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Quality Reporting: An Overview of the IMPACT Act

Enacted in late 2014, the Improving Medicare Post-Acute Care Transformation Act, *42 U.S.C.A. § 1395* (IMPACT Act) was designed to raise the quality and efficiency of post-acute care (PAC) services by enhancing the reporting of outcomes and service costs to the federal government and consumers. The law directly affects four PAC settings: home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs) and skilled nursing facilities (SNFs).[1] (See Figure 1 on page 3.)

Prior to the IMPACT Act, it was nearly impossible to directly compare the care provided in similar types of settings. The act addresses this issue by authorizing the Centers for Medicare & Medicaid Services (CMS) to create a standardized assessment vocabulary for PAC providers, as well as a uniform reporting system for critical care measures. These tools facilitate CMS efforts to …

- **Evaluate resident/patient progress** across the PAC continuum.
- **Compare and contrast care and outcomes** among different PAC providers.

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- **Improve discharge planning** in hospitals and PAC settings.
- **Reform the PAC payment structure**, utilizing newly available data.

From the perspective of PAC providers, probably the most significant aspect of the IMPACT Act is its ambitious mandate to compile and report assessment data and clinical measures of individual residents/clients. To achieve compliance, aging services organizations and providers must establish an effective quality reporting program (QRP) and implement other measures relating to measurement and transparency.

1 The IMPACT Act also affects regulation of Medicare-certified hospice programs in various ways, including number of surveys, timing of medical reviews and calculation of annual payment caps. See MHOTARD, **"How Will the IMPACT Act Impact Hospice Care?"** *Policy Interns*, October 29, 2014.

Figure 1: PAC Settings Affected by the IMPACT Act

HOME HEALTH AGENCIES (HHAs)

Skilled nursing or therapy services provided to homebound Medicare beneficiaries.

Website: Home Health Quality Reporting Requirements.

INPATIENT REHABILITATION FACILITIES (IRFs)

Inpatient services involving physical, occupational and speech therapy.

Website: Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program (QRP).

LONG-TERM CARE HOSPITALS (LTCHs)

Inpatient rehabilitation services, pain management, traumatic brain injury treatment and respiratory therapy.

Website: Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP).

SKILLED NURSING FACILITIES (SNFs)

Short-term skilled nursing and rehabilitation services for persons whose health condition is too complicated for assisted living or home care settings.

Website: SNF Quality Reporting Program (IMPACT Act 2014).

This edition of *CareFully Speaking*® examines the two major components of the IMPACT Act: clinical assessment data collection parameters and standardized quality and resource use reporting measures. (See page 3 for a description of the law's other provisions.) The article also offers a range of practical takeaways and additional resources intended to help aging services organizations enhance quality and compliance in the areas of greatest scrutiny.

CLINICAL ASSESSMENT DATA

The first key requirement of the IMPACT Act involves collecting clinical assessment data. As of October 1, 2018 for IRFs, LTCHs and SNFs (and January 1, 2019 for HHAs), PAC providers must report to CMS a range of resident/patient assessment data regarding physical and mental condition, goals, preferences and activities of daily living, among other health and well-being measures. Each type of PAC has its own specific patient/resident assessment tool:

- For HHAs – Outcome and Assessment Information Set (OASIS).
- For IRFs – Patient Assessment Instrument (IRF-PAI).
- For LTCHs – Continuity Assessment Record and Evaluation (CARE) Tool.
- For SNFs – Minimum Data Set (MDS) 3.0.

These tools must be modified in order to produce a uniform, comparable set of resident/patient assessment data in the following five areas:

1. **Functional status,** including mobility and such self-care capabilities as walking, eating, grooming and toileting.
2. **Cognitive function,** including the ability to express ideas and understand directives, as well as the presence of depression and/or dementia.
3. **Special services, treatments and interventions,** such as the need for ventilator use, dialysis, chemotherapy, central line placement and/or total parenteral nutrition.
4. **Medical conditions and comorbidities,** including such chronic conditions as diabetes, congestive heart failure and pressure ulcers.
5. **Impairments,** such as incontinence and impaired ability to hear, see or swallow.

PAC providers will be required to report these data to the U.S. Department of Health and Human Services at the time of resident/patient admission, as well as upon discharge. The IMPACT Act further requires that duplicative or overlapping data elements within the respective assessment tools be revised or replaced.

