items with corresponding items within Medicare Program.

2. Integrate FASI into CMS’ data element library or item bank on assessment items.

3. Seek NQF endorsement for quality measures based on FASI.
PROGRESS TO DATE

- **October 2015:**
  - Input from Technical Expert Panel

- **December 2015:**
  - Pilot-Tested items in Connecticut to evaluate usability

- **February 2016:**
  - Revised FASI set for Round 1 testing

- **May 2, 2016:**
  - FASI published in Federal Register for public comment
NEXT STEPS

- **Fall 2016:**
  - Online FASI training Go-Live
  - Round 1 Data Collection Begins

- **November-March 2016:**
  - Data Collection/Analysis
  - FASI revisions

- **March 2016:**
  - State-specific reports
  - Round 2 State Data Collection
HOW CAN STATES USE FASI?

- Determine eligibility Medicaid HCBS programs
- Develop person-centered service plans
- Monitor quality and measure program impact
- Report across multiple programs within a state especially rebalancing initiatives
- Update systems to reflect national standards
- Create exchangeable data platform
PERSON-CENTERED CARE PLANNING

- The Medicaid HCBS rules require states practice person-centered care planning
- Person’s voice as the driver of the decision-making
UPDATE STATE IT SYSTEMS

- States can benefit from federally-funded information technology efforts
- Exchangeable data formats exist for existing function items
  - These are being developed for FASI
- TEFT e-LTSS provides “envelopes” for exchanging FASI
- FASI code is in the public domain
  - Available through the CMS website
Thank YOU!

☒ Additional Information on TEFT and FASI may be found at:

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/teft-program.html
More Information:

- Barbara Gage, PhD
- Research Faculty
- George Washington University
- School of Medicine
- Center for Healthcare Innovation and Policy Research
- bgage@gwu.edu
eLTSS Round 2 Pilot Status

Evelyn Gallego, MBA, MPH, CPHIMS
eLTSS Initiative Coordinator
EMI Advisors LLC, Contractor to ONC
eLTSS Initiative At-A-Glance

- **eLTSS Initiative Kick-Off**: November 2014
- **Pilot Starter Kit Complete**
- **Use Case Complete**
- **Project Charter Complete**
- **Round 1 Pilots Kick-Off**
- **Q1 2015**
- **Q2 2015**
- **Q3 2015**
- **Q4 2015**
- **2016**
- **Q1 2016**
- **Q2 2016**
- **Q3 2016**
- **Q4 2016**
- **2017**
- **Q1 2017**
- **Q2 2017**
- **Q3 2017**
- **Q4 2017**
- **2018**
- **Q1 2018**
- **Q2 2018**
- **Q3 2018**
- **Q4 2018**

- **eLTSS Dataset Harmonization Kick-Off**
- **Pilot Presentations Complete**
- **eLTSS Core Components Complete**
- **Round 2 Pilots**
- **eLTSS Dataset Validation**
- **Grantees complete Round 2 Pilots**
- **eLTSS Round 2 Dataset Harmonization Complete**
- **eLTSS Dataset Ballot**
- **Harmonized Dataset presented to Standards Development Organization (SDO) for balloting**

TEFT DEMONSTRATION ENDS
Round 2 Pilots Timeline

22SEP16 Round 2 Pilots Kick-Off
- Round 2 Pilot Presentations
- Pilots work with Providers to validate eLTSS dataset
- Pilots report findings, timeline updates and challenges during All-Hands Calls
- Incorporate Person Centered Planning Elements

APR17 Round 2 Testing Complete

SEP17 Round 2 Pilot Close Out

Clean-up and Harmonize any Core Elements Based on Pilot Feedback

Round 2 Pilot Completion Report Outs

Publish Final Dataset (core plus PCP)
eLTSS Round 2 Pilots

• Kicked off on September 22, 2016
• Round 2 pilots consist of testing the agreed upon “Core” Plan elements identified by eLTSS Community as part of Round 1 Pilot activities
• Piloting can include:
  » Updating the Pilot organization’s current Service Plan to include the eLTSS Core data elements
  » Mapping the existing organization’s Service Plan to the eLTSS Core data elements
• Piloting MUST include sending the Plan to multiple provider groups
  » Plan can be sent electronically using secure email and/or fax
• Providers ‘receiving’ the plan must provide feedback on the eLTSS Core data elements
eLTSS Round 2 Pilots: Focus on LTSS Providers

