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Proposed Specifications for IRF QRP Quality Measures and Standardized Patient Assessment Data Elements (SPADEs)

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Chapter 1 IMPACT ACT Measures Beginning with the FY 2022 IRF QRP

Section 1. Cross-Setting Measures Development Work: An Introduction

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), enacted October 6, 2014, directs the Secretary of Health and Human Services to “specify quality measures on which Post-Acute Care (PAC) providers are required under the applicable reporting provisions to submit standardized patient assessment data” in several quality measure domains including incidence of major falls, skin integrity and changes in skin integrity, medication reconciliation, functional status, transfer of health information and care preferences when an individual transitions, and resource use and other measures. The IMPACT Act requires the implementation of quality measures to address these measure domains in Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs).

The IMPACT Act also requires, to the extent possible, the submission of such quality measure data through the use of a PAC assessment instrument and the modification of such instrument as necessary to enable such use. This requirement refers to the collection of such data by means of the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for IRFs, LTCH Continuity Assessment Record and Evaluation Data Set (LTCH CARE Data Set or LCDS) for LTCHs, the Minimum Data Set (MDS) 3.0 for SNFs, the and the Outcome and Assessment Information Set (OASIS-D) for HHAs.

For more information on the statutory history of the IRF, LTCH, or SNF QRP, please refer to the FY 2015 final rules and for the HHA QRP, please refer to the CY 2016 final rules. More information on the IMPACT Act is available at <https://www.govtrack.us/congress/bills/113/hr4994>.

In this document, we present specifications for the standardized patient assessment data elements (SPADEs) and the following (2) measures proposed for adoption for the IRF QRP through the FY 2020 IRF PPS proposed rule:

The Transfer of Health Information measure concept consists of two companion measures:

1. Transfer of Health Information to the Provider–Post-Acute Care Measure
2. Transfer of Health Information to the Patient–Post-Acute Care Measure

We also provide updated specifications for the previously adopted Discharge to Community measure.

Section 2. Cross-Setting Proposed Measure: Transfer of Health Information to the Provider–Post-Acute Care Measure

Measure Description

The proposed measure, the Transfer of Health Information to the Provider, assesses for the timely transfer of health information, specifically a reconciled medication list. This measure evaluates for the transfer of information when a patient is transferred or discharged from their current setting to a subsequent provider. For this proposed measure, the subsequent provider is defined as a short-term general hospital, a SNF, intermediate care, home under care of an organized home health service organization or hospice, hospice in an institutional facility, an IRF, an LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a critical access hospital.

This proposed measure, developed under the intent of the IMPACT Act, has been developed conceptually as a standardized measure for the IRF, LTCH, SNF, and HHA settings. This proposed measure is calculated by one standardized data element that asks at the time of discharge, did the facility provide the patient’s current reconciled medication list to the subsequent provider. It also includes one data element that asks the route of transmission of the reconciled medication list (Appendix A). In order to track discharge to a subsequent provider, the IRF-PAI will be used to track discharge location status. Guidance for what is considered a reconciled medication list is discussed in greater detail in the section below. The measure is conceptualized uniformly across the PAC settings. The measure is calculated using data from the IRF-PAI for IRF patients, the LCDS for LTCH patients, the MDS 3.0 assessment instrument for SNF residents, and the OASIS-D for HHA patients. Data are collected and calculated separately in each of the four settings using standardized data elements. The collection of this measure and the components tied to the standardized data element used to calculate this measure are described in Chapter 1, Section 1.

The Reconciled Medication List

This proposed measure evaluates if information was sent to the subsequent provider upon a PAC discharge. Information, in this instance, is a reconciled medication list. To guide data collection efforts, CMS outlines a general overview of what could be included in a reconciled medication list, but this is not exhaustive of all information that could be transferred. We would like to stress that this information is for guidance purposes only and is not a requirement for the types of information to be included in a PAC provider’s reconciled medication list in order to meet the Transfer of Health Information to the Provider–Post-Acute Care measure criteria. While the information for reconciled medication lists is guidance, we anticipate that the timely transfer of medication information should drive safer care coordination.