STANDARDIZED QUALITY/EFFICIENCY MEASURES

The second major requirement of the IMPACT Act involves measuring and reporting quality of care and efficiency of resource use. PAC providers already have begun reporting these data, using eight standard measures that were adopted following a lengthy public comment period. (See Figure 2, below.)

Reporting began in 2016 for most of these measures, with the remainder commencing in 2017, 2018 or 2019. (See Figure 3 on page 4 for effective dates.) Starting in October 2017 and on a quarterly basis thereafter, PAC providers will receive confidential feedback on reported measures, while public reporting of quality data will commence in October 2018. At that time, PAC providers not in compliance with data submission requirements will see a two percentage point decrease in their Medicare payment rate.

The following setting-specific resources contain more comprehensive compliance information regarding reporting measure specifications and QRP requirements:

- For HHAs – "Measure Specifications for Measures in the CY 2017 HH QRP Final Rule."
- For IRFs – "IRF Quality Reporting Measures Information."
- For LTCHs – "LTCH Quality Reporting Measures Information."
- For SNFs – Skilled Nursing Facility Quality Reporting Program (SNF QRP): Requirements for the Fiscal Year (FY) 2018 Reporting Year.

Major Provisions of the IMPACT Act

1. **Post-acute Care (PAC) providers must incorporate standardized clinical assessment parameters,** including elements of the Continuity Assessment Record and Evaluation (CARE) Tool Institutional Admission dataset, into their existing resident/patient assessment process.
2. **CMS is required to develop quality and resource use measures across PAC settings** and to publicly report on provider adherence to these measures. Providers who fail to comply with these reporting provisions will be subject to a reduction in the annual Medicare payment increase.
3. **Hospitals and PAC organizations are required to work together to ensure continuity of care whenever patients/residents transition to a PAC provider.** The process should include appropriate safety and quality measures, such as medication reconciliation, a written discharge plan and a post-discharge follow-up call.
4. **The U.S. Department of Health and Human Services and the Medicare Payment Advisory Commission will conduct studies linking Medicare payment to quality of care.** A final report to Congress recommending future payment plans for PAC providers is expected by October 2021. (See "The IMPACT Act: Setting the Stage for a New Medicare Payment Structure" on page 5.)
5. **CMS will measure staffing levels by using payroll data** obtained from PAC facilities.

