CMS Quality 2023 Conference

Building Resilient Communities:

Having an Equitable Foundation for Quality Healthcare

Leveraging Standardized Functional Status and Cognitive Data to Inform Care Coordination Across the Health Care Ecosystem












AGENDA

- Background on OBRHI
- Overview of CMS efforts to promote interoperable exchange of standardized clinical and social determinants assessment data (Lorraine Wickiser, CMS)
- Overview on ONC policies that are enabling health information exchange (Brenda Akinnagbe, ONC)
- Lessons learned and recommendations for optimizing the use of standardized cognitive and functional decline data across the healthcare ecosystem (Terry O'Malley Mass. General Hospital and Spaulding Nursing & Therapy Center North End, Retired)
- Case study on the use of interoperable data to facilitate care coordination and optimize population health (Constantine Lyketsos, John Hopkins Health System)

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Learning Objectives

- Promote knowledge on the role standardized data has in coordinating health and social needs.
- Discuss advancements on exchanging USCDI and standardized data using FHIR, including PACIO's efforts on advanced directives, function, cognition and more.
- Learn how healthcare systems leverage standardized functional and cognitive status to optimize health outcomes.

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Background on OBRHI

Liz Palena-Hall
Health Insurance Specialist, MIS, MBA, RN

Beth Connor
Health Insurance Specialist, RN

Office of Burden Reduction and Health Informatics (OBRHI) Vision & Goals

OBRHI envisions a future with a healthcare enterprise that operates seamlessly and equitably to achieve health.

OBRHI's work is guided by a strategic plan, which establishes four key goals and objectives governing the planning and implementation of operational activities.

Overview of CMS Efforts to Promote Interoperable Exchange of Standardized Clinical and Social Determinants Assessment Data

Lorraine Wickiser

Nurse Consultant, RN

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IMPACT Act of 2014

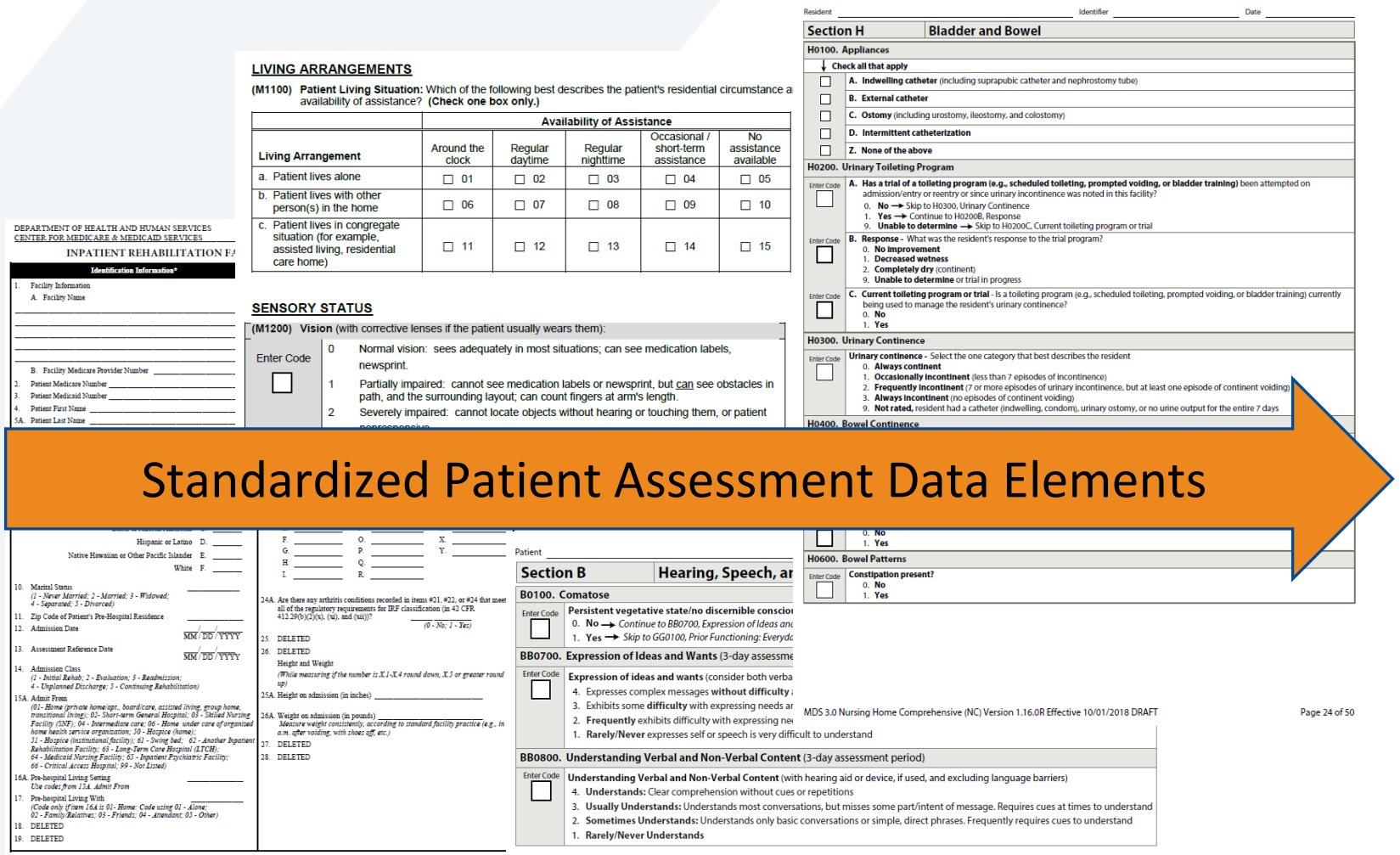
- Bi-partisan bill passed on September 18, 2014, and signed into law October 6, 2014
- The Act requires *standardized* patient assessment data elements for:
  - Long-term Care Hospitals (LTCHs)
  - Skilled Nursing Facilities (SNFs)
  - Home Health Agencies (HHAs)
  - Inpatient Rehabilitation Facilities (IRFs)
- The Act specifies the 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…".
- Standardized patient assessment data element Clinical Categories:
  - Functional status
  - Cognitive function and mental status
  - Special services, treatments, and interventions
  - Medical conditions and co-morbidities
  - Impairments

