

Functional Assessment, Interoperability, and Quality Measurement: FASI Paves the Way

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Disclaimer

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Today's Presenters

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Learning Objectives

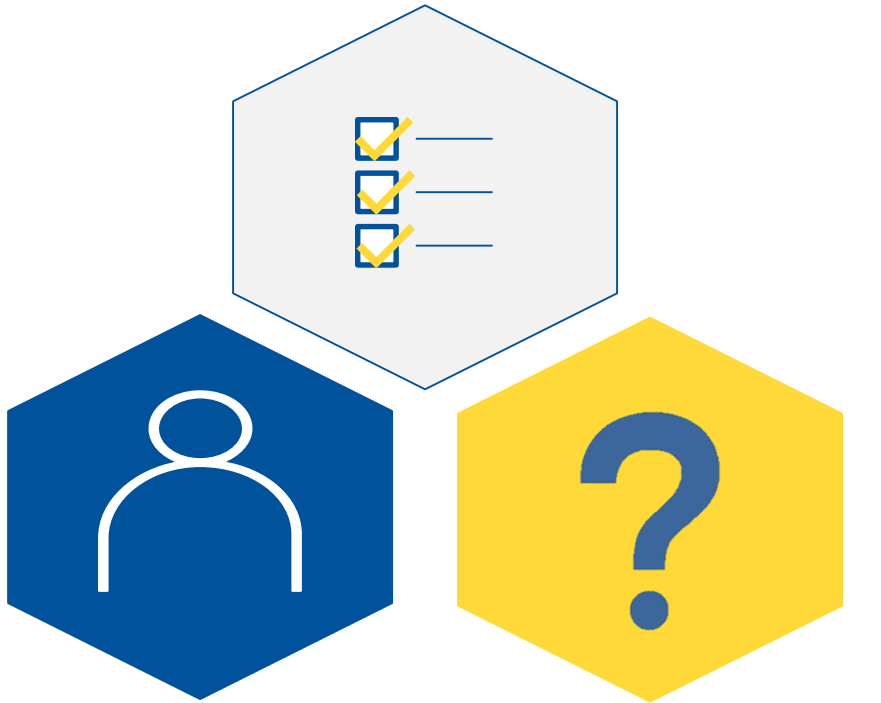
1. Learn how states are building their HCBS delivery system in support of interoperability and quality.
2. Discover new CMS updates about interoperability and care coordination using the CMS Data Element Library (DEL) and Post-Acute Care Interoperability Project (PACIO) use cases
3. Learn about the two FASI performance measures.

Introduction to FASI

Trudy Mallinson, George Washington University

What is FASI?

Person-centered, standardized item set

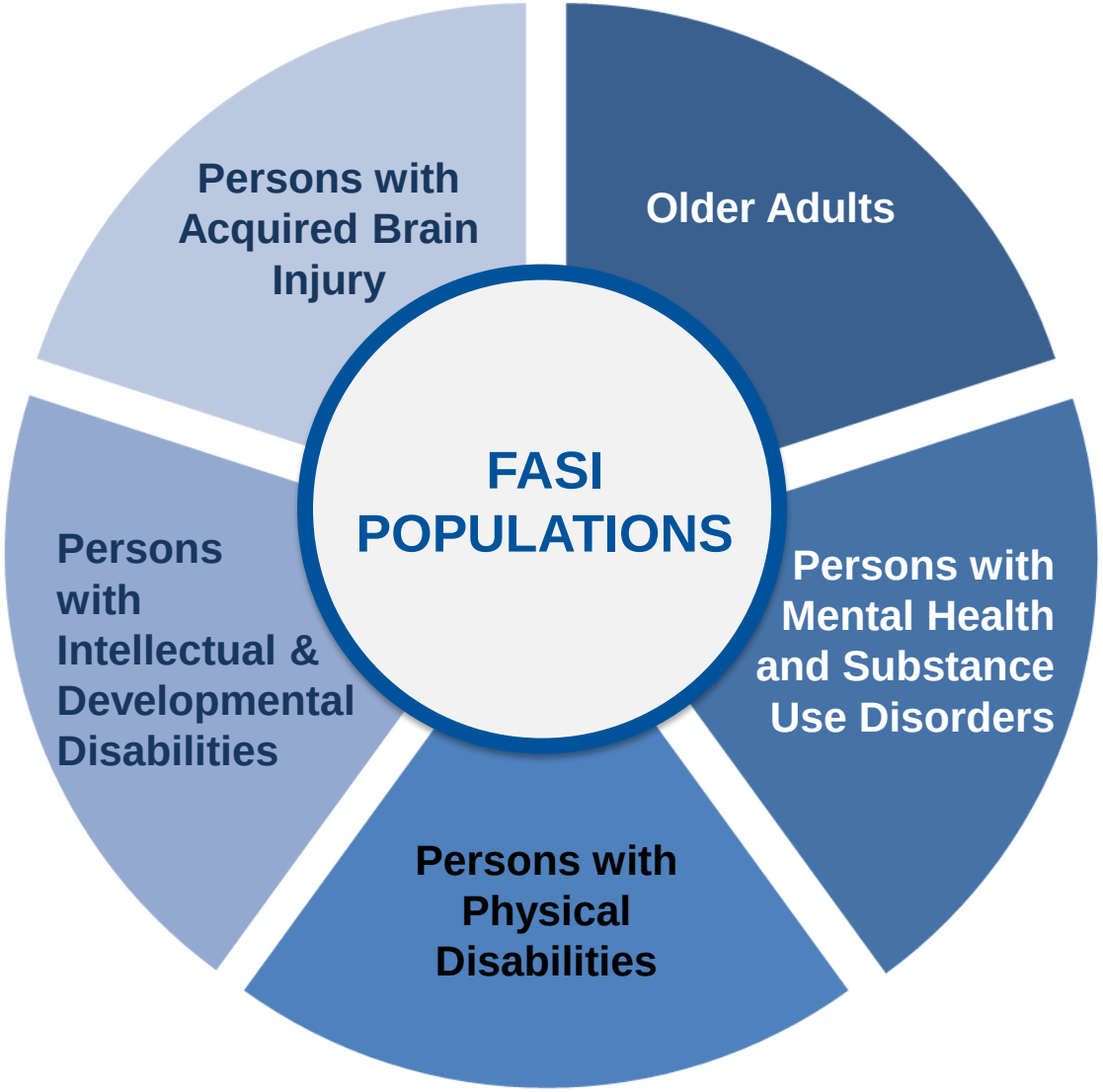


Identifies personal priorities for functioning

Assesses for functional status and need for assistance in daily activities

Adapted from Looking Forward: HCBS Quality Measures Alignment and HCBS CAHPS, CMS, Center for Clinical Standards and Quality