- Providers that ‘receive’ the plan must validate the plan meets their information needs—*does the information in the plan contain everything the Provider needs to know to provide the best and required service to the individual?*
- Need to confirm what information in the plan works, what does not work, and what is missing
  - Information or elements that are ‘missing’ will be evaluated as either being ‘core’ to the plan or ‘optional’
- Need to confirm whether the Provider can electronically receive, view and accept the Plan

Grantee Pilot Sites encouraged to identify 3 to 4 different types of providers to work with where at least one of these requires most of the information in the plan to deliver and/or coordinate service.
What is being Piloted? eLTSS Core Dataset

- Pilots must test at least **80% or 38 elements from dataset**
- **Total Number of Elements: 47**

<table>
<thead>
<tr>
<th>Risk: 1 Element</th>
<th>Financial Information: 4 Elements</th>
<th>Service Provider Name &amp; Other Identifiers: 5 Elements</th>
<th>Plan Signatures: 9 Elements</th>
<th>Service Information: 11 Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified Risk</td>
<td>Plan Funding Source</td>
<td>Support Planner Name</td>
<td>Person Signature</td>
<td></td>
</tr>
<tr>
<td>Plan Period/Plan Effective Dates: 1 Element</td>
<td>Program Name</td>
<td>Support Planner Phone Number</td>
<td>Person Printed Name</td>
<td></td>
</tr>
<tr>
<td>Plan Effective Date</td>
<td>Total Plan Budget</td>
<td>Service Provider Name</td>
<td>Person Signature Date</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Paid Service Provider Relationship Type</td>
<td>Guardian / Legal Representative Signature</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Service Provider Phone Number</td>
<td>Guardian / Legal Representative Printed Name</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency Backup Plan: 4 Elements</td>
<td>Non-Paid Service Provider Relationship Type</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency Backup Name</td>
<td>Service Provider Phone Number</td>
<td>Guardian / Legal Representative Signature Date</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Paid Emergency Backup Relationship Type</td>
<td>Support Planner Name</td>
<td>Support Planner Signature</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency Backup Phone Number</td>
<td>Support Planner Phone Number</td>
<td>Support Planner Printed Name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency Backup Plan Text</td>
<td>Person Name</td>
<td>Support Planner Signature Date</td>
<td></td>
</tr>
<tr>
<td>Goals &amp; Strengths: 4 Elements</td>
<td>Beneficiary Demographic: 6 Elements</td>
<td>Person Identifier</td>
<td>Total Cost of Service</td>
<td></td>
</tr>
<tr>
<td>Assessed Needs</td>
<td>Person Name</td>
<td>Person Identifier Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>Person Date of Birth</td>
<td>Person Phone Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step or Action</td>
<td>Person Address</td>
<td>Person Phone Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengths</td>
<td></td>
<td>Person Address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Service Preferences: 2 Elements
- Person Service Agreement Indicator
- Person Service Provider Choice Indicator

Risk: 1 Element
- Identified Risk

Plan Period/Plan Effective Dates: 1 Element
- Plan Effective Date

Goals & Strengths: 4 Elements
- Assessed Needs
- Goal
- Step or Action
- Strengths

Financial Information: 4 Elements
- Plan Funding Source
- Program Name
- Total Plan Budget
- Total Plan Cost

Service Provider Name & Other Identifiers: 5 Elements
- Support Planner Name
- Support Planner Phone Number
- Service Provider Name
- Non-Paid Service Provider Relationship Type
- Service Provider Phone Number

Plan Signatures: 9 Elements
- Person Signature
- Person Printed Name
- Person Signature Date
- Guardian / Legal Representative Signature
- Guardian / Legal Representative Printed Name
- Guardian / Legal Representative Signature Date

Service Information: 11 Elements
- Service Name
- Service Start Date
- Service End Date
- Service Comment
- Service Funding Source
- Unit of Service Type
- Service Unit Quantity
- Unit of Service Type
- Service Rate per Unit
- Service Total Units
- Total Cost of Service
### eLTSS Round 2 Pilot Organizations