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

Source: CMS DCPAC

Post-Acute Care Assessments Submitted Electronically

PAC Setting	CMS PAC Assessments
Long-term Care Hospitals (LTCHs)	LTCH Continuity Assessment Record & Evaluation (CARE) Data Set (LCDS)
Skilled Nursing Facilities (SNFs)	Resident Assessment Instrument (RAI) Minimum Data Set (MDS)
Home Health Agencies (HHAs)	Outcome and Assessment Information Set (OASIS)
Inpatient Rehabilitation Facilities (IRFs)	IRF Patient Assessment Instrument (IRF-PAI)
Hospices	Hospice Item Set (HIS)
Home & Community Based Services	HCBS Functional Assessment Standardized Items (FASI)



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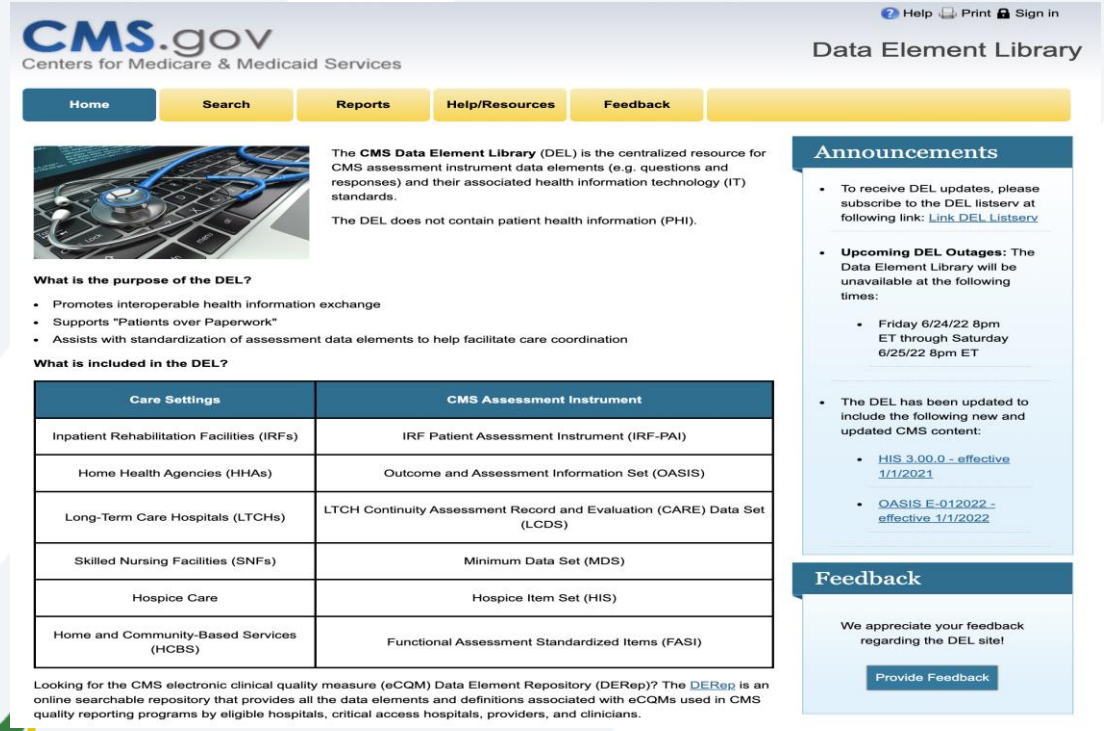
The CMS Data Element Library (DEL)