FASI Populations



Adapted from FASI Final Report

FASI Domains and Data Element Codes

Data Element Code	Domain
GG0130	Self-Care (e.g., Eating, Bathing, Dressing)
GG0170-0175	Mobility (e.g., Positioning, Transfers, Ambulation, Wheeling)
GG0185	Instrumental Activities of Daily Living (IADLs) (e.g., Meal Preparation, Shopping)
GG0125	Assistive Devices for Everyday Activities
F0900-0920	Living Arrangements, Availability of Assistance, Availability of Paid and Unpaid Assistance
GG0135, GG0180, GG0190, FO910, F0925	Personal Priorities

FASI Rating Scale

- FASI includes a standardized rating scale across all Self-Care, Mobility, and IADL Domains.
- Scale options range from Independent to Dependent and are similar to rating scales used across functional assessments used by most states
- Responses are based upon Usual and Most Dependent performance

Performance Level (Enter Codes in Boxes)	
7. Usual	8. Most Dependent

Coding Safety and Quality of Performance: If helper assistance is required because person's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.*

06. **Independent** - Person completes the activity by him/herself with no assistance from a helper.
05. **Setup or cleanup assistance** - Helper sets up or cleans up; person completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as person completes activity. Assistance may be provided throughout the activity or intermittently.
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.
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.
01. **Dependent** - Helper does ALL of the effort. Person does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the person to complete the activity.

Personal Priorities

- Open-ended response opportunity at the end of a section for individuals to list their top two priorities for the next 6 months
- Asked at the end of:
  - Self-Care
  - Mobility
  - IADL
  - Living Arrangements
  - Paid and Unpaid Assistance

GG0135. Self-Care Priorities:

Please ask the person to describe at least one or two personal priorities in the area of self-care for the next six months. If the person does not express any personal priorities in this area, please note this below.

A. *I want to eat with a fork, without assistance after food is put on the table.*

B. *I want to be able to go to the bathroom without help.*

Value of Using FASI

Heather Johnson, The Lewin Group

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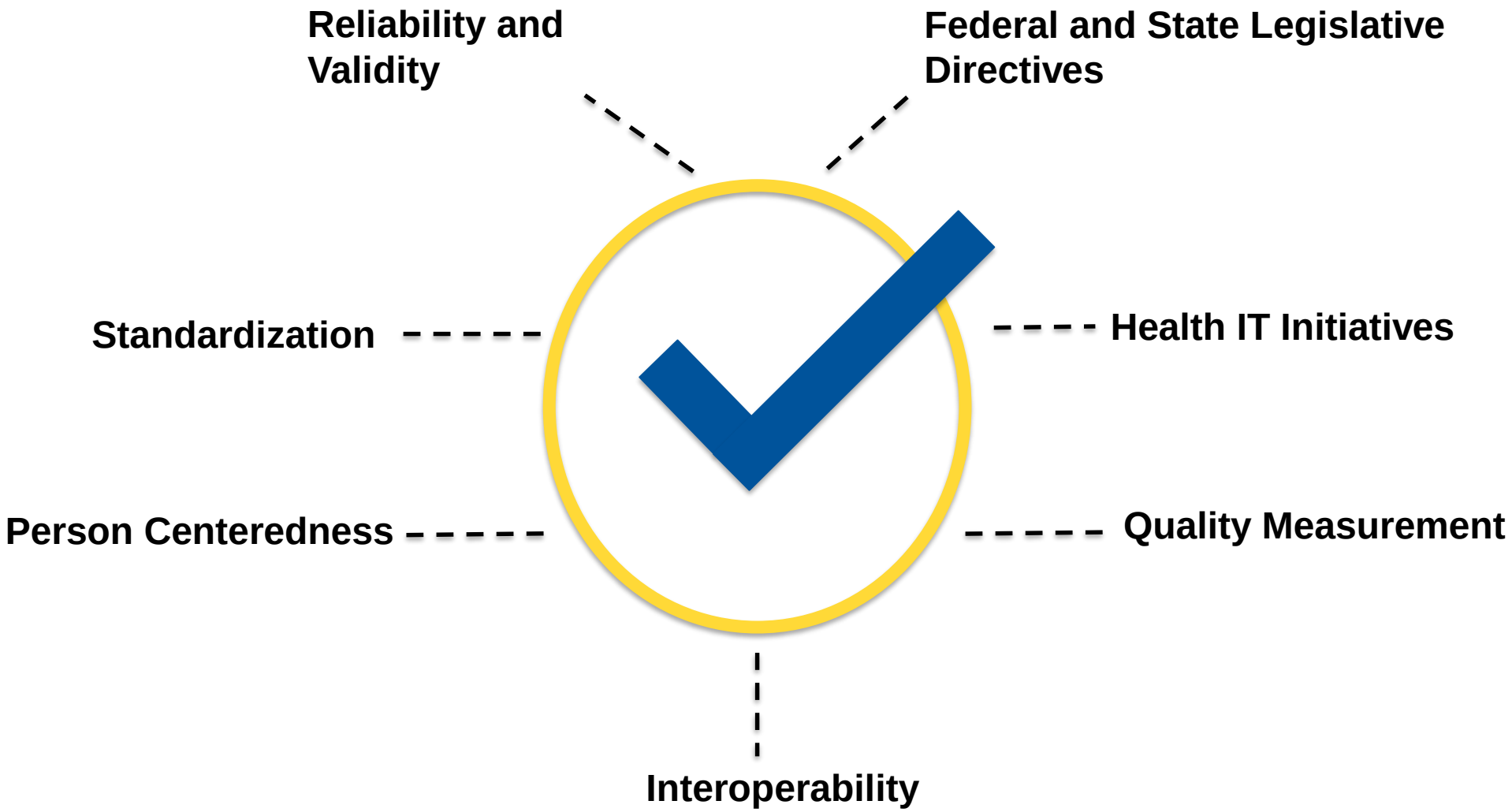
Selection of FASI: Key Considerations



How Can States and Managed Care Plans Use FASI?