<table>
<thead>
<tr>
<th>TEFT Organization</th>
<th>User Story To Be Tested</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CO</strong>: Dept. of Health Care Policy &amp; Financing</td>
<td>User Story 1: LTSS Eligibility, eLTSS Plan Creation and Approval</td>
</tr>
<tr>
<td><strong>CT</strong>: Dept. of Social Services Division of Health Services</td>
<td>User Story 2: Sharing a Person-Centered eLTSS Plan</td>
</tr>
<tr>
<td><strong>GA</strong>: Dept. of Community Health</td>
<td>User Story 1: LTSS Eligibility, eLTSS Plan Creation and Approval</td>
</tr>
<tr>
<td><strong>KY</strong>: Office of Administrative &amp; Technology Services</td>
<td>User Story 1: LTSS Eligibility, eLTSS Plan Creation and Approval User Story 2: Sharing a Person-Centered eLTSS Plan</td>
</tr>
<tr>
<td><strong>MD</strong>: Dept. of Health &amp; Mental Hygiene</td>
<td>User Story 2: Sharing a Person-Centered eLTSS Plan</td>
</tr>
<tr>
<td><strong>MN</strong>: Dept. of Human Service</td>
<td>User Story 2: Sharing a Person-Centered eLTSS Plan</td>
</tr>
</tbody>
</table>

Detailed presentations from each of the Pilot Sites available here: [http://oncprojecttracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Pilots#eLTSSPilots-Round2PilotPlanPresentations](http://oncprojecttracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Pilots#eLTSSPilots-Round2PilotPlanPresentations)

**eLTSS Pilots are open to all participants regardless of participating grant program**
Other Education/Outreach activities: Engagement with HL7

• In September 2016, ONC Team introduced the eLTSS Initiative at the HL7 September Working Group Meeting in Baltimore, MD

• Presentations to two HL7 Working Groups:
  » **Community-Based Collaborative Care (CBCC):** facilitate development and use of HL7 standards that support and integrate the provision of health and human services in community and non-acute care residential settings (e.g. Data Provenance, Data Segmentation for Privacy, Data Access Consent)
  » **Patient Care (PC):** define the technical requirements and solutions to support the needs of communicating information related to the creation, management, execution and quality of care provision (e.g. Care Plan, Care Team, Diet and Nutrition Orders, representation of vital signs)

• Purpose was to bring awareness of the eLTSS Initiative and emerging dataset, and to inquire about existing standards development projects that can inform or be informed by the eLTSS Initiative

Health Level Seven (HL7) is a not-for-profit standards development organization that provides a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery and evaluation of health services: www.hl7.org
Federal Partner Discussion
Key Asks:
Opportunities for Broader Federal Partner Engagement

• Are there other Federal Partner Projects focused on use of data elements similar to those for IMPACT and FASI?
• Which Federal Partners are currently working with SDOs to include HL7, Integrating the Health Enterprise (IHE) International, International Health Terminology Standards Development Organization (IHTSDO) and Regenstrief Institute?
  » Is there opportunity to collaborate amongst the Federal Partner Projects?
Next Steps for Federal Partner Engagement

• **Participate in eLTSS Quarterly Meetings:**
  » Seeking other Federal Partner Project presentations
  » Next one to be scheduled for **March 3, 2017**
  » Upcoming Meetings:
    – May 2017
    – Aug 2017
    – Nov 2017

• **Identify additional organizations that can contribute to testing and validating of eLTSS dataset**
eLTSS Initiative Contacts

- **ONC Leadership**
  - Caroline Coy ([caroline.coy@hhs.gov](mailto:caroline.coy@hhs.gov))
  - Elizabeth Palena-Hall ([elizabeth.palenahall@hhs.gov](mailto:elizabeth.palenahall@hhs.gov))

- **CMS Leadership**
  - Mike Smith ([Michael.Smith1@cms.hhs.gov](mailto:Michael.Smith1@cms.hhs.gov))
  - Kerry Lida ([Kerry.Lida@cms.hhs.gov](mailto:Kerry.Lida@cms.hhs.gov))

- **Federal Partner Leadership**
  - Shawn Terrell ([shawnterrell@acl.hhs.gov](mailto:shawnterrell@acl.hhs.gov))
  - Caroline Ryan ([caroline.ryan@acl.hhs.gov](mailto:caroline.ryan@acl.hhs.gov))
  - Marisa Scala-Foley ([marisa.scala-foley@acl.hhs.gov](mailto:marisa.scala-foley@acl.hhs.gov))