For the purpose of providing guidance for this measure, a reconciled medication list is a list of the current prescribed and over the counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route to the patient/resident at the time of discharge or transfer. Medications may also include but are not limited to total parenteral nutrition (TPN) and oxygen. The current medications should include those that are: 1) active, including those that will be discontinued after discharge; and 2) those held during the stay and planned to be continued/resumed after discharge. If deemed relevant to the patient’s/resident’s care by the subsequent provider, medications discontinued during the stay may be included.

A reconciled medication list often includes important information about: 1) the patient/resident - including their name, date of birth, information, active diagnoses, known medication and other allergies, and known drug sensitivities and reactions; and 2) each medication, including the name, strength, dose, route of medication administration, frequency or timing, purpose/indication, any special instructions (e.g., crush medications), and, for any held medications, the reason for holding the medication and when medication should resume. This information can improve medication safety. Additional information may be applicable and important to include in the medication list such as the patient’s/resident’s weight and

date taken, height and date taken, patient's preferred language, patient's ability to self-administer medication, when the last dose of the medication was administered by the discharging/transferring provider, and when the final dose should be administered (e.g., end of treatment).

Documentation sources for reconciled medication list information include electronic and/or paper records, including discharge summary records, a Medication Administration Record (MAR), Intravenous Medication Administration Record (IVAR), home medication list, and physician orders.

The guidance given with respect to what is incorporated in a reconciled medication list is aligned to the provisions in the proposed Discharge Planning for Hospitals, Critical Access Hospital, and Home Health Agencies regulation, which outlines discharge planning and the documentation of medications (please see: <https://www.federalregister.gov/documents/2015/11/03/2015-27840/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals>). In addition, this guidance follows the requirements finalized in the Reform of Requirements for Long-Term Care Facilities (please see: <https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>).

Purpose/Rationale for the Quality Measure

In 2013, 22.3 percent of all acute hospital discharges were discharged to PAC settings, including 11 percent who were discharged to home under the care of a home health agency, and 9 percent who were discharged to SNFs.¹ The proportion of patients being discharged from an acute care hospital to a PAC setting was greater among beneficiaries enrolled in fee-for-service (FFS) Medicare. Among FFS patients discharged from an acute hospital, 42 percent went directly to PAC settings. Of that percent, 20 percent were discharged to a SNF, 18 percent were discharged to a Home Health Agency (HHA), three percent were discharged to an IRF, and one percent were discharged to an LTCH.² Of the Medicare FFS beneficiaries with an IRF stay in FYs 2016 and 2017, an estimated 10 percent were discharged or transferred to an acute care hospital, 51 percent were discharged home with home health services, 16 percent were discharged or transferred to a SNF, and 1 percent were discharged or transferred to another PAC setting (for example, another IRF, a hospice, or an LTCH).³

The transfer and/or exchange of health information from one provider to another commonly takes several forms including verbal (e.g. clinician to clinician communication by telephone or in-person), paper-based (e.g. faxed or printed copies of records) and electronic communication (e.g. via health information exchange network, using an electronic health/medical record, secure messaging). Health information, such as medication information, that is incomplete or missing increases the likelihood of a

¹ Tian, W. "An all-payer view of hospital discharge to postacute care," May 2016. Available at: <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb205-Hospital-Discharge-Postacute-Care.jsp>.

² Tian, W. "An all-payer view of hospital discharge to postacute care," May 2016. Available at: <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb205-Hospital-Discharge-Postacute-Care.jsp>.

³ RTI International analysis of Medicare claims data for index stays in IRF 2016/2017. (RTI program reference: MM150).

patient/resident safety risk, often life-threatening.^{4 5 6 7 8 9} Poor communication and coordination across health care settings contributes to patient complications, hospital readmissions, ED visits, and medication errors.^{10 11 12 13 14 15 16 17 18 19} Communication has been cited as the third most frequent root cause in sentinel events, which The Joint Commission defines²⁰ as a patient safety event that results in death, permanent harm, or severe temporary harm. Failed or ineffective patient handoffs are estimated to play a role in 20 percent of serious preventable adverse events.²¹ When care transitions are enhanced through care coordination activities, such as expedited patient information flow, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans and prevent medical errors.²²

⁴ Kwan, J. L., Lo, L., Sampson, M., & Shojanian, K. G., "Medication reconciliation during transitions of care as a patient safety strategy: a systematic review," *Annals of Internal Medicine*, 2013, Vol. 158(5), pp. 397-403.