Assist in determining eligibility for Medicaid HCBS programs

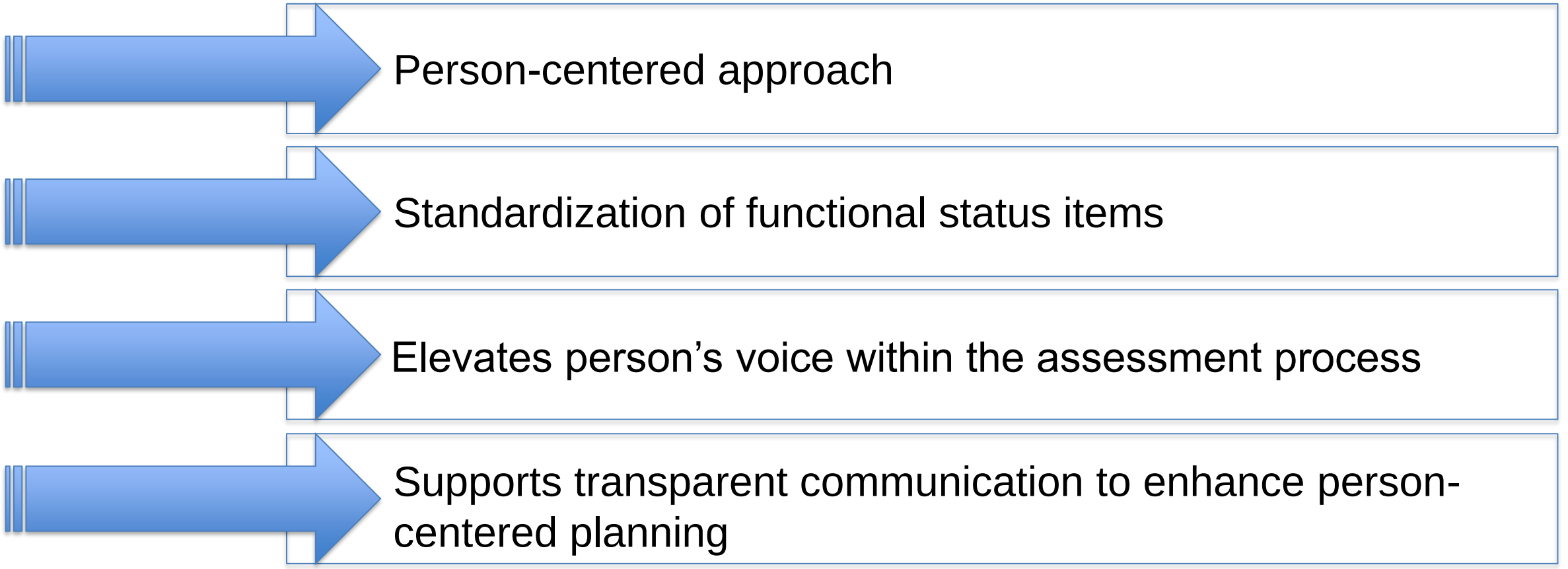
Assist in developing person-centered service plans

Monitor quality and measure program impact

Report across multiple programs within a state

Stakeholder Engagement: Build Value Propositions

- Stakeholders use, interact with, and benefit from functional assessments in different ways and for different reasons
- Stakeholders have different perspectives about maintaining and changing current state assessment practices.



FASI Performance Measures

Measures the percentage of home and community-based (HCBS) recipients **aged 18 and over** who have **documented needs determined by FASI…**

Newly Endorsed NQF 3593: Identifying Personal Priorities for FASI

AND who have **identified at least as many total personal priorities (up to 3)** as needs in the areas of Self-Care, Mobility, or Instrumental Activities of Daily Living (IADL)as determined by their most recent FASI assessment.

Alignment of services with needs

AND documentation of a **comprehensive person-centered service plan** that **addressed identified functional needs** within the reporting period.

Alignment of person-centered service plans with functional needs

To locate measure, visit the NQF website: https://www.qualityforum.org/Home.aspx

NQF 3593 Quality Measure: Why It Is Important

- The endorsement of NQF 3593 demonstrates a thorough and successful examination of the measure's reliability, validity, and importance.
- In 2020, NQF's Person-Centered Planning and Practice Committee released a report with a framework for quality measurement related to person-centered planning, especially for those in HCBS settings.
- This report specifically recognizes the FASI item set as one of the few person-centered assessments available and calls for quality measures that ensure that individuals' needs, and priorities are appropriately assessed and documented within the individuals' service plan.

States and managed care plans can incorporate the FASI set into Medicaid HCBS assessments and use the information for developing person-centered service plans that specify the type and level of services and supports necessary to meet those needs.

Oregon’s Use of FASI

Fred Jabin, representing Oregon Office of Developmental Disability Services

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WHY WAS THE OREGON NEEDS ASSESSMENT (ONA) DEVELOPED?

- **CMS required that everyone receiving I/DD services receive an annual functional needs assessment**

- **Oregon legislature required that ODDS (Oregon Developmental Disabilities Services) use a single assessment tool for all services**

CURRENT ASSESSMENT TOOLS

Supports Intensity Scale (SIS)

– Used for group homes, vocational services

Support Needs Assessment Profile (SNAP)

– Used for Foster care homes

Adult Needs Assessment (ANA)

– Used for adult's in-home services

Child's Needs Assessment (CNA)

– Used for children's in-home services

STAKEHOLDER INPUT

Stakeholders did a national search and narrowed it to four assessment tools:

- **But eventually rejected all the tools**

- **ODDS decided to adapt the Adult Needs Assessment/Children's Needs Assessment (ANA/CNA) to be used for all service elements**