- The DEL is a centralized resource for CMS assessment data elements (e.g., questions and response options), and their related mappings to nationally accepted health IT standards
  - Maintains consistency in format, meaning, and use of Assessment Instrument DE
  - Allows for access to and enables reuse and exchange of data elements
  - Contains no patient level data



DEL Contents

- Assessment and version (e.g., MDS 3.0 v. 1.16)
- Item label (e.g.- GG0170)
- Item status (Published, Active, Inactive)
- Copyright information (if applicable)
- CMS usage (Payment, Quality Measure, Survey and Certification, etc.)
- Identification of skip pattern triggers and lookback periods
- Health IT standards (e.g., LOINC, SNOMED)

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

Source: CMS DCPAC

Standardized PAC Assessment Items Relevant to Dementia

Cognitive Patterns and Communication	FASI	HH	IRF	LTCH	SNF
BB0700. Expression of Ideas and Wants BB0800. Understanding Verbal and Non-Verbal Content	-	-	X	-	-
B0700. Makes Self Understood B0800. Ability to Understand Other	-	-	-	-	X
Brief Interview of Mental Status (BIMS) C0200. Repetition of Three Words C0300. Temporal Orientation C0400. Recall C0500. BIMS Score	-	x	X	X	X
Staff assessment for mental status C0700. Short-term Memory OK C0800. Long-term Memory OK	-	-	-	-	X
Staff assessment for mental status cont'd C0900. Memory/Recall Ability	-	-	X	-	X
C1000. Cognitive Skills for Daily Decision Making	-	-	-	-	X
M1700. Cognitive Functioning M1710. When Confused M1720. When Anxious	-	X	-	-	-
C1310. Signs and Symptoms of Delirium (from CAM)	-	X	X	X	X

Source: CMS DCPAC

Office of the National Coordinator for Health Information Technology (ONC) Policies that are Enabling Health Information Exchange

Brenda Akinnagbe
Policy Analyst

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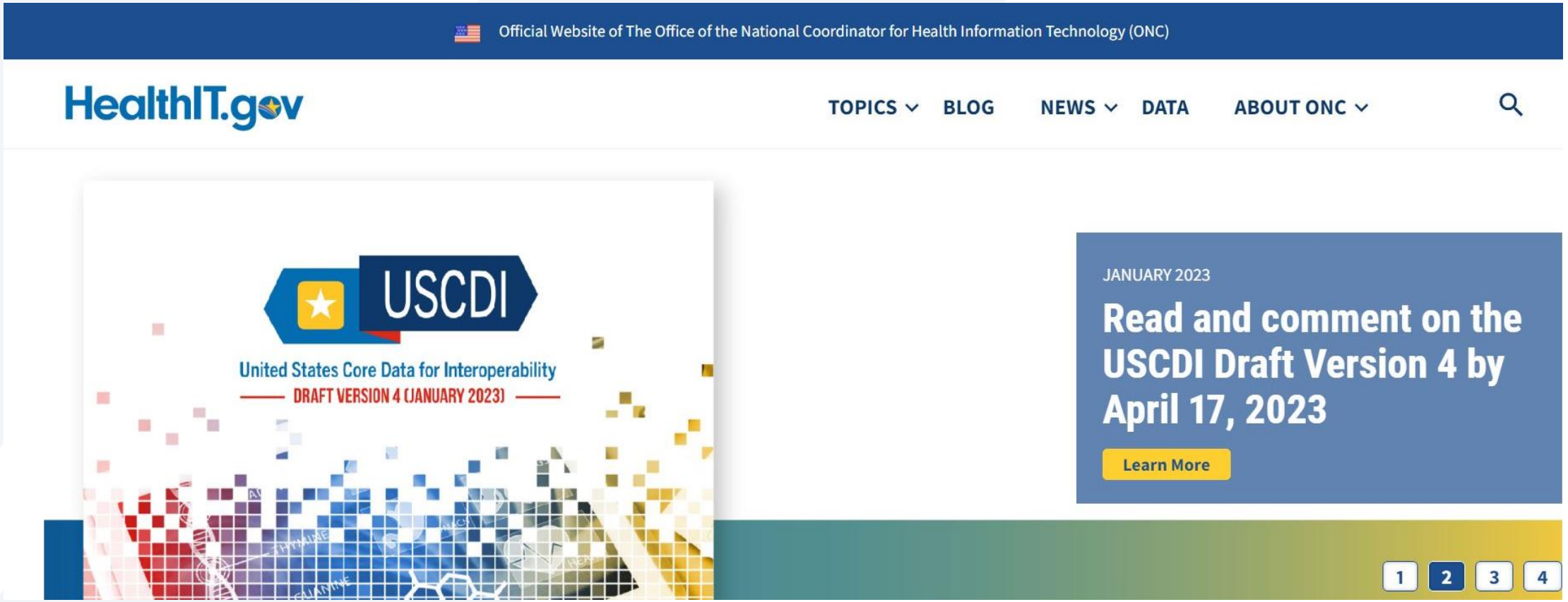
ONC – HealthIT.gov



Lessons Learned and Recommendations for Optimizing the Use of Standardized Cognitive and Functional Decline Data across the Healthcare Ecosystem

Terry O'Malley, MD
Corresponding Faculty

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The Road to Interoperability

IMPACT Act

SNOMED and LOINC

Data Element Library (DEL)

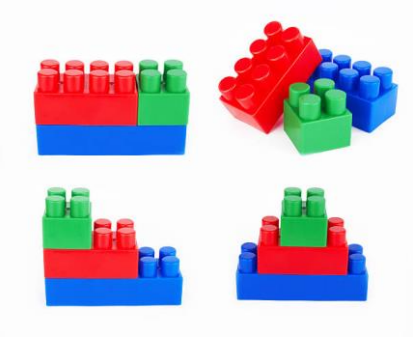
PACIO-HL7

USCDI

Value Set Authority Center (VSAC)

Interoperability Standards Advisory (ISA)

LEGOs



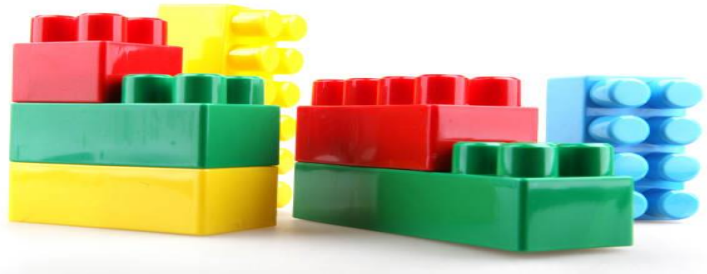
Same Data-Two Uses

Home Health Aide Report

- Observations of function and cognition
- Manage populations at high risk for hospitalization
- Proactive interventions
- Reduce hospitalizations
- Success under Value Based Payment

Transitions of Care

- Establish continuity of shared care plan
- Observations of function and cognition
- Other essential data: SDOH, Goals, Preferences, and Priorities (GPPs)



Recommendations

- Establish standards for Transitions of Care (ToC)
  - Content
  - Timeliness
  - Usability
- Create quality measures to drive ToC improvement
- Expand the standardized vocabulary

Case Study on the Use of Interoperable Data to Facilitate Care Coordination and Optimize Population Health

Constantine Lyketsos, MD, MHS, FACLP, FACPsych, FACNP

Physician

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