Figure 2: Quality and Resource Use Measures

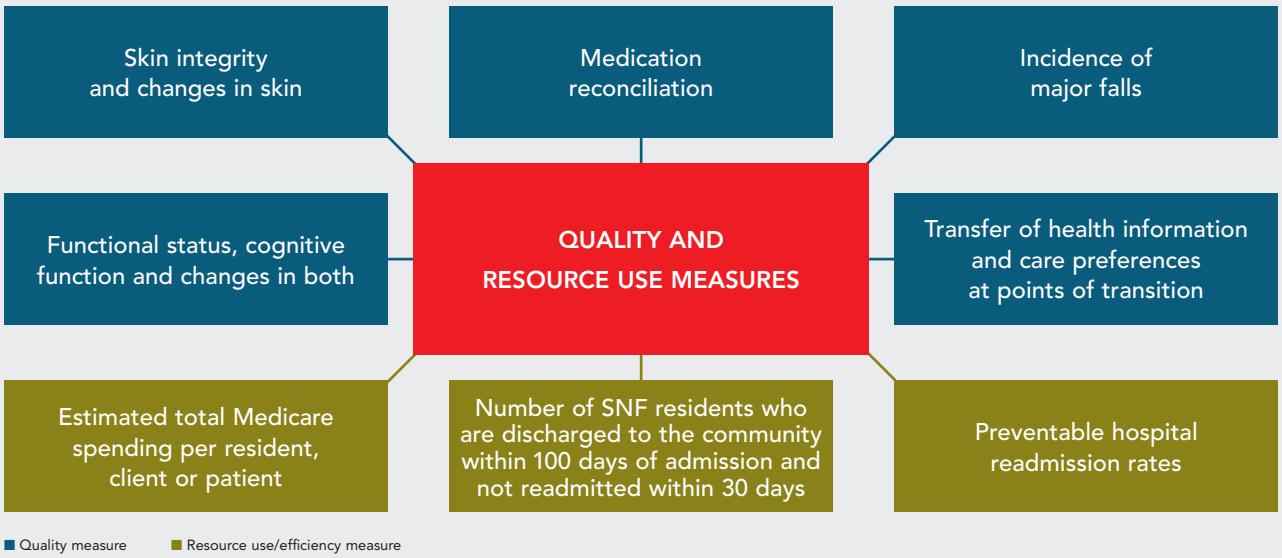


Figure 3: Dates for Reporting on Quality, Resource Use and Efficiency Measures

PAC SETTING:	HHAs	SNFs	IRFs	LTCHs
QUALITY MEASURES:				
Functional status	1/1/2019	10/1/2016	10/1/2016	10/1/2018
Skin integrity	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Medication reconciliation	1/1/2017	10/1/2018	10/1/2018	10/1/2018
Incidence of major falls	1/1/2019	10/1/2016	10/1/2016	10/1/2016
Transfer of health information	1/1/2019	10/1/2018	10/1/2018	10/1/2018
RESOURCE USE MEASURES:				
Medicare spending per beneficiary	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Discharge to community	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Potentially preventable hospital readmissions	1/1/2017	10/1/2016	10/1/2016	10/1/2016

■ Reporting began in 2016-17 ■ Reporting commences in 2018 or 2019

Figure 4: Measures Used to Evaluate Functional Abilities and Cognitive Level

ABILITIES	MEASURES				
Self-care	Bathing.	Oral hygiene.	Dressing.	Toileting hygiene.	Eating.
Mobility	Walking, in terms of distance and need for assistance.	Wheelchair use, e.g., ability to self-maneuver and make turns.	Changing bodily position, e.g., moving from supine to sitting.	Transferring, e.g., bed to chair and wheelchair to toilet.	Rolling from side to side in bed.
Cognitive function	Mental status. (See "Brief Interview for Mental Status [BIMS]."")	Ability to express ideas and wants.	Understanding others, including verbal directives.	Behavioral signs and symptoms. (See the Geropsychiatric Education Program's "GPEP Behavioural Assessment Tool.")	Presence of confusion. (See the Baylor College of Medicine's Confusion Assessment Method [CAM Tool] Shortened Version Worksheet.)

To avoid inappropriate placements, PAC staff must measure and document the cognitive level and functional abilities of patients/residents, both upon admission and at transfer/discharge.

PRACTICAL TAKEAWAYS

For PAC providers, the major areas of oversight under the IMPACT Act include clinical assessment, handoffs, hospital readmissions, patient choice, transfer/discharge and skin integrity. The following recommendations are designed to help organizations focus their compliance efforts on these critical processes and programs:

1. Emphasize functional and cognitive status when documenting assessments.

One of the primary goals of the IMPACT Act is to identify the most suitable care environment for every patient/resident, thereby avoiding potentially costly and risky mismatches, which may occur when placement decisions are made before the functional and cognitive status of patients/residents has been accurately assessed.

To avoid inappropriate placements, PAC staff must measure and document the cognitive level (including memory, attention span, problem-solving skills and executive functioning) and functional abilities of patients/residents,[2] as noted on page 4. (See Figure 4.) These assessments must be conducted upon admission and at transfer/discharge.

2. Develop enhanced handoff protocols.

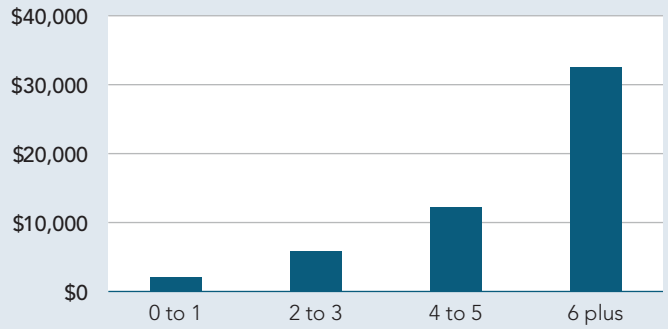
Resident/patient transitions from one PAC setting to another often become points of failed or interrupted care, as providers rely upon incomplete and/or obsolete summaries and fail to communicate or request critical information. To comply with the IMPACT Act requirement that providers transfer resident/patient health information and care preferences whenever transitions occur, organizations must develop and utilize a strategic handoff protocol that promotes active communication between caregivers at each PAC location.