BACK TO THE DRAWING BOARD

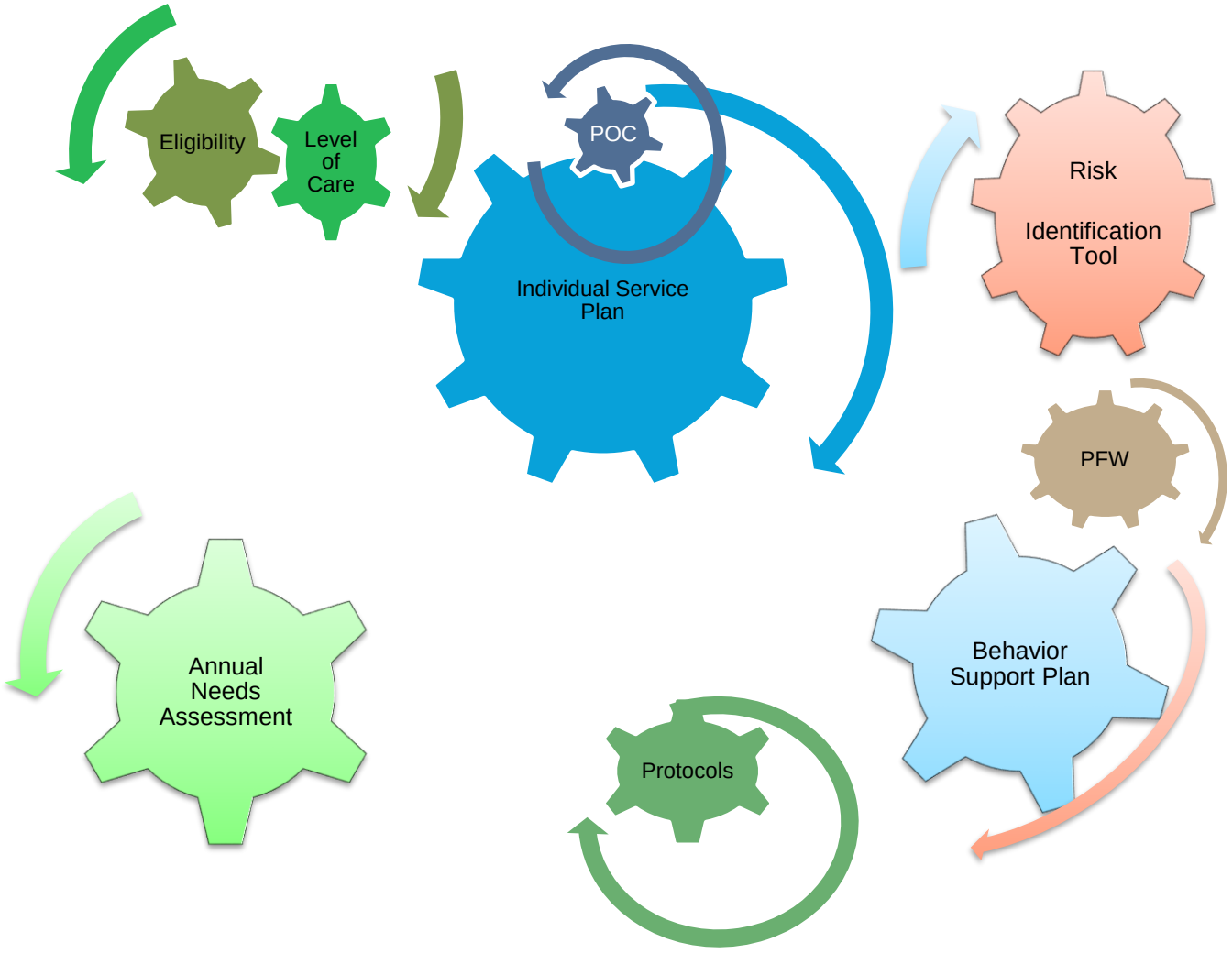
- **ODDS determined that it would adapt the ANA/CNA tools to be used for all the service elements**

ANA/CNA NEEDED REVISIONS

- **ODDS knew that there were some items in the ANA/CNA that weren’t reliable or valid**

- **ODDS held focus groups around the state to determine what stakeholders wanted changed in the ANA/CNA**

CONSUMER VIEW



TOP REQUESTS FOR THE ASSESSMENT PROCESS

1. **Avoid Duplication**
2. **Get rid of repetitive answers**
3. **Don’t make us do the same thing over and over again**
4. **No need to reproduce similar responses**
5. **Remove repetition**
6. **Take out redundancy**
7. **Reiteration isn’t necessary**

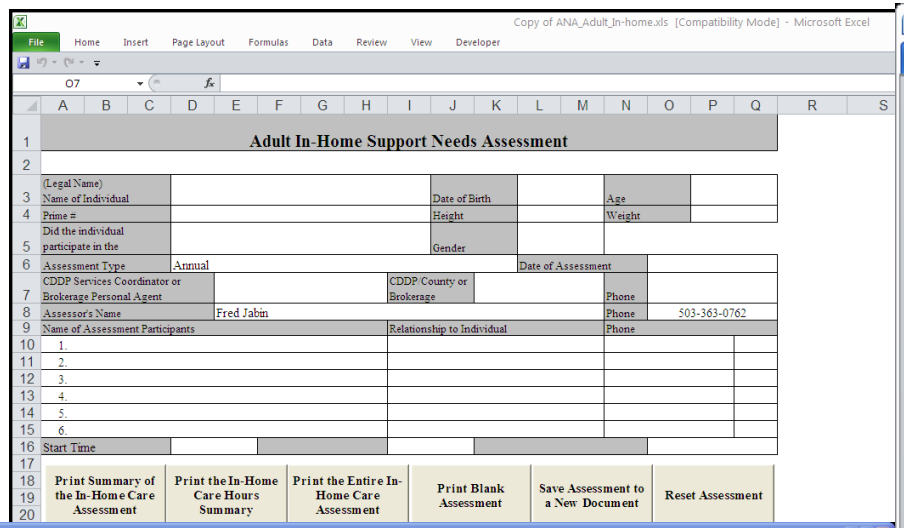
COMMON ISSUES AND CONCERNS

- **Person Centered**
- **Avoid Duplication**
- **Simple to Use/Easy to Understand**
- **Covers the Needs**
- **Useful to Service Planning**
- **Meets State and Federal Requirements**

HOPEFUL GOALS

- **Free up time for Services Coordinators and Personal Agents.**
- **Less Probing of individual who receive services**
- **More accurate capturing of support needs**
- **Smoother more streamlined process**