- **Initiative Coordinator**
  - Evelyn Gallego ([evelyn.gallego@emiadvisors.net](mailto:evelyn.gallego@emiadvisors.net))
Back-Up
Defined by Medicaid under § 441.301(c) as part of the scope of services and supports required under the State’s 1915(c) Home and Community-Based Settings (HCBS) waiver to include:

- The setting in which the individual resides is chosen by the individual
- Individual’s strengths and preferences
- Clinical and support needs as identified through an assessment of functional need
- Individual’s identified goals and designed outcomes
- Services and supports that will assist individual to achieve identified goals, and providers that will perform services
- Risk factors and measures in place to minimize them
- Individual and/or entity responsible for monitoring the plan
- Informed consent of the Individual
- Services the individual elects to self-direct

Key eLTSS Plan Input:
Person-Centered Profile

- Introductory Information: strengths/preferences, positive reputation, etc.

~ Ruth’s One Page Description (at home) ~

**What People Like and Admire about Ruth**

- Such a “grandmother”
- A true lady
- Has the gift of gab ~ can hold a conversation with anyone!
- Always dressed so nice ~ everything always matches, right down to socks and earrings
- Very liberal thinker for her age

**What is Important to Ruth**

- Living with granddaughter and grandson-in-law
- Being warm and feeling safe with caregivers
- Having “a little pour” before bed (rum and tea)
- Being a part of whatever is going on at home ~ being in the middle of it!
- Sweets during the day!

**Supports Ruth Needs to be Happy, Healthy and Safe**

- Needs people to ask frequently if she is warm enough and help her put on sweater/sweatshirt if she is not (she’ll be cold when you’re not)
- Must have assistance with her medications ~ knows them by color but you need to dole them out and keep track of times
- Needs assistance with bathing and dressing ~ will tell you what clothes she wants to wear for the day/event
- When bathing, no water on face ~ she will wash with cloth
- Must talk with daughter 2-3 times a week on the phone ~ will need you to dial for her
- Must see her doctor right away if she has cough, fever or is “off balance” ~ indications of systemic infection that will grow quickly!

**People Who Support her Best**

- Like to chit chat
- Are timely and stay busy
- Polite and mannerly
- Have a witty and dry sense of humor
- Can be reassuring and help Ruth feel safe
## Who participates in the eLTSS Initiative?

### 321 Total Members
- **96 Committed Members**
- **225 Other Interested Party**
- **289 Not Registered** (attended 1+ meeting)

### Stakeholder Group Type/ Total Participants

<table>
<thead>
<tr>
<th>Stakeholder Group Type</th>
<th>Total Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon Community, Quality Improvement Organizations, or similar organization</td>
<td>4</td>
</tr>
<tr>
<td>Consumer / Patient Advocate</td>
<td>11</td>
</tr>
<tr>
<td>Contractor / Consultant</td>
<td>31</td>
</tr>
<tr>
<td>Federal, State, Local Agency</td>
<td>141</td>
</tr>
<tr>
<td>Health Information Exchange (HIE) / Health Information Organization (HIO)</td>
<td>10</td>
</tr>
<tr>
<td>Health IT Vendor (EHR, EMR, PHR, HIE)</td>
<td>44</td>
</tr>
<tr>
<td>Health Professional (DO, MD, DDS, RN, Tech, etc.)</td>
<td>9</td>
</tr>
<tr>
<td>Healthcare Payer/Purchaser or Payer Contractor</td>
<td>5</td>
</tr>
<tr>
<td>Licensing / Certification Organization</td>
<td>2</td>
</tr>
<tr>
<td>Provider Organization (institution / clinically based)</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stakeholder Group Type</th>
<th>Total Participants</th>
</tr>
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<tbody>
<tr>
<td>Research Organization</td>
<td>15</td>
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<tr>
<td>Standards Organization</td>
<td>4</td>
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<tr>
<td>Service Provider (community-based)</td>
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<tr>
<td>Service Provider Professional (community-based)</td>
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</tr>
<tr>
<td>Other System IT Vendor (Community-Based IT Vendor or Other)</td>
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<tr>
<td>Other</td>
<td>46</td>
</tr>
<tr>
<td>Unknown</td>
<td>171</td>
</tr>
<tr>
<td>TEFT Leadership / TA</td>
<td>33</td>
</tr>
<tr>
<td>ONC Staff / Contractor</td>
<td>26</td>
</tr>
</tbody>
</table>
Vision for eLTSS Dataset Integration

eLTSS Plan Dataset can be incorporated into various programs and health/wellness IT systems