⁵ Boockvar, K. S., Blum, S., Kugler, A., Livote, E., Mergenhagen, K. A., Nebeker, J. R., & Yeh, J., "Effect of admission medication reconciliation on adverse drug events from admission medication changes," *Archives of Internal Medicine*, 2011, Vol. 171(9), pp. 860-861.

⁶ Bell, C. M., Brener, S. S., Gunraj, N., Huo, C., Bierman, A. S., Scales, D. C., & Urbach, D. R., "Association of ICU or hospital admission with unintentional discontinuation of medications for chronic diseases," *JAMA*, 2011, Vol. 306(8), pp. 840-847.

⁷ Basey, A. J., Krska, J., Kennedy, T. D., & Mackridge, A. J., "Prescribing errors on admission to hospital and their potential impact: a mixed-methods study," *BMJ Quality & Safety*, 2014, Vol. 23(1), pp. 17-25.

⁸ Desai, R., Williams, C. E., Greene, S. B., Pierson, S., & Hansen, R. A., "Medication errors during patient transitions into nursing homes: characteristics and association with patient harm," *The American Journal of Geriatric Pharmacotherapy*, 2011, Vol. 9(6), pp. 413-422.

⁹ Boling, P. A., "Care transitions and home health care," *Clinical Geriatric Medicine*, 2009, Vol.25(1), pp. 135-48.

¹⁰ Barnsteiner, J. H., "Medication Reconciliation: Transfer of medication information across settings—keeping it free from error," *The American Journal of Nursing*, 2005, Vol. 105(3), pp. 31-36.

¹¹ Arbaje, A. I., Kansagara, D. L., Salanitro, A. H., Englander, H. L., Kripalani, S., Jencks, S. F., & Lindquist, L. A., "Regardless of age: incorporating principles from geriatric medicine to improve care transitions for patients with complex needs," *Journal of General Internal Medicine*, 2014, Vol. 29(6), pp. 932-939.

¹² Jencks, S. F., Williams, M. V., & Coleman, E. A., "Rehospitalizations among patients in the Medicare fee-for-service program," *New England Journal of Medicine*, 2009, Vol. 360(14), pp. 1418-1428.

¹³ Institute of Medicine. "Preventing medication errors: quality chasm series," Washington, DC: The National Academies Press 2007. Available at: <https://www.nap.edu/read/11623/chapter/1>

¹⁴ Kitson, N. A., Price, M., Lau, F. Y., & Showler, G., "Developing a medication communication framework across continuums of care using the Circle of Care Modeling approach," *BMC Health Services Research*, 2013, Vol. 13(1), pp. 1-10.

¹⁵ Mor, V., Intrator, O., Feng, Z., & Grabowski, D. C., "The revolving door of rehospitalization from skilled nursing facilities," *Health Affairs*, 2010, Vol. 29(1), pp. 57-64.

¹⁶ Institute of Medicine. "Preventing medication errors: quality chasm series," Washington, DC: The National Academies Press 2007. Available at: <https://www.nap.edu/read/11623/chapter/1>

¹⁷ Kitson, N. A., Price, M., Lau, F. Y., & Showler, G., "Developing a medication communication framework across continuums of care using the Circle of Care Modeling approach," *BMC Health Services Research*, 2013, Vol. 13(1), pp. 1-10.

¹⁸ Forster, A. J., Murff, H. J., Peterson, J. F., Gandhi, T. K., & Bates, D. W., "The incidence and severity of adverse events affecting patients after discharge from the hospital." *Annals of Internal Medicine*, 2003,138(3), pp. 161-167.

¹⁹ King, B. J., Gilmore-Bykovskiy, A. L., Roiland, R. A., Polnaszek, B. E., Bowers, B. J., & Kind, A. J. "The consequences of poor communication during transitions from hospital to skilled nursing facility: a qualitative study," *Journal of the American Geriatrics Society*, 2013, Vol. 61(7), 1095-1102.