THREE TOOLS

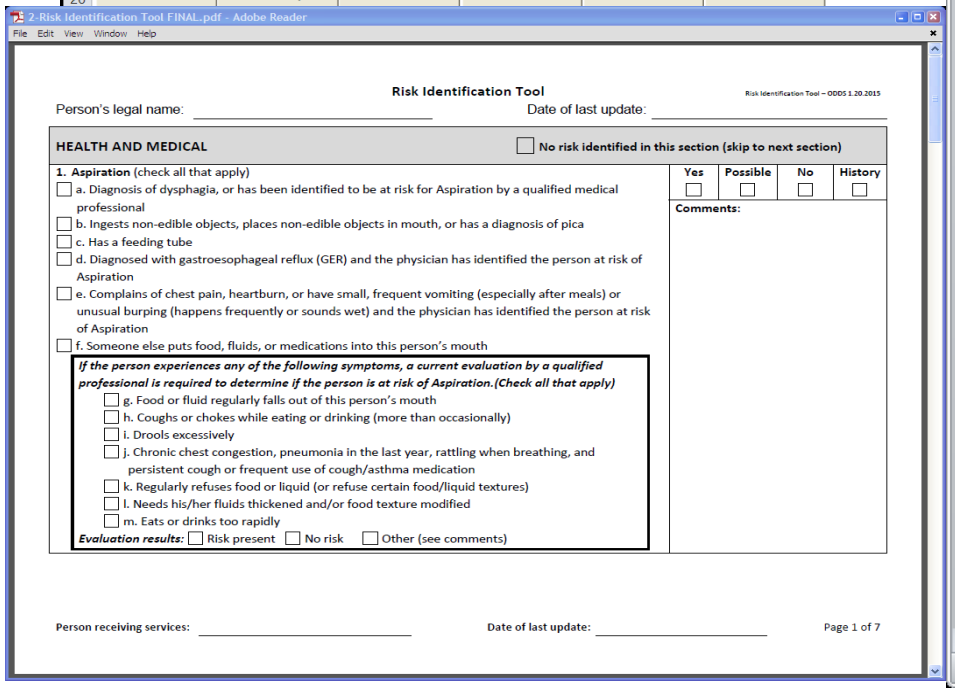


Copy of ANA_Adult_In-home.xls [Compatibility Mode] - Microsoft Excel

Adult In-Home Support Needs Assessment

(Legal Name) Name of Individual	Date of Birth / Age
Prime #	Height / Weight
Did the individual participate in the	Gender
Assessment Type: Annual	Date of Assessment
CDDP Services Coordinator or Brokerage Personal Agent	CDDP County or Brokerage / Phone
Assessor's Name: Fred Jabin	Phone: 503-363-0762
Name of Assessment Participants	Relationship to Individual / Phone
1.	
2.	
3.	
4.	
5.	
6.	
Start Time	

Print Summary of the In-Home Care Assessment | Print the In-Home Care Hours Summary | Print the Entire In-Home Care Assessment | Print Blank Assessment | Save Assessment to a New Document | Reset Assessment



2-Risk Identification Tool FINAL.pdf - Adobe Reader

Risk Identification Tool

Person's legal name: _____ Date of last update: _____

HEALTH AND MEDICAL ☐ No risk identified in this section (skip to next section)

1. Aspiration (check all that apply)	Yes	Possible	No	History
☐ a. Diagnosis of dysphagia, or has been identified to be at risk for Aspiration by a qualified medical professional				
☐ b. Ingests non-edible objects, places non-edible objects in mouth, or has a diagnosis of pica				
☐ c. Has a feeding tube				
☐ d. Diagnosed with gastroesophageal reflux (GER) and the physician has identified the person at risk of Aspiration				
☐ e. Complains of chest pain, heartburn, or have small, frequent vomiting (especially after meals) or unusual burping (happens frequently or sounds wet) and the physician has identified the person at risk of Aspiration				
☐ f. Someone else puts food, fluids, or medications into this person's mouth				

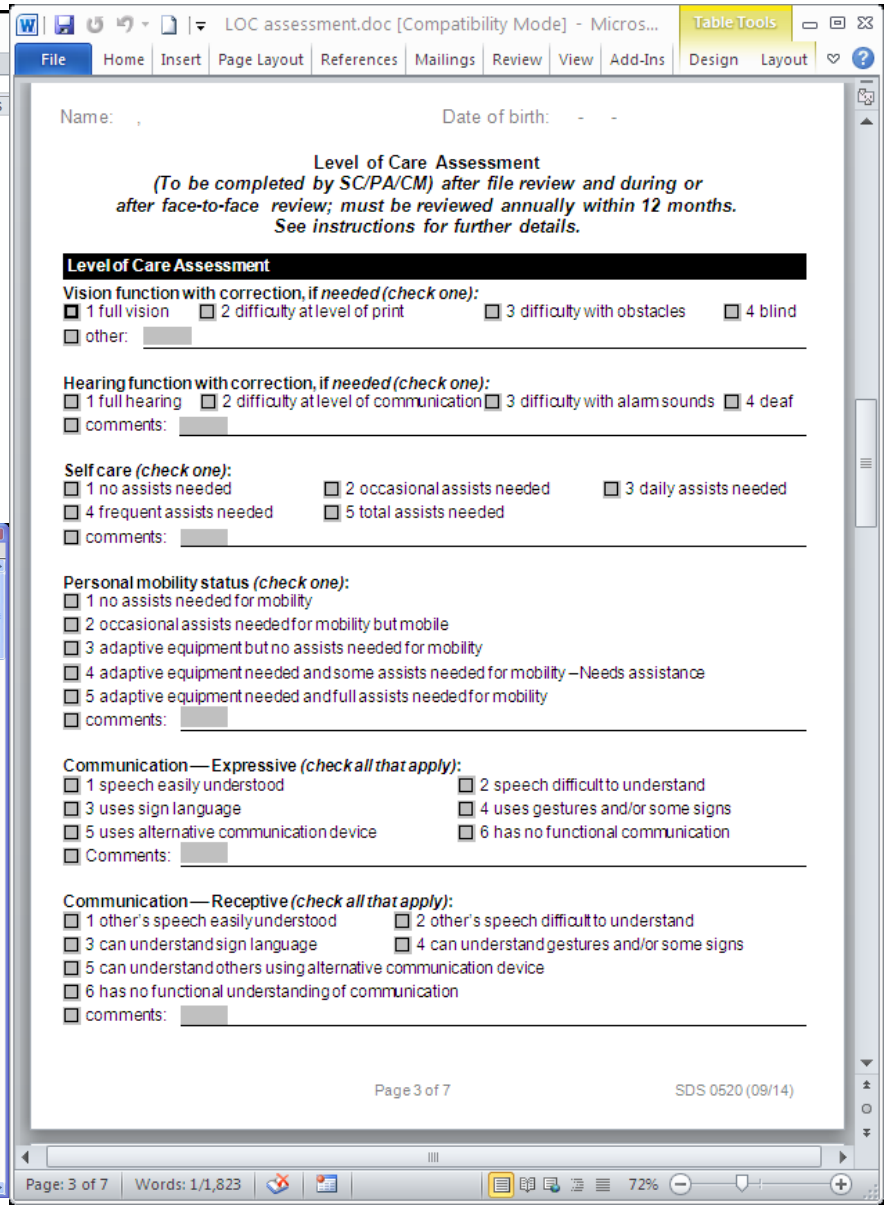
Comments:

If the person experiences any of the following symptoms, a current evaluation by a qualified professional is required to determine if the person is at risk of Aspiration.(Check all that apply)

- ☐ g. Food or fluid regularly falls out of this person's mouth
- ☐ h. Coughs or chokes while eating or drinking (more than occasionally)
- ☐ i. Drools excessively
- ☐ j. Chronic chest congestion, pneumonia in the last year, rattling when breathing, and persistent cough or frequent use of cough/asthma medication
- ☐ k. Regularly refuses food or liquid (or refuse certain food/liquid textures)
- ☐ l. Needs his/her fluids thickened and/or food texture modified
- ☐ m. Eats or drinks too rapidly

Evaluation results: ☐ Risk present ☐ No risk ☐ Other (see comments)

Person receiving services: _____ Date of last update: _____ Page 1 of 7



LOC assessment.doc [Compatibility Mode] - Micros...

Name: , Date of birth: - -

Level of Care Assessment

(To be completed by SC/PA/CM) after file review and during or after face-to-face review; must be reviewed annually within 12 months. See instructions for further details.

Level of Care Assessment

Vision function with correction, if *needed (check one)*:
☐ 1 full vision ☐ 2 difficulty at level of print ☐ 3 difficulty with obstacles ☐ 4 blind
☐ other: _____

Hearing function with correction, if *needed (check one)*:
☐ 1 full hearing ☐ 2 difficulty at level of communication ☐ 3 difficulty with alarm sounds ☐ 4 deaf
☐ comments: _____

Self care *(check one)*:
☐ 1 no assists needed ☐ 2 occasional assists needed ☐ 3 daily assists needed
☐ 4 frequent assists needed ☐ 5 total assists needed
☐ comments: _____

Personal mobility status *(check one)*:
☐ 1 no assists needed for mobility
☐ 2 occasional assists needed for mobility but mobile
☐ 3 adaptive equipment but no assists needed for mobility
☐ 4 adaptive equipment needed and some assists needed for mobility –Needs assistance
☐ 5 adaptive equipment needed and full assists needed for mobility
☐ comments: _____

Communication — Expressive *(check all that apply)*:
☐ 1 speech easily understood ☐ 2 speech difficult to understand
☐ 3 uses sign language ☐ 4 uses gestures and/or some signs
☐ 5 uses alternative communication device ☐ 6 has no functional communication
☐ Comments: _____

Communication — Receptive *(check all that apply)*:
☐ 1 other's speech easily understood ☐ 2 other's speech difficult to understand
☐ 3 can understand sign language ☐ 4 can understand gestures and/or some signs
☐ 5 can understand others using alternative communication device
☐ 6 has no functional understanding of communication
☐ comments: _____

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Page: 3 of 7 | Words: 1/1,823 | 72%

SIDE BY SIDE COMPARISON

Risk Identification Tool	Adult Needs Assessment	Level Of Care
Enters into contracts that he/she may not be able to complete	Shopping and Money management	Independently manages finances to ensure basic necessities are met?
Unsafe medication management	Medication Management Supports	Medical management
Significant risk of exploitation	Safety	Will take action to protect self from threatening acts or gestures?
Self-Injury	Behavior Supports -- Formal Plan	Observed behavior support needs

NEXT STEPS

- **Combined all items into one large spreadsheet.**
- **Returned to stakeholders for additional input**

“It is too long, and you missed _____

And you should add it”

RELIABILITY AND VALIDITY TESTING

- **ODDS contracted with Mission Analytics**
- **MA determined that many of the items were unlikely to meet reliability and validity the way they were written**
- **Suggested using FASI items that had similar intent when available and used items from other tools if there weren't FASI items**

STAKEHOLDER REVIEW

- **Stakeholders didn’t think the 3-day look back was a good fit for our services**

- **Items were changed to consider supports needed over the previous 30 days**

THREE COMPONENTS

1. **Documentation review**
2. **Face-to-face observation of the individual**
3. **Interview with individual and those they invite**

PILOTING THE ONA

- **ONA was tested using Inter-rater reliability**
- **Focus groups of ONA participants were interviewed and items cut**

FASI ITEMS USED

Eating Oral Hygiene Toileting Hygiene Shower/Bath Self Upper Body Dressing Lower Body Dressing Putting on/Taking off Roll Left to Right Sit to Stand Chair/Bed to Chair Transfer Toilet Transfer Car Transfer	Does the person walk? Walks 150 feet 1 step curb 12 steps Wheels 150 feet Light Shopping Medication mgmt. oral Medication mgmt. inhalant Medication mgmt. injectable	*Adapted items from FASI* Does the person use a W/C? Makes a light meal? Housework? Money management?

TRAINING

- **ONA assessors attend a 2-day training to receive a certification to conduct ONAs.**
- **ONA assessors are also required to attend quarterly trainings (usually 4 hours) that address changes, error trends, and facilitation techniques.**
- **ONA assessors have a monthly call ins to address additional issues and ask questions**
- **ONA assessors are assigned a Quality Assurance & Training (QAT) staff who can help them with difficult coding decisions.**

QUALITY ASSURANCE

- **Assessments are processed through a “flagging tool” that flags items that show possible inconsistencies in the ONA.**
  QATs review flagged ONAs and make recommendations about needed changes to assessors.

- **Assessors will be required to have a QAT review them conducting an ONA annually and will receive a certification to continue conducting ONAs if they meet coding requirements.**

SERVICE GROUPS

Adult 18+	Adolescent 12 – 17	Child 4 – 11	Infant/Toddler 0 - 3
1 Very low	1 Very Low	3 Very Low to Low	5 5(b) Infant/Toddler Supports 5(m)
2 Low	2 Low	4 Moderate	
3 Moderate	3 Moderate		
4 High	4 High	5 5(b) High to Very High 5(m)	
5 5(b) Very High 5(m)	5 5(b) Very High 5(m)		

EXCEPTIONS

An exception process is available for those whose Service Group does not meet their support needs.

AUTOMATED SYSTEM

LESSONS LEARNED

- **It is very difficult to find objective criteria to determine support needs for human beings with diverse issues in a person-centered manner**
- **Flexibility and the ability to use professional judgment for outliers is key**
- **The funding algorithm should be considered at the same time the items and coding are chosen**
- **Don’t have an international pandemic during the final steps of implementation**

For further information about Oregon’s ongoing FASI use, please contact Chelas Kronenberg, Office of Developmental Disabilities Services.

Colorado’s Use of FASI

Michelle Topkoff, Colorado Department of Health Care Policy & Financing

Current Assessment Tools

The current tools used to assess LTSS populations include:

ULTC 100.2	**Home-grown tool**
Supports Intensity Scale (SIS) for I/DD Populations	**Standardized, nationally used tool**
Supplemental tools	**Over 30 supplemental tools created by Department and local staff to support access processes**

Assessment and access processes vary significantly across populations and programs

Limitations to Legacy Tools

ULTC 100.2

- No set timeframes (e.g., in last 30 days)
- Definitions and responses are vague and overlapping
- Collects very little information outside of ADLs
- Limited use when developing support plan

SIS

- Requires agency staff to be specially trained on tool and pay for training/tool
- Some stakeholders unhappy with the use of the SIS: length of time to complete; concerns that it doesn't capture enough information; concerns about the use for development of Support Levels

Limitations to Legacy Tools (cont.)

Local agencies have developed 30+ non-standardized tools to collect missing information from legacy tools

Other issues with tools include:

- ☒ No person-centered information
- ☒ No natural support and caregiver information
- ☒ No screen of other areas of interest/need (e.g., employment, self-direction)
- ☒ Very limited information that is useful for support planning

Stakeholder Input into the Development of the Process

Stakeholder input during development of the intake and assessment tools included:

Input from community members and staff from over

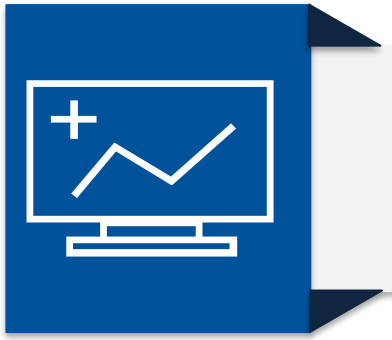
15 agencies

8 stakeholder meetings
on child assessment tool

21 stakeholder meetings
on adult assessment tool

Stakeholder Input into the Development of the Process (cont.)

Developed a blog to share information and collect feedback: [Colorado Assessment Blog]



Made major changes to the modules and process as a result of stakeholder input

Now conducting meetings throughout state to share progress and gather feedback

Colorado Crosswalk of LTSS Assessment Tools

Crosswalk of LTSS Assessment Tools by Purposes of Tools Endorsed by Stakeholders and States

		interRAI	CARE	WI	MN	WA	MA	SIS	ICAP
Driving Systems Change	Person-Centered	Could Add	Could Add	Could Add	Included	Could Add	Could Add	Limited	Limited
	Self-Direction	Could Add	Could Add	Could Add	Included	Could Add	Could Add	Limited	Limited
	Coordination w/ medical services	Yes	Facilitates	Facilitates	Facilitates	Facilitates	Facilitates	Limited	Limited
	Employment	Could Add	Could Add	3 items	Included	Could Add	Included	No	No
Determining Eligibility for Different Populations	EBD	Yes	Developing	Yes	Yes	Yes	Yes	No	No
	Mental Health	Yes	Developing	Yes	Yes	No	Yes	No	No
	IDD	Yes	Developing	Yes	Yes	No	No	Yes	Yes
	Brain Injury	Yes	Developing	Yes	Yes	Yes	Yes	No	No
	Spinal Cord Injury	Yes	Developing	Yes	Yes	Yes	Yes	No	No
	Children	Yes	No Plans	Yes	Yes	No	No	No	No
Resource Allocation	EBD	Existing	Could Develop	State-specific	State-specific	State-specific	State-specific	No	No
	Mental Health	Developing	Could Develop	State-specific	State-specific	State-specific	State-specific	No	No
	IDD	Existing	Could Develop	State-specific	State-specific	No	No	State-specific	State-specific
	Brain Injury	Existing	Could Develop	State-specific	State-specific	State-specific	State-specific	No	No
	Spinal Cord Injury	Existing	Could Develop	State-specific	State-specific	State-specific	State-specific	No	No
	Children	Developing	No	State-specific	State-specific	No	No	No	No
Opera-tions	Intake & Triage tools	Existing	Could Develop	Could Develop	State-specific	State-specific	State-specific	No	No
	Support Planning Tools	Existing	Could Develop	Could Develop	State-specific	State-specific	State-specific	Yes	Yes
Quality	Clinical/Functional Issues	Existing	Yes	State-specific	Could Develop	Yes	Could Develop	No	No
	Quality of Live/ Participant Experience	Could Add	Developing	Could Add	State-specific	Could Add	Could Add	Could Develop	Could Develop
	Empirically Validated	Yes	Yes	Yes	No	Yes	MDS portion	Yes	Yes
	Used in other States	Multiple	No	1 State	1 State	1 State	1 State	Multiple	Multiple
	CMS Endorsed	No	Yes	No	No	No	No	No	No

Tools Selected as Starting Point for the Assessment Process

After careful review, Department and stakeholders decided to use components of the following tools:

CMS' CARE tool (Later changed to FASI)

- Standardized items throughout the tool (e.g., functioning, health)

Minnesota's MnCHOICES comprehensive assessment

- Modular format would serve as basis for CO process
- Person-centered items and modules (e.g., Personal Story)
- Items CARE/FASI did not contain (e.g., Psychosocial/Behaviors)

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Approach for Developing the New Assessment Process

- **Understand** current LTSS assessment process
- **Identify** how processes can be improved (redesign goals and outcomes)
- **Identify** existing tools to be included in the new assessment process
- **Customize** the tools to meet Colorado's needs
- **Pilots** for components of the process
- **Adapt** process for children
- **Develop** plans for Person-centered Support Plan, automation, full-scale testing, and statewide implementation

Other LTSS Systems Changes New Assessment Process will Support

- More **person-centered system**
- More **informed choice** about self-direction
- **Restructuring case management** including being able to tailor amount and type to participant preferences and needs
- Foster **competitive employment**
- **Support** emerging separation of eligibility assessment vs. support planning and ongoing case management

Other LTSS Systems Changes New Assessment will Support (cont.)

- Objective and empirically-based **person-centered budgets**

  Give people more choice and control over services

  Allows expansion of consumer-directed principles to other services

- Enhance **quality management efforts**, including quality of life/participant experience data

Project Status Update

New Assessment and Person-Centered Support Plan is finalized

Designing and developing the IT system automation of the assessment instruments and process

Following GO LIVE of system/assessments, will finalize person-centered budget algorithm using assessment data

Standardized data will inform performance measures and quality improvement strategies

CMS Data Element Library and LOINC

Lorraine Wickiser, CMS

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Interoperability: Different Lenses, Shared Goals

Individuals should have the ability to move from payer to payer, provider to provider, and have both their clinical and administrative information travel with them throughout their journey.
- CMS Interoperability and Patient Access Final Rule

Individuals, their families and health care providers should be able to send, receive, find and use electronic health information in a manner that is appropriate, secure, timely and reliable to support the health and wellness of individuals through informed, shared decision-making.
- ONC Shared Nationwide Interoperability Roadmap, Version 1

The ability of two or more systems or components to exchange information and to use the information to make better decisions.
- Administration for Children and Families (ACF)

Source: CMS InCK Model Informational Webinar on Interoperability, July 28, 2020 and CMS Interoperability and Patient Access Final Rule

FASI Implementation: CMS Data Element Library and Interoperability

FASI is included in several current interoperability initiatives:

- CMS Data Element Library (DEL), which serves as a repository of data elements used in CMS Assessment Instruments and their associated health IT standards.

- Logical Observation Identifiers Names and Codes (LOINC), a clinical terminology standard that provides a set of universal codes and structured names to unambiguously identify things you can observe and measure.

- PACIO-eLTSS-PAC Transition Summary Use Cases

Adapted from FASI Final Report

DEL 101: What is the CMS Data Element Library?

- The CMS DEL is the centralized resource for CMS assessment instrument data elements (e.g., questions and responses) and their associated health information technology (IT) standards.
- The purpose of the DEL is to:
  - Promote interoperable health information exchange,
  - Support “Participants over Paperwork”, and
  - Assist with standardization of assessment data elements to help facilitate care coordination.
- The DEL includes CMS assessment instruments across multiple care settings.
- The DEL does not contain personal health information (PHI).

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

Source: CMS website: https://del.cms.gov/DELWeb/pubHome

What are the Goals of the DEL?

- Supports provider exchange of electronic health information for better care coordination to facilitate real-time, data driven, clinical decision making.
- Enables more seamless/less costly health information exchange.
- Reduces overall provider burden through use and exchange of health care data.
- Promotes high quality, personalized, efficient health care.
- Maintains consistency in format, meaning, and use of Assessment Instrument data element.
- Allows for access to and enables reuse and exchange of data elements.

Source: CMS Data Element Library HCBS Conference Presentation

LOINC 101: What are LOINC Codes?

- LOINC is the universal standardized language for identifying clinical tests and observations, for example, laboratory tests or vital signs.
- It is a common language for identifying health measures, observations and documents.
- LOINC codes represent the “question” for a test or measurement (in this case, FASI questions) and the person specific input represents the answer, or from FASI response scales (e.g., independent, partial/moderate assistance)

Source: LOINC home website: https://loinc.org/get-started/what-loinc-is/

Post Acute Care Interoperability (PACIO) Project

The PACIO Project is a collaborative effort to:

- Advance interoperable health data exchange between post-acute care (PAC) and other providers, participants, and key stakeholders
- Promote health data exchange in collaboration with policy makers, standards organizations, and industry through a consensus-based approach.
- http://pacioproject.org

Source: Adapted from - Advancing Interoperability: Supporting Electronic Data Exchange Between PAC and Other Providers Using FHIR February 27, 2020
https://confluence.hl7.org/download/attachments/86977192/2020-02-24%202020%20DEL-PACIO%20QualConference%20Slides_FINAL_v2%202017%20data.pdf?version=1&modificationDate=1596121191018&api=v2

Helpful Resources and Technical Assistance Opportunities

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Helpful Websites

FASI Version 1.1. Please email the HCBS Measures Inbox at HCBSMeasures@Lewin.com for a copy of the FASI Template V1.1.

CMS Data Element Library: https://del.cms.gov/DELWeb/pubHome

LOINC FASI Codes: https://loinc.org/94848-9/

Post-Acute Care Interoperability Project (PACIO): https://confluence.hl7.org/display/PC/PACIO+Project+Functional+Status

CMS Testing Experience & Functional Tools (TEFT) Demonstration Reports: https://www.medicaid.gov/medicaid/long-term-services-supports/testing-experience-functional-tools/index.html

ONC Interoperability Roadmap Final Version 1.0: https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf

Technical Assistance Available

FASI technical assistance is available free from the Lewin Group for interested state and local agencies and managed care plans, including:

- One-on-one assistance with planning, analysis, and using FASI performance measures to inform quality improvement activities
- FASI Early Adoption Work Group
- Contact hcbsmeasures@lewin.com for more information or to request TA

Thank You