Measures relating to care transitions have not yet been published by CMS. In the interim, PAC providers can consult the National Learning Consortium's "Universal Summary of Care Items for Transition to LTPAC," which contains reporting requirements that may be mandated by CMS. (See pages 8-10 of the "Care Coordination Tool for Long-Term and Post-Acute Care.") The Universal Summary's information categories are a useful starting point for reviewing and revising organizational handoff protocols.

The IMPACT Act: Setting the Stage for a New Medicare Payment Structure

Medicare currently spends an average of $9,738 annually per fee-for-service beneficiary. The cost of care increases exponentially for patients with common chronic conditions, such as high blood pressure, heart disease, chronic obstructive pulmonary disease and diabetes. Costs for beneficiaries with four or five chronic conditions average $12,174, while average costs for those with six or more conditions – about 14 percent of the Medicare population – are more than triple the overall average at $32,658. (See Figure 5, below.)

Figure 5: Annual Medicare Spending per Beneficiary by Number of Chronic Conditions



Source: CMS Chartbook: 2012 Edition, *Chronic Conditions Among Medicare Beneficiaries*. Centers for Medicare & Medicaid Services.

By applying uniform data standards that are valid across PAC settings, the IMPACT Act permits Medicare to establish payment rates reflecting individual characteristics of residents/patients, rather than the specific setting in which they receive care. The goal is to shift away from traditional fee-for-service and toward a prospective payment system based upon value and quality of care. According to the Medicare Payment Advisory Commission, preliminary findings suggest that such a system is feasible. See Connole, P. "MedPAC Wants Unified PAC Payment System Sooner Rather Than Later." *Provider*, April 7, 2017.

2 With respect to SNFs, the MDS 3.0 resident assessment tool has been revised to more precisely determine resident/patient functional cognition. (See section GG.)

3. Identify and address sources of potentially preventable hospital readmissions.

In response to escalating expenditures resulting from repeated and extended hospital stays, the IMPACT Act assigns responsibility to PAC organizations and providers for tracking the presence of certain medical conditions and clinical events associated with preventable 30-day readmissions.

A formal audit program of resident/patient healthcare information records can help identify high-risk individuals and trigger clinical intervention before hospitalization becomes necessary. Record audits should focus on the following five sources of preventable hospital readmissions, among others:

- **Inadequate management of chronic conditions,** e.g., angina, asthma, diabetes, chronic obstructive pulmonary disorder, hypertension.
- **Inadequate management of infections,** e.g., bacterial pneumonia, urinary tract infection, Clostridium difficile infection, septicemia, skin and subcutaneous tissue infections, kidney infection.
- **Inadequate management of other unplanned events,** e.g., adverse drug reactions, dehydration, aspiration pneumonitis, fluid and electrolyte disorders, anticoagulation complications, acute renal failure.
- **Inadequate prophylaxis,** e.g., anemia, gastrointestinal hemorrhage, intestinal impaction, pressure injuries, deep vein thrombosis, pulmonary embolism.
- **Inadequate injury prevention,** e.g., burns, falls, fractures, heat or cold exposure.

In the event a high-risk condition necessitates hospital readmission within the 30-day time frame, providers should document the rationale for readmission in terms of the following queries:

- **Health status:** Are there other medical conditions and comorbidities that increase the risk of hospitalization?
- **Benefits:** How will the hospitalization potentially help the resident/patient?
- **Risks:** If the resident/patient remains in the PAC setting, what is the likelihood of complications or other negative outcomes?
- **Capabilities:** Does the PAC setting have the capacity and resources necessary to safely and effectively manage the resident's/patient's care without hospitalization?

4. Include residents/patients in care-related decisions.

The IMPACT Act emphasizes the importance of resident/patient choice in PAC placement and related care. The following measures can help aging services organizations and providers identify the preferences and priorities of residents/patients:

- **Draft a PAC placement decision guide for providers** that emphasizes the need to obtain input from residents/patients and family when determining the most appropriate and least restrictive environment of care.
- **Encourage residents/patients to ask questions about their care needs,** seek clarification regarding service offerings and voice their opinions during the care planning process.
- **Hold regular resident/patient council meetings** to promote discussion of issues and concerns, provide information, resolve minor disputes and solicit suggestions. Document all meetings, including names of participants.
- **Ensure that the healthcare team, resident/patient and family members confer frequently,** in order to discuss assessment findings, relay changes in condition, obtain consensus on care-related decisions, and incorporate requests and preferences into the care plan.
- **Conduct quarterly surveys of resident/patient and family satisfaction,** focusing on specific aspects of care and service. Record findings and document follow-up actions taken in response to stated concerns.

5. Review the discharge planning process and revise as necessary.

A central goal of the IMPACT Act is to improve discharge planning and execution. To achieve compliance, referring organizations (including hospitals) must consider published quality ratings of PAC facilities when discharging patients to another level of care. CMS recommends using Nursing Home Compare and Home Health Compare until another set of measures is available.

In addition, PAC providers are expected to enhance transparency and safety by implementing the following strategies, among others:

- **Articulate discharge goals within 24 hours of admission,** based upon discussion with the resident/patient and family.
- **Establish an individualized care plan** that emphasizes discharge-related goals.
- **Reconcile medications before discharge** and list current medications in the discharge summary.
- **Make follow-up calls** and document post-discharge contacts with residents/patients.

6. Focus on pressure injury prevention and management. As part of its skin integrity quality initiative, the IMPACT Act requires organizations to report the percentage of patients and short-stay residents (i.e., those staying 100 or fewer days in an SNF) with stage 2-4 pressure injuries that are either new or have worsened since admission. This measure applies to all patients with qualifying injuries in LTCHs, but is limited to Medicare (Part A and Part C) patients in IRFs.

A formal pressure injury prevention program can help improve skin care while controlling costs and precluding potential reimbursement problems. The program should include the following actions, among others:

- **Conduct a comprehensive skin integrity assessment upon admission** and at regular intervals thereafter.
- **Develop effective wound care protocols** based upon widely recognized resources and established clinical guidelines.
- **Stage wounds in a consistent manner,** adhering to the pressure injury staging guidelines of the National Pressure Ulcer Advisory Panel.
- **Identify potential nutrition and hydration problems,** using validated nutrition screening and assessment tools. (See Posthauer, M. "The Case for Implementing Validated Nutrition Screening Tools in Wound Care." *Wound Source*, February 15, 2012.)
- **Consult with a registered dietician if residents/patients are deemed to be at nutritional risk,** and order dietary interventions as indicated to help promote wound healing.

For additional strategic and proactive measures to promote pressure injury prevention and mitigation, contact your CNA Healthcare risk control consultant.

With its focus on standardized measurement and enhanced transparency, the IMPACT Act imposes rigorous compliance demands upon every type of PAC provider. By reviewing assessment practices, quality reporting protocols, transition/discharge procedures and skin integrity programs, as well as strengthening basic documentation, communication and care planning processes, organizations can enhance quality and continuity of care while minimizing the risk of regulatory sanctions and reduced reimbursement.

Effect of the IMPACT Act upon the CMS Five-Star Rating System

One of the first industry-wide shifts to occur under the IMPACT Act involved the "Five-Star" rating system for nursing homes. (See CNA's *AlertBulletin*® 2015 - issue 3, **"CMS Five-Star Quality Ratings: A Look at Recent System Changes."**) Prior to the 2015 overhaul, critics of the rating system argued that self-reporting of data by organizations without outside verification did not always produce accurate and useful results.

The IMPACT Act seeks to strengthen validation procedures for two of the rating system's three data categories: quality measure scores (as discussed within this article) and staffing levels. With respect to the latter, the IMPACT Act directs the Centers for Medicare & Medicaid Services (CMS) to conduct a pilot test relating to verification of staffing levels, which occurred in fiscal year 2015. Going forward, the goal is to establish a national electronic reporting system that utilizes payroll information to corroborate staffing levels on a quarterly basis.

CMS plans to issue its first report of quality of care data derived from the new system in October 2018. According to CMS, the initial reporting sequence will not affect star ratings. However, future reports may well have tangible consequences for PAC providers.

QUICK LINKS

- IMPACT Act Downloads and Videos. Centers for Medicare & Medicaid Services (CMS), August 2017.
- IMPACT Act of 2014 Data Standardization & Cross Setting Measures. CMS, September 2016.
- IMPACT Act Spotlights and Announcements. CMS, August 2017.
- Pitts, P., Christy D. and McCurdy, D. "Analysis and Impact of the Improving Medicare Post-Acute Care Transformation Act of 2014." Reed Smith, October 2014.

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