²⁰ The Joint Commission, "Sentinel Event Policy" available at https://www.jointcommission.org/sentinel_event_policy_and_procedures/

²¹ The Joint Commission. "Sentinel Event Data Root Causes by Event Type 2004–2015." 2016. Available at: https://www.jointcommission.org/assets/1/23/jconline_Mar_2_2016.pdf.

²² Mor, V., Intrator, O., Feng, Z., & Grabowski, D. C., "The revolving door of rehospitalization from skilled nursing facilities," *Health Affairs*, 2010, Vol. 29(1), pp. 57-64.

^{23 24 25 26} The rising incidence of preventable adverse events, complications and hospital readmissions have drawn national attention to the importance of the timely transfer of health information and care preferences at transitions. However, there is limited information about the route or mode (for example, paper-based, verbal, and electronic) of transmission used by PAC providers to transfer health information. PAC provider health information exchange supports the goals of: high quality, personalized, and efficient healthcare; care coordination and person-centered care; and supports real-time, data driven, clinical decision making.

PAC patients often have complicated medication regimens and require efficient and effective communication and coordination of care between settings, including transfer of detailed medication information.^{27 28 29} Individuals in PAC settings may be vulnerable to adverse health outcomes due to insufficient medication information on the part of their health care providers, and their higher likelihood for multiple comorbid chronic conditions, polypharmacy, and complicated transitions between care settings.^{30 31} Preventable adverse drug events (ADEs) occur after hospital discharge in a variety of settings including PAC.³²

Patients in PAC settings are often taking multiple medications. Consequently, PAC providers regularly are in the position of starting complex new medication regimens with little knowledge of the patient or their medication history upon admission. Furthermore, inter-facility communication barriers delay resolving medication discrepancies during transitions of care.³³ The transfer of a medication list between providers is necessary for medication reconciliation interventions, which have been shown to be

²³ Institute of Medicine, "Preventing medication errors: quality chasm series," Washington, DC: The National Academies Press, 2007. Available at: <https://www.nap.edu/read/11623/chapter/1>.

²⁴ Starmer, A. J., Sectish, T. C., Simon, D. W., Keohane, C., McSweeney, M. E., Chung, E. Y., Yoon, C.S., Lipsitz, S.R., Wassner, A.J., Harper, M. B., & Landrigan, C. P., "Rates of medical errors and preventable adverse events among hospitalized children following implementation of a resident handoff bundle," *JAMA*, 2013, Vol. 310(21), pp. 2262-2270.

²⁵ Pronovost, P., M. M. E. Johns, S. Palmer, R. C. Bono, D. B. Fridsma, A. Gettinger, J. Goldman, W. Johnson, M. Karney, C. Samitt, R. D. Sriram, A. Zenooz, and Y. C. Wang, Editors. *Procuring Interoperability: Achieving High-Quality, Connected, and Person-Centered Care*. Washington, DC, 2018. National Academy of Medicine. Available at: https://nam.edu/wp-content/uploads/2018/10/Procuring-Interoperability_web.pdf.

²⁶ Balaban, R.B., Weissman, J.S., Samuel, P.A., & Woolhandler, S., "Redefining and redesigning hospital discharge to enhance patient care: a randomized controlled study," *J Gen Intern Med*, 2008, Vol. 23(8), pp. 1228-33.

²⁷ Starmer A. J., Spector N. D., Srivastava R., West, D. C., Rosenbluth, G., Allen, A. D., Noble, E. L., ... & Landrigan, C. P., "Changes in medical errors after implementation of a handoff program," *N Engl J Med*, 2014, Vol. 37(1), pp. 1803-1812.

²⁸ Kruse, C.S. Marquez, G., Nelson, D., & Polomares, O., "The use of health information exchange to augment patient handoff in long-term care: a systematic review," *Applied Clinical Informatics*, 2018, Vol. 9(4), pp. 752-771

²⁹ Brody, A. A., Gibson, B., Tresner-Kirsch, D., Kramer, H., Thraen, I., Coarr, M. E., & Rupper, R., "High prevalence of medication discrepancies between home health referrals and Centers for Medicare and Medicaid Services home health certification and plan of care and their potential to affect safety of vulnerable elderly adults," *Journal of the American Geriatrics Society*, 2016, Vol. 64(11), pp. e166-e170.

³⁰ Chhabra, P. T., Rattinger, G. B., Dutcher, S. K., Hare, M. E., Parsons, K., L., & Zuckerman, I. H., "Medication reconciliation during the transition to and from long-term care settings: a systematic review," *Res Social Adm Pharm*, 2012, Vol. 8(1), pp. 60-75.

³¹ Levinson, D. R., & General, I., "Adverse events in skilled nursing facilities: national incidence among Medicare beneficiaries." Washington, DC: U.S. Department of Health and Human Services, Office of the Inspector General, February 2014. Available at: <https://oig.hhs.gov/oci/reports/oci-06-11-00370.pdf>.

³² Battles J., Azam I., Grady M., & Reback K., "Advances in patient safety and medical liability," AHRQ Publication No. 17-0017-EF. Rockville, MD: Agency for Healthcare Research and Quality, August 2017. Available at: https://www.ahrq.gov/sites/default/files/publications/files/advances-complete_3.pdf.

³³ Patterson M., Foust J. B., Bollinger, S., Coleman, C., Nguyen, D., "Inter-facility communication barriers delay resolving medication discrepancies during transitions of care," *Research in Social & Administrative Pharmacy* (2018), doi: 10.1016/j.sapharm.2018.05.124.

a cost-effective way to avoid ADEs by reducing errors,^{34 35 36} especially when medications are reviewed by a pharmacist and when it is done in conjunction with the use of electronic medical records.³⁷

Denominator

The target population is all patients discharged or transferred to a subsequent provider from an IRF.

IRF Denominator

The denominator is the total number of IRF Medicare Part A and Medicare Advantage (Part C) patient stays ending in discharge to a short-term general hospital, a SNF, intermediate care, home under care of an organized home health service organization or hospice, hospice in an institutional facility, a swing bed, another IRF, an LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a critical access hospital. Discharge to one of these providers is determined based on response to the discharge location item, 44D, of the IRF-PAI assessment, shown below:

44D. Patient's discharge destination/living setting, using codes below: _____
(answer only if 44C = 1; if 44C = 0, skip to item 46)

(01. Home (e.g. private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements); 02. Short-term General Hospital; 03. Skilled Nursing Facility (SNF); 04. Intermediate care; 06. Home under care of organized home health service organization; 50. Hospice (home); 51. Hospice (medical facility); 61. Swing Bed; 62. Another Inpatient Rehabilitation Facility; 63. Long-Term Care Hospital (LTCH); 64. Medicaid Nursing Facility; 65. Inpatient Psychiatric Facility; 66. Critical Access Hospital (CAH); 99. Not Listed

Numerator

IRF Numerator: The numerator is the number of stays for which the IRF-PAI indicated that the following is true:

At the time of discharge, the facility provided a current reconciled medication list to the subsequent provider (A2121= [1]).

Measure Time Window

The measure will be calculated quarterly. All IRF stays during the quarter will be included in the denominator and are eligible for inclusion in the numerator. For patients with multiple stays during the quarter, each stay is eligible for inclusion in the measure.

³⁴ Boockvar, K. S., Blum, S., Kugler, A., Livote, E., Mergenhausen, K. A., Nebeker, J. R., & Yeh, J., "Effect of admission medication reconciliation on adverse drug events from admission medication changes," *Archives of Internal Medicine*, 2011, Vol. 171(9), pp. 860-861.

³⁵ Kwan, J. L., Lo, L., Sampson, M., & Shojanian, K. G., "Medication reconciliation during transitions of care as a patient safety strategy: a systematic review," *Annals of Internal Medicine*, 2013, Vol. 158(5), pp. 397-403.

³⁶ Chhabra, P. T., Rattinger, G. B., Dutcher, S. K., Hare, M. E., Parsons, K., L., & Zuckerman, I. H., "Medication reconciliation during the transition to and from long-term care settings: a systematic review," *Res Social Adm Pharm*, 2012, Vol. 8(1), pp. 60-75.

³⁷ Agrawal A, