

October 2016

**Technical Expert Panel Summary Report:
Development of two quality measures to satisfy the Improving
Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)
Domain of Transfer of Health Information and Care Preferences When
an Individual Transitions for Skilled Nursing Facilities (SNFs),
Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals
(LTCHs), and Home Health Agencies (HHAs)**

Deliverable 14

Prepared for

**Stella Mandl, RN, BSN
Tara McMullen, PhD
Charlayne D. Van, JD
Teresa Mota, BSN, RN, WCC
Christine Grose, RN, MS**

Centers for Clinical Standards and Quality
Division of Chronic and Post Acute Care
Centers for Medicare & Medicaid Services
Mail Stop C3-19-26

7500 Security Boulevard, Baltimore, MD 21244-1850

Prepared by

**Colene Byrne, PhD
Samantha Clark, BA
Lindsey Free, BS
Laura Smith, PhD
Denise Tyler, PhD**

RTI International

3040 E. Cornwallis Road, Research Triangle Park, NC 27709

**Alrick Edwards, MPH
Marian Essey, RN, BSN
Sara Galantowicz, MPH
Linda Krulish, PT, MHS
Lynn Martin, PhD, RPh
Abt Associates**

55 Wheeler Street, Cambridge, MA 02138
RTI Project Number 02014077.001
CMS Contract No. HHSM-500-2013-130151

TECHNICAL EXPERT PANEL SUMMARY REPORT: DEVELOPMENT OF TWO
QUALITY MEASURES TO SATISFY THE IMPROVING MEDICARE POST-ACUTE CARE
TRANSFORMATION ACT OF 2014 (IMPACT ACT) DOMAIN OF TRANSFER OF
HEALTH INFORMATION AND CARE PREFERENCES WHEN AN INDIVIDUAL
TRANSITIONS FOR SKILLED NURSING FACILITIES (SNFS), INPATIENT
REHABILITATION FACILITIES (IRFS), LONG-TERM CARE HOSPITALS (LTCHS), AND
HOME HEALTH AGENCIES (HHAS)

DELIVERABLE 14

By

Colene Byrne, PhD
Samantha Clark, BA
Lindsey Free, BS
Laura Smith, PhD
Denise Tyler, PhD

Project Director: Karen Reilly, ScD

Federal Quality Measure Lead: Tara McMullen, PhD

Contracting Officer's Representative: Charlayne D. Van, JD

RTI International

Abt Associates

CMS Contract No. HHSM-500-2013-13015I

September 2016

This project was funded by the Centers for Medicare & Medicaid Services under contract no. 500-00-1234. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report.

TABLE OF CONTENTS

List of Acronyms and Short Forms.....	v
1. Introduction And Overview	1
1.1 Introduction.....	1
1.2 Background.....	1
1.3 Summary of Quality Measure Background and Concept	1
1.4 Process of the TEP Meeting.....	2
1.4.1 TEP Nomination Process	2
1.4.2 TEP Webinar.....	2
1.5 Organization of the Report.....	3
2. Measure Description and Specifications.....	5
2.1 PAC Admission Quality Measure: Transfer of Information at Post-Acute Care Admission, Start or Resumption of Care from Other Providers/Settings.....	5
2.1.1 Numerator Definition.....	5
2.1.2 Denominator Definition.....	5
2.1.3 Denominator Exclusions	5
2.2 PAC Discharge Measure: Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings	6
2.2.1 Numerator Definition.....	6
2.2.2 Denominator Definition.....	6
2.3 Risk Adjustment.....	6
2.4 Provider to Provider Transfer of Health Information	6
3. Current Practices Related to Information Transfer for PAC Providers	9
3.1 TEP Discussion.....	9
3.1.1 Modes by Which Information is Commonly Transferred.....	9
3.1.2 Discussion of Timely Transfer.....	9
3.1.3 Caregiver Role in Transfer of Information	10
3.1.4 Discussion of Provider to Provider Information Transfer	10
4. TEP Input on Data Elements, Quality Measures, Concepts, and Calculations.....	11
4.1 Discussion of Types of Information to Be Transferred	11
4.2 Discussion of Modes of Transfer.....	12
4.3 Discussion of Interrupted Stays, Observation Stays, and Emergency Department (ED) Transfers in Discharge Measure	12
4.4 Discussion of Including Patient Care Preferences and Goals in the Measures.....	13
4.5 Discussion of Potential Unintended Consequences.....	13
5. Post-TEP Poll Information.....	15
6. Next Steps	17

Appendixes

A: TEP Members19
B: Measure Development Team21
C: TEP Webinar Agenda23
D: Data Collection Items for TEP Review25
E: Post-TEP Poll Questions.....28

List of Tables

1 Example of Providers Included in the Transfer of Health Information Measures..... 7

LIST OF ACRONYMS AND SHORT FORMS

CMS	Centers for Medicare & Medicaid Services
ED	Emergency Department
HHA	Home Health Agency
HIE	Health Information Exchange
IMPACT Act	Improving Medicare Post-Acute Care Transformation Act of 2014
IRF	Inpatient Rehabilitation Facility
IRF-PAI	Inpatient Rehabilitation Facility-Patient Assessment Instrument
LTCH	Long-Term Care Hospital
MDS	Minimum Data Set
MOLST	Medical Orders for Life-Sustaining Treatment
NF	Nursing Facility
NQF	National Quality Forum
OASIS	Outcome and Assessment Information Set
PAC	Post-Acute Care
PCP	Primary Care Physician
POLST	Physician Orders for Life-Sustaining Treatment
PPS	Prospective Payment System
QRP	Quality Reporting Program
SNF	Skilled Nursing Facility
RAI	Resident Assessment Instrument
RTI	Research Triangle Institute
TEP	Technical Expert Panel

[This page intentionally left blank.]

SECTION 1 INTRODUCTION AND OVERVIEW

1.1 Introduction

On behalf of the Centers for Medicare & Medicaid Services (CMS), RTI International and Abt Associates convened a Technical Expert Panel (TEP) to seek expert input on the development of a quality measure that would satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain Transfer of Health Information and Care Preferences When an Individual Transitions. A quality measure to meet the mandate of the IMPACT Act was developed for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs). Two measures were developed to meet the mandate of the IMPACT Act, one collected at admission and one collected at discharge. A TEP was convened to review and opine on this development work. The TEP meeting for this quality measure development consisted of a half-day webinar held on September 27, 2016.

This report provides a summary of the TEP proceedings, detailing the key issues of measure development and TEP discussion around those issues. In this section, we provide a summary of the background, the quality measure background and concept, process for the TEP meeting, and organization of the TEP report.

1.2 Background

CMS has contracted with RTI International and Abt Associates (hereinafter referred to as RTI and Abt) to develop quality measures reflective of quality of care, resource use and other measures for post-acute care (PAC) settings in order to meet the mandate of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) and to support CMS quality initiatives. The PAC settings included in this measure development are SNFs, IRFs, LTCHs and HHAs. The contract names are Development and Maintenance of Symptom Management Measures (HHSM-500-2013-13015I; Task Order HHSM-500-T0001) and Outcome and Assessment Information Set (OASIS) Quality Measure Development and Maintenance (HHSM-500-2013-13001I; Task Order HHSM-500-T0002).

As part of its measure development process, CMS asks contractors to convene groups of stakeholders and experts who contribute direction and thoughtful input to the measure contractor during measure development. The objective of the TEP meeting was to seek expert input on the development of transfer of health information and care preferences quality measures for PAC settings. TEP objectives additionally included receiving input regarding the measure specifications and calculations, current practices related to information transfer for PAC providers, modes of information transfer, and potential unintended consequences and future directions for the measure development.

1.3 Summary of Quality Measure Background and Concept

This measure addresses one of the domains required by the IMPACT Act of 2014, which mandates specification of cross-setting quality, resource use, and other measures for post-acute

care providers. The IMPACT Act requires a quality measure for “accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions — (i) from a hospital or critical access hospital to another applicable setting, including a PAC provider or the home of the individual; or (ii) from a PAC provider to another applicable setting, including a different PAC provider, a hospital, a critical access hospital, or the home of the individual.”

The Transfer of Health Information measure concept consists of two quality measures that provide measurement of: 1) transfer of information to the PAC at PAC admission, start of care, and/or resumption of care; and 2) transfer of information from the PAC at PAC discharge, and/or transfer. The Transfer of Health Information quality measure specifications discussed would assess the transfer of health information between PAC providers, hospitals, and patients/residents. In addition, the Transfer of Health Information quality measures collect information on the modes of information transfer.

1.4 Process of the TEP Meeting

1.4.1 TEP Nomination Process

On August 8, 2016, RTI and Abt solicited for participants in this TEP by posting a Call for TEP members on the CMS Measures Management System website.¹ The TEP nomination period lasted thirteen days. Information about the opportunity to participate as a TEP member was also disseminated to national provider and professional associations, measure development experts, patient advocacy groups, potential consumer/patient representatives, and other stakeholder organizations. RTI and ABT selected fourteen nominees from a total of 98 nominees that were submitted for participation. These final 14 TEP members represented caregivers, patients, and the various PAC settings. These nominees offered a diverse range of clinical, research, and administrative expertise, including expertise in the various PAC settings (SNF, IRF, LTCH, HHA), and knowledge of discharge planning and care transitions. The TEP composition was chosen to offer a range of perspectives related to performance measurement, quality improvement, clinical disciplines, experience in SNFs, IRFs, LTCHs and HHAs settings, care transitions and information transfer during transitions, purchaser, insurer, payment model perspective, consumer/patient/family caregiver perspective, integrated care models, and health care disparities. Two members of the 14-member panel were patient and caregiver representatives. *Appendix A* provides the final TEP composition list.

1.4.2 TEP Webinar

The half-day TEP webinar was held on September 27, 2016. All 14 of the selected TEP members attended the meeting. Discussion was moderated and facilitated by Loretta Randolph, from MITRE Corporation, with support from various members of the RTI and Abt measure development team. Representatives from CMS were also in attendance. The following key topics were discussed: (i) the measure concept; (ii) the current practices related to information transfer

¹ <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/TechnicalExpertPanels.html>

to and from PAC providers; (iii) measure specifications and data elements; (iv) patient care preferences and goals; and (v) potential unintended consequences related to measure utilization. The meeting was audio recorded and transcribed by a professional transcriptionist for the purpose of summarizing TEP proceedings in this report.

On October 13, 2016, the TEP members were requested to reply by email to follow-up questions regarding the re-wording of one data item, their general understanding of several key terms and concepts, and feasibility of data collection. Eight of the 14 TEP members provided responses to these additional questions submitted by RTI and Abt. Information on this follow-up communication with the TEP can be found in Section 5 and Appendix D of this document.

1.5 Organization of the Report

The following sections of the report discuss and summarize the discussions with and feedback obtained from the TEP members during the TEP webinar. **Section 2** summarizes the measure description and specifications. **Section 3** summarizes the TEP discussion on current practices related to information transfer for PAC providers. **Section 4** summarizes TEP input on the measures, data elements, and calculations. **Section 5** summarizes information from our post-TEP polling activities.

[This page intentionally left blank.]

SECTION 2 MEASURE DESCRIPTION AND SPECIFICATIONS

2.1 PAC Admission Quality Measure: Transfer of Information at Post-Acute Care Admission, Start or Resumption of Care from Other Providers/Settings

2.1.1 Numerator Definition

The numerator for the PAC Admission measure is the number of patient/resident stays/episodes with an admission/start of care/resumption of care assessment indicating that health information was received at admission/start of care/resumption of care. In other words, selection of response choice #1 (“yes”) in measure 1, Question 1 (see Appendix C) would be required for inclusion in the numerator. In addition, selection of at least one response choice in measure 1, Question 2 would also be required. The TEP was asked to discuss how many response choices in Question 2 would need to be selected for inclusion in the numerator and which, if any, of the responses would be most important to include (see Section 4 for details about this discussion).

2.1.2 Denominator Definition

The denominator for the PAC Admission measure is the total number of patient/resident stays/episodes. This is measured slightly differently for each setting due to provider specific data set requirements, as shown below:

SNF Denominator: The denominator for the admission measure is the total number of SNF Medicare Part A covered resident stays.

IRF Denominator: The denominator for the admission measure is the total number of IRF patient stays (Part A and Part C).

LTCH Denominator: The denominator for the admission measure is the total number of LTCH patient stays.

HHA Denominator: The denominator for the admission measure is the number of Medicare (Part A and Part C) and Medicaid home health quality episodes.

2.1.3 Denominator Exclusions

Patient/resident stays would be excluded from the quality measure if the patient was not under the care of another provider immediately prior to the SOC/ROC/Admission. In other words, selection of response choice #3 (“NA – Patient was not under the care of another provider immediately prior to this SOC/ROC/Admission”) for measure 1, Question 1 (see Appendix C).

2.2 PAC Discharge Measure: Transfer of Information at Post-Acute Care Discharge or End of Care to Other Providers/Settings

2.2.1 Numerator Definition

The numerator for the PAC Discharge measure is the number of patient/resident stays/episodes with a discharge assessment indicating that health information was provided to the next provider or agency at patient discharge. In other words, selection of response choice #1 (“yes”) in measure 2, Question #1 (see Appendix C) would be required for inclusion in the numerator. In addition, selection of at least one response choice in measure 2, Question #2 would also be required. The TEP was asked to discuss how many response choices in Question #2 would need to be selected for inclusion in the numerator and which, if any, of the responses would be most important to include (see Section 4 for details about this discussion).

2.2.2 Denominator Definition

The denominator for the PAC Discharge measure is the total number patient/resident stays/episodes. This is measured slightly differently across settings due to provider specific data set requirements, as shown below:

SNF Denominator: The denominator for this measure is the total number of SNF Medicare Part A covered resident stays.

IRF Denominator: The denominator for this measure is the total number of IRF patient stays (Part A and Part C).

LTCH Denominator: The denominator for this measure is the total number of LTCH patient stays.

HHA Denominator: The denominator for this measure is the number of Medicare (Part A and Part C) and Medicaid home health quality episodes

Patients/residents who expired during their PAC stay/episode are excluded from the denominator as are patients/residents who were not transferred to the care of another provider at discharge or transfer (i.e., measure 2, Question #1 = 3). For HHA, patients are also excluded from the denominator if the HHA was not made aware of their transfer in a timely manner (i.e., measure 2, Question #1 = 4).

2.3 Risk Adjustment

This is a process measure, so there is no risk adjustment.

2.4 Provider to Provider Transfer of Health Information

The Transfer of Health Information quality measures would assess the transfer of health information between PAC providers (SNFs, IRFs, LTCHs, and HHAs) and other healthcare providers. The focus of the measure is provider to provider transfer of information.

Table 1 describes examples of receiving and providing providers that would be covered by these measures as well as the information sources for the transfer information. The single asterisk (*) indicates the providers that will collect the transfer information data included in the Transfer of Health Information Measures. The double asterisk (**) indicates that information should be shared with the patient and patient’s primary care physician.

Table 1.
Example of Providers Included in the Transfer of Health Information Measures

From (Sending Provider)	To (Receiving Provider)	Receiving Provider receives Transfer Information from:
Hospital/CAH	SNF* IRF* LTCH* Home Health*	<ul style="list-style-type: none"> ▪ Hospital/CAH and/or ▪ Physician(s) (Hospital/CAH and/or ▪ Physician(s) (e.g. PCP, Family Physician, NP, Clin Nurse Specialist, PA, Specialist, etc.)
SNF*	Hospital/CAH IRF* LTCH* Home Health* Home without PAC** Another SNF*	<ul style="list-style-type: none"> ▪ SNF and/or ▪ Physician(s) (Hospital/CAH and/or ▪ Physician(s) (e.g. PCP, Family Physician, NP, Clin Nurse Specialist, PA, Specialist, etc.)
IRF*	Hospital/CAH SNF* LTCH* Home Health* Home without PAC** Another IRF*	<ul style="list-style-type: none"> ▪ IRF and/or ▪ Physician(s) (Hospital/CAH and/or ▪ Physician(s) (e.g. PCP, Family Physician, NP, Clin Nurse Specialist, PA, Specialist, etc.)
LTCH*	Hospital/CAH SNF* IRF* Home Health* Home without PAC** Another LTCH*	<ul style="list-style-type: none"> ▪ LTCH and/or ▪ Physician(s) (Hospital/CAH and/or ▪ Physician(s) (e.g. PCP, Family Physician, NP, Clin Nurse Specialist, PA, Specialist, etc.)

(continued)

Table 1. (continued)
Example of Providers Included in the Transfer of Health Information Measures

From (Sending Provider)	To (Receiving Provider)	Receiving Provider receives Transfer Information from:
Home Health Agency*	Hospital/CAH SNF* IRF* LTCH* Home without PAC** Another Home Health Agency*	<ul style="list-style-type: none"> ▪ Home Health and/or ▪ Physician(s) (Hospital/CAH and/or ▪ Physician(s) (e.g. PCP, Family Physician, NP, Clin Nurse Specialist, PA, Specialist, etc.
Home	SNF* IRF* LTCH* Home Health*	<ul style="list-style-type: none"> ▪ Physician(s) (Hospital/CAH and/or ▪ Physician(s) (e.g. PCP, Family Physician, NP, Clin Nurse Specialist, PA, Specialist, etc.)

SECTION 3

CURRENT PRACTICES RELATED TO INFORMATION TRANSFER FOR PAC PROVIDERS

3.1 TEP Discussion

TEP members were asked to provide input on current practices related to health information transfer when a PAC patient/resident transitions across care settings. TEP members discussed commonly used practices and modes of transfer when a patient/resident transitions across care settings. The topics of discussion described in this section were the opening topics of discussion with the TEP. These were driven by the ideas and concepts addressed by the measures under development rather than by the specific data elements. Discussion of specific data elements are described in the next section. The main themes from this discussion described listed below.

3.1.1 Modes by Which Information is Commonly Transferred

TEP members were asked to discuss the methods by which information is currently being transferred across care settings, such as printed copies, telephone communication and electronic means. One TEP member representing HHAs and SNFs said that patients, families and caregivers are given hard copies of their records. Another TEP member used 'Telemetra', a virtual conferencing system, to transfer patient/resident data across care settings. Another TEP member noted that electronic transfer is the most commonly used mode for transferring information, with a majority of data and information being pulled from the electronic medical record system. A majority of the TEP members agreed that electronic transfer of information was the most efficient method of transfer. Additionally, TEP members stressed that there should also be direct clinician-to-clinician communication (i.e., a "warm hand-off").

3.1.2 Discussion of Timely Transfer

We asked TEP members to describe how they conceptualize timely transfer of health information across care settings, including how they would define the term "timely." TEP members agreed unanimously that timely transfer is key to ensuring quality patient/resident care. They also stated that information becomes less valuable the longer after transition that it is sent. TEP members discussed the common consequences of information not being transferred in a timely manner, including the patient/resident being sent back to the previous facility if admitted without a complete discharge summary, the current provider not having a clear point of contact to follow-up with on the patient's status and previous care, and lack of information resulting in a medical emergency for the patient/resident.

Although TEP members did not come to agreement on a definition for 'timely transfer,' TEP members stated that timeliness should mean at the time of patient/resident transfer or following soon after because the longer that time span is between patient transition and information transfer, the less valuable the information is. One TEP member encouraged interoperability and looking at standardized data in a way that can be implemented into an electronic system to ensure timely transfer.

3.1.3 Caregiver Role in Transfer of Information

TEP members were asked to discuss the caregiver's role in information transfer. One TEP member who provided the patient/caregiver and rural healthcare perspectives, stated that the PAC facility should be held responsible for the timely transfer of information, but since there is often no medical person involved in the transition, he personally carries a physical file containing his wife's medical records as she transitions to other care settings. It was generally agreed upon by TEP members that caregivers and patients/residents need more information related to self-management such as medication list, diet restrictions and other diagnosis-specific orders. One TEP member representing the HHA and SNF perspective said that patients/family members are given hard copies of their medical records.

3.1.4 Discussion of Provider to Provider Information Transfer

The TEP also discussed the importance of provider to provider information transfer. Multiple TEP members expressed the importance of communication between the primary care physician (PCP) and interim accepting physicians. As mentioned by one TEP member, in facilities such as hospitals, oftentimes the physician listed on medical records has not seen or followed the patient/resident for a length of time and does not follow-up with the PCP making the receiving provider unaware of the patient's history and needs of care upon admission. For hospitals that use a hospitalist model, often those patients are referred to PAC and the primary physician is not aware of the plan for the patient. There was concern that, although it is a best practice, it is rare for the primary care physician to stay up-to-date on the patient's status and care throughout transitions across the care continuum. This results in the current provider not knowing who to turn to when an emergency with the patient/resident occurs. One TEP member acknowledged that provider to provider communication is ideal, but not always feasible, and there is a real need for clearer ways to coordinate communication when a new physician is taking over the patient's care.

One TEP member stressed the importance of patient/resident engagement and stated that the handoff from physician to physician often excludes the patient/resident or is unclear to the patient/resident in terms of who they should be communicating with regard to their care. The TEP also said that transfer of information is expected to occur as soon as possible, meaning prior to the admission or shortly after to ensure that information is not lost during a patient's transition in care.

SECTION 4 TEP INPUT ON DATA ELEMENTS, QUALITY MEASURES, CONCEPTS, AND CALCULATIONS

4.1 Discussion of Types of Information to Be Transferred

This section describes TEP feedback on specific measure questions, data items and response choices. The data collection items, current at the time of the TEP meeting, are shown in Appendix C.

The TEP was asked to provide input on the types of information that should be transferred between providers. This discussion was meant to inform the choices provided in Question #2 for both Admission and Discharge Measures (Measures #1 and #2 in Appendix C), which asks about the specific types of information transferred. The response choices provided to the TEP for Question #2 (see Appendix C) were derived primarily from the domains delineated in the IMPACT Act.

Several of the TEP members expressed that the measure should “start simple” and that successful transfer of information for the measures should be based on very few types of information. However, most TEP members stated that including a comprehensive list of the types of information that *could* be transferred would provide a prompt to providers about the types of information that *should* be transferred. Most TEP members felt that it would be important to transfer the following types of information:

- Demographics
- Caregiver/family contact information
- Advance Directives, POLST (Physician Orders for Life-Sustaining Treatments) and MOLST (Medical Orders for Life-Sustaining Treatments) forms, code status
- Medication list
- Diagnoses
- MDS 3.0 Section GG - Functional Abilities and Goals
- Psychosocial assessment
- Tests and pending results

In discussing the type of information that should be included in the Discharge data element (Measure #2 in Appendix C), TEP members generally agreed that the categories included for provider to provider transfers (Measure #2, Question #2 in Appendix C) should not be those included for families at transfer to home (Measure #2, Question #5 in Appendix C). Rather, TEP members stated that families need information on how to safely care for patients/residents post-discharge and that this should include the following types of information:

- Medication list
- Education on transferring and bathing
- Signs and symptoms
- Diet
- Other information specific to the diagnosis

One TEP member also noted that patient and caregiver information must be written at the third grade reading level and that one wouldn't want to limit providers to only exchanging information written at that level. TEP participants stated that it would be important to include patients/residents in their care planning and ensuring the transfer of health information and care preferences for patients/residents who are discharged home. However, the TEP expressed concern over how PACs would be held accountable for the transfer of information to a patient/family/caregiver and the feasibility of capturing these data.

4.2 Discussion of Modes of Transfer

TEP members were asked to comment on the modes of information transfer. This is related to Question #3 in Appendix C, which includes verbal, paper, and electronic modes as choices for mode of information transfer. Some TEP members commented that there is not much value in gathering and reporting these data and questioned the utility of publicly reporting a facility's mode(s) of information transfer. One identified a possible benefit of reporting this information - to look at the accuracy and the quality of the documentation and see if it is more complete when sent electronically. A few TEP members questioned whether mode of transfer would be useful or important to patients/residents and consumers.

TEP members made strong cases for the value of electronic modes of transfer as well as direct (i.e. verbal) clinician to clinician communication. Several TEP members expressed that the goal of a measure of information transfer should be to encourage adoption of electronic health information exchange (HIE). However, an equal number of TEP members stressed that recent research and anecdotal information suggest that direct communication between clinicians (i.e., a "warm hand-off") is the gold standard for transferring information in a timely manner.

4.3 Discussion of Interrupted Stays, Observation Stays, and Emergency Department (ED) Transfers in Discharge Measure

TEP members were asked to provide feedback on whether the measure should include transfer of information when a stay is interrupted, including during observation stays and transfers to ED. Some TEP members stated that patients/residents are "getting lost" during observation stays, and "if the information is not there, there is a lot of redundancy in testing, phone calls going back and forth, and confusion," therefore, transferring this information would be important during these transitions. During a short stay in observation, providers don't have time to collect the information, so having it transferred is critical. Another TEP member stated that sometimes when nursing home residents go to the ED it is just for consultation and it would be a wasted effort to transfer information to the hospital just for the purpose of a consultation visit.

4.4 Discussion of Including Patient Care Preferences and Goals in the Measures

TEP members were asked about their understanding of the term “patient goals and preferences.” The vast majority of TEP members stated that information on patient/resident goals and preferences was important information to transfer. However, there were differences expressed in terms of what is most important to transfer at patient/resident transition. For example, some TEP members expressed that they would want to know whether there had been a discussion about goals but not necessarily what the specific goals were as these should be reassessed post-transition. Some TEP members shared the opinion that goals and care preferences should be included in the same category (i.e. “patient goals and preferences”). Others also felt that it was important that goals be established with the patient/resident. In terms of preferences, TEP members suggested that the following information is important to transfer between providers:

- Language – spoken and written
- Cultural preferences
- Caregivers, family members and physicians with whom patient/residents want to communicate information
- Restrictions on visitors who may pose a danger

4.5 Discussion of Potential Unintended Consequences

There was a considerable amount of discussion among the TEP regarding the unintended consequences of these measures and the time required for data collection. TEP members stressed that the burden of data collection should be balanced by the benefits of the measure. In other words, data should only be collected if it has the potential to improve patient/resident outcomes. Several TEP members also expressed concern that this measure could result in an increased amount of information being shared between providers, but that the increased volume of information would result in the need to hire more staff and increased effort to sift through the information to find the information that is most relevant to patient/resident care. Similarly, another TEP member worried that the measure could result in duplication of information transferred. Another concern voiced by the TEP was that the measure may promote electronic transfer of information despite evidence that verbal communication between clinicians (i.e. a “warm hand-off”) may be better.

TEP members had some concerns related to the HIT implications of these measures. This included concerns about the high costs of HIE and being forced to move to EHR. One TEP member said that “HIE systems don’t have the ability to share, so something will have to be built or paid for” and that PAC providers would “have to build interfaces with lots of systems.” In a related comment, one TEP member stated that this could promote unwarranted standardization and that individual patient/resident nuances may get lost.

There were several concerns raised related to increased burden on providers to gather and send information and track this measure. As well as the additional burden on providers to transition from current modes of transfer to the adoption of EHRs.

Some TEP members expressed concern that the data collected will not be actionable and meaningful, including the possibility that these measures could become simple check boxes rather than something used to improve quality. One TEP member noted that it could be “finished, but not finished well.”

Other TEP members expressed fear that hospitals would not engage with PAC providers to work on improving processes and systems for transferring information and that PAC providers would be penalized for process failures that were not entirely within their control. TEP members were concerned that PAC providers do not have complete control over the information they receive. Most agreed that the receiving provider does not have control over what is sent by the discharging provider (i.e. Measure #1, Question #1 in Appendix C, which asks if the PAC provider received information from the referring/ sending/discharging provider). The TEP was also very concerned that there may be a penalty associated with this measure and that PAC providers will be held accountable for something they have little control over. The TEP members described the ways in which they acquire information, including passively receiving information that is sent to them by other providers as well as actively obtaining information that they need to care for the patient/resident. All TEP members agreed that it was important for PAC providers to “get credit” for both receiving and obtaining information.

SECTION 5 POST-TEP POLL INFORMATION

Approximately two weeks after the TEP, TEP members were asked to respond to additional questions by email. These questions focused on the possible re-wording of one data element, their understanding of some key terms and concepts and the amount of burden that these measures may pose for PAC providers. TEP members were asked to respond to several multiple choice questions and provide their reasons for their choices. See Appendix D for the post-TEP poll questions.

First, we provided TEP members with current and revised wording for data elements in quality measures 1 and 2, Question 1, and asked for their input regarding whether the revised wording better captured the intent of the measure. Seven of the eight responding TEP members indicated that the revised wording did better reflect the intent of the measure. For example, one wrote “wording is better [and] the frame of reference will make it easier to answer consistently.” The eighth TEP member indicated that the revised wording was appropriate for measure 1, but that the original wording should be retained for measure 2.

Next, we asked TEP members their perception of the burden that completing these new measures would pose for PAC providers. There was no consensus among TEP members regarding burden, with some indicating no or minimal burden, some indicating a small burden and one indicating significant burden. However, a few TEP members did comment that while these data elements alone may not present significant burden, these in addition to other data elements and mandates together present significant burden. As one TEP member wrote:

“I do understand the value of collecting this information to move the process forward. Regardless, CMS must recognize that this is a ‘sort of’ unfunded mandate which comes at the same time that MANY alternative value based payment programs are coming into play. Taken together, all of these ‘small items’ begin to add into a big burden.”

Finally, we asked several questions to determine TEP members’ understanding of the words “receive” and “obtain” and the concepts of active and passive transfer of information. We did this because, as described above, during the TEP most participants reported that PAC providers generally utilize both active and passive means for acquiring the information needed to care for patients/residents. In order to better reflect the active and passive methods used to acquire patient/resident information, we suggested several possible revisions to measure 1, Question 1. All of these modifications involved the addition, in one way or another, of the word “obtain.” In all instances, the TEP members agreed with the addition of the word “obtain” in order to better reflect real-world processes of information transfer. For example, one wrote, “If the provider has to take action to get information, then they ‘obtain’ it, if the provider does not have to take any action then they ‘receive’ it.”

[This page intentionally left blank.]

SECTION 6 NEXT STEPS

In summary, reaction to the measures by the TEP was generally favorable. TEP members supported the idea that these measures could help improve communication and information transfer between providers. Some members of the TEP expressed that their organization would have little control over the information sent to them during patient transfer. However, other members of the TEP expressed that PAC providers could exert influence over partner hospitals with regard to the transfer of health information and that this could help strengthen organizational relationships between these providers.

Feedback from this TEP has been used to develop measure specifications for these measures. For example, the TEP suggested several ways to enhance the response choices for Question #2 (see Appendix C). While these response choices have been driven primarily by the domains of the IMPACT Act, the measure specifications now also include response choices suggested by the TEP. Additionally, suggestions from the TEP will be used to inform the guidance for these measures. For example, we expect that TEP input regarding examples of patient care preferences (see Section 4) to help shape the guidance provided for that response choice.

These measure specifications will be posted on November 11, 2016 and a public comment period is scheduled from November 11, 2016 through December 11, 2016.

[This page intentionally left blank.]

**APPENDIX A
TEP MEMBERS**

- ❖ **Maria Brenny-Fitzpatrick DNP, RN, FNP-C, GNP-BC**
Director of Transitional Care
University of Wisconsin Hospitals and Clinics
Madison, WA

- ❖ **Bruce Hanson, BA, MS (patient/caregiver perspective)**
Rural Parish Pastor
Evangelical Lutheran Church
Patient Advocate
National Patient Advocacy Foundation
Garnavillo, IA

- ❖ **Robert Latz, PT, DPT, CHCIO**
Chief Information Officer (CIO)
Trinity Rehabilitation Services
St. Clairsville, OH

- ❖ **Cheryl Meyer, MS, RN, PHCNS-BC**
Director of Clinical Excellence
Advocate at Home
Oak Brook, IL

- ❖ **Cheryl Miller, DrOT**
National Director of Therapy Operations
HealthSouth
Sunrise, FL

- ❖ **Angela Orsky, DNP, LNHA, RN**
Assistant Vice President, Continuing Care Services Division
Carolinas HealthCare System
Charlotte, NC

- ❖ **Marjory Palladino, RN, BS, MSN, CRRN, CSPHSP**
Director of Nursing
Southington Care Center, Hartford Healthcare Senior Services
Chicago, IL

- ❖ **Jane Pederson, MD, MS**
Chief Medical Quality Officer
 Stratis Health
Bloomington, MN

- ❖ **Robert Rosati, PhD**
Chair, Connected Health Institute
 VNA Health Group
Red Bank, NJ

- ❖ **Wayne Saltsman, MD, PhD, CMD, FACP**
Chief, Geriatrics/Transitional Care
 Lahey Health
Burlington, MA

- ❖ **Susan Tracy Moore, MPH, RN, CCM**
Senior Director of Case Management
 Spaulding Rehabilitation Network
Cambridge, MA

- ❖ **Mary Van de Kamp, MS, CCC-SLP**
Senior Vice President of Quality
 Kindred Healthcare
Louisville, KY

- ❖ **Grace Wummer, RN (patient/caregiver representative)**
Clinical Director of Senior Services
 Main Line Health
Bryn Mawr, PA

- ❖ **Victoria Zombek, RN, BSN, ACM**
Director of Post Acute Liaisons
 University of Pittsburgh Medical Center
Pittsburgh, PA

**APPENDIX B
MEASURE DEVELOPMENT TEAM**

Abt Associates

- ❖ **Alrick Edwards, MPH**
- ❖ **Marian Essey, RN, BSN**
- ❖ **Sara Galantowicz, MPH**
- ❖ **Linda Krulish, PT, MHS**
- ❖ **Lynn Martin, PhD, RPh**

RTI International

- ❖ **Colene Byrne, PhD**
- ❖ **Laura Smith, PhD**
- ❖ **Michelle Dougherty, MA**
- ❖ **Karen Reilly, ScD**
- ❖ **Terry Eng, PhD**
- ❖ **Anne Deutsch, PhD**
- ❖ **Julie Seibert, PhD**
- ❖ **Lindsey Free, BS**
- ❖ **Susan Mitchell, MA**
- ❖ **Roberta Constantine, PhD**
- ❖ **Denise Tyler, PhD**
- ❖ **Samantha Clark, BA**

[This page intentionally left blank.]

**APPENDIX C
TEP WEBINAR AGENDA**

**Technical Expert Panel (TEP) Meeting Agenda
Development of quality measures to satisfy the IMPACT Act domain of: Transfer of
Health Information and Care Preferences When an Individual Transitions**

1:00pm-5:00pm EST, Tuesday, September 27, 2016

Dial-in Number: 1-888-706-0584 / Access Code 3790594# (see attachment for instructions to join the
webinar)

—TEP Schedule—

<i>Time</i>	<i>Agenda Item</i>	<i>Lead</i>
1:00–1:30 pm	Welcome and Introductions -RTI International, Abt Associates, and CMS -Moderated by Loretta Randolph, the MITRE Corp.	RTI/Abt/CMS
1:30–1:40 pm	Project Objectives, IMPACT Act, TEP Objectives -Presentation Overview -Review of agenda -TEP objectives, ground rules	Moderator
1:40–1:50 pm	Background discussion -Project and TEP objectives -The IMPACT Act and the Quality Reporting Programs -Importance of timely transfer of information at transitions -Measure Concept and Outcomes	RTI
1:50–2:00 pm	Measure Specifications and Data Collection -Provider-to-provider information transfer -Quality Measure #1 (Admission) and #2 (Discharge) -Data collection – general concepts	Abt
2:00–2:10 pm	Break (10 min)	
2:10–3:20 pm	Walk-Through of Measure Specifications & Data Collection Questions Admission QM#1 Discharge QM#2 -Review of all measure description and data collection items -Discussion on data collection	Abt
3:20–3:30 pm	Break (10 min)	Abt
3:30–4:50 pm	TEP Discussion Questions	Moderator
4:50–5:00 pm	Concluding Remarks, Next Steps	Moderator

[This page intentionally left blank.]

APPENDIX D
DATA COLLECTION ITEMS FOR TEP REVIEW

Data Collection Items for Measure #1 (Admission/SOC/ROC)²:

Q1. Transfer of Health Information to PAC Provider at Admission/Start of Care/Resumption of Care:

Did this PAC provider receive health information relevant to the care of this patient from the referring/sending/discharging provider when this patient transitioned between providers/settings?

- Yes (*go to Q2*)
- No (*skip Q2 and Q3*)
- NA – Patient was not under the care of another provider immediately prior to this SOC/ROC/Admission. (*skip Q2 and Q3*)

Q2. Types of Health Information Received by PAC Provider at Admission/Start of Care/Resumption of Care: Indicate what types of health information were received from the referring/sending/discharging provider. (select all that apply):

- Functional status
- Cognitive function and mental status
- Special services, treatments, and interventions (e.g., ventilator support, dialysis, IV fluids, parenteral nutrition, blood product use)
- Medical conditions and co-morbidities (e.g., pressure injuries and skin status, pain)
- Impairments (e.g., incontinence, sensory)
- Medication list
- Patient care preferences (e.g., advance directives, etc.)
- Patient goals of care
- Other
- None of these types of health information were received

Q3. Route of Information to PAC Provider at Admission/Start of Care/Resumption of Care: Indicate the route(s) of transmission of health information from the referring/sending/discharging provider (select all that apply):

- Electronic means using an interoperable, health information exchange
- Other electronic means (e.g., non-interoperable health information exchange, secure messaging, email, e-fax, EMR, portal)
- Verbal (e.g. in-person, telephone, video conference)
- Paper-based (e.g. fax, copies/printouts)

² Current as of September 27, 2016

Data Collection Items for Measure #2 (Discharge, Program Interruption, and/or Transfer)³

Q1. Transfer of Health Information by PAC Provider at Transfer/Program Interruption/Discharge: Did this PAC provider send health information relevant to the care of this patient to the receiving/admitting provider when this patient transitioned between providers/settings or when the patient received care from another setting during this stay?

- Yes
- No (*skip Q2 and Q3*)
- NA (Home Health only) – The agency was not made aware of this transfer timely and therefore was unable to transfer health information to the receiving facility. (*skip Q2 and Q3*)

- NA – Patient was not discharged to the care of another provider at the time of this Transfer/Program Interruption/Discharge. (*skip Q2 and Q3*)

Q2. Types of Health Information Sent by PAC Provider at Transfer/Program Interruption/Discharge:

Indicate what types of health information were sent by this PAC provider to the receiving/admitting provider. (select all that apply):

- Functional status
- Cognitive function and mental status
- Special services, treatments, and interventions (e.g., ventilator support, dialysis, IV fluids, parenteral nutrition, blood product use)
- Medical conditions and co-morbidities (e.g., pressure injuries and skin status, pain)
- Impairments (e.g., incontinence, sensory)
- Medication list
- Patient care preferences (e.g., advance directives, etc.)
- Patient goals of care
- Other
- None of these types of health information were received

Q3. Route of Information from PAC Provider at Transfer/Program Interruption/Discharge: Indicate the route(s) of transmission of health information from this facility/agency to the receiving/admitting provider: (select all that apply):

- Electronic means using interoperable, health information exchange
- Other electronic means (e.g., secure messaging, email, e-fax, EMR, portal)
- Verbal (e.g. in-person, telephone, video conference)
- Paper-based (e.g. fax, copies/printouts)

³ Current as of September 27, 2016

Q4. Transfer of Health Information to Patient/Family/Caregiver at Transfer/Program

Interruption/Discharge: Did this PAC provider provide the Patient/Family/Caregiver with health information relevant to their care when this patient transitioned between providers/settings?

- Yes
- No (*skip Q5*)
- NA (Home Health only) – The agency was made not made aware of this transfer timely and therefore was unable to transfer health information to the patient/family/caregiver. (*skip Q5*)

- NA – Patient was not discharged to the care of another provider at the time of this Transfer/Program Interruption/Discharge. (*skip Q5*)

Q5. Types of Health Information Received by the Patient/Family/Caregiver at Transfer/Program

Interruption/Discharge: Indicate what types of health information were provided to the Patient/Family/Caregivers by the PAC provider at the time of Transfer/Program Interruption/Discharge (select all that apply):

- Functional status
- Cognitive function and mental status
- Special services, treatments, and interventions (e.g., ventilator support, dialysis, IV fluids, parenteral nutrition, blood product use)
- Medical conditions and co-morbidities (e.g., pressure injuries and skin status, pain)
- Impairments (e.g., incontinence, sensory)
- Medication list
- Patient care preferences (e.g., advance directives, etc.)
- Patient goals of care
- Other
- None of these types of health information were received

APPENDIX E POST-TEP POLL QUESTIONS

RTI and Abt request additional input on the data collection for the transfer of health information and care preferences admission and discharge quality measures. Table 1 (found on page 4) provides the original draft assessment items discussed during the TEP webinar and revised items based on the TEP feedback. Please provide your name and answer the questions below.

Background: TEP members discussed the importance of timely transfer of information, with certain types of information being very important to receive before or at admission. TEP members also agreed that care preferences are important to transfer at transitions. Admission and Discharge Q1 were revised in light of the TEP input.

TEP members also indicated that PACs and other providers share accountability for the transfer of patient information and described many ways that PAC providers get information, including passively receiving information and actively requesting/ pursuing information from the sending provider.

1. Do the revised admission and discharge items (see page 3, Table 1, column 2) *better* capture the quality measure concept of transferring important information in a timely, actionable manner? (Please check one response)
 - Yes
 - No
 - Other response or undecided for following reason:

Please provide a brief explanation for your response to Question 1:

2. Do you feel that this measure should separately capture the processes of: a) directly, passively receiving information from the provider; and b) actively obtaining information, as shown by the highlighted example below? (Please check one response)
 - Yes, ask Q1A and Q1B
 - No
 - Other response or undecided for following reason:

Item Example

Q1A. At the time of admission, did your facility/agency receive from the referring /sending /discharging provider the patient’s health information and care preferences that were needed to plan and provide care?

- Yes
- No
- NA – Patient was not under the care of another provider immediately prior to this SOC/ROC/Admission.

Q1B. At the time of admission, did your facility/agency contact the referring/sending/discharging provider or use other means to obtain the needed information?

- Yes
- No

Please provide a brief explanation for your response to Question 2.

3. Is it feasible for PAC providers to answer the revised admission and discharge items, Q1?

- Yes
- No
- Other response or undecided for following reason:

Please provide a brief explanation for your response to Question 3:

4. How much of a burden would answering the revised admission and discharge items, Q1, pose for PAC providers?

- Significant burden
- Small burden
- No or minimal burden
- Other response or undecided for following reason:

Please provide brief explanation for your response to Question 4

5. If you answered 'No' to Question 2, please indicate how you feel Admission Q1 (see page 3, Table 1, Row 1, Column 2) should be worded and reason: (please check one response)

- Ask if PAC provider 'received' information, do not include the words 'or obtained', and refer to guidance for clarification of the term 'receive' to include passive and active means of getting, obtaining, and pursuing information.
- Ask if PAC provider 'received' information, do not include the words 'or obtained', and the measure and guidance should not include the broader definition of 'receive'. Receive should only refer to the directly getting information from the referring /sending /discharging provider.
- Ask if PAC provider 'received or obtained' information, guidance will also clarify that the phrase 'receive or obtain' includes passive and active means of getting, obtaining, and pursuing information
- Suggest different wording provided here:

- Other response or undecided for following reason:

Please provide a brief explanation for your response to Question 5.

6. Indicate how you feel PAC facilities/agencies would interpret and consider the following means of getting information as ‘receive’ information AND ‘obtain’ information (Check all that apply).

Means of getting information	Receive Information	Obtain Information
PAC provider contacts and subsequently gets information from the sending provider (by any mode of transfer)	<input type="checkbox"/>	<input type="checkbox"/>
PAC provider gets information from shared EHR (e.g., transition from acute care to IRF unit)	<input type="checkbox"/>	<input type="checkbox"/>
PAC provider gets information from a portal or EHR that a non-affiliated provider has made available	<input type="checkbox"/>	<input type="checkbox"/>

Please provide a brief explanations for your responses to Question 6:

Table 1. Current item #1 provided to TEP and revised items for TEP input

Current	Revised
ADMISSION ASSESSMENT	
<p>Q1. Did this PAC provider receive health information relevant to the care of this patient from the referring /sending /discharging provider when this patient transitioned between providers/settings?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> NA – Patient was not under the care of another provider immediately prior to this SOC/ROC/Admission.</p>	<p>Q1. At the time of admission, did your facility/agency receive from the referring/sending /discharging provider the patient’s health information and care preferences that were needed to plan and provide care?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> NA – Patient was not under the care of another provider immediately prior to this SOC/ROC/Admission.</p>
DISCHARGE ASSESSMENT	
<p>Q1. Did this PAC provider <u>send</u> health information relevant to the care of this patient to the receiving/admitting provider when this patient transitioned between providers/settings?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> NA (Home Health only) – The agency was not made aware of this transfer timely and therefore was unable to transfer health information to the receiving facility.</p> <p><input type="checkbox"/> NA – Patient was not discharged to the care of another provider at the time of this Transfer/Program Interruption/Discharge</p>	<p>Q1. At the time of discharge, transfer, program interruption, did your facility/agency send the patient’s health information and care preferences to the receiving/admitting provider?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> NA (Home Health only) – The agency was not made aware of this transfer timely and therefore was unable to transfer health information to the receiving facility.</p> <p><input type="checkbox"/> NA – Patient was not discharged to the care of another provider at the time of this Transfer/Program Interruption/Discharge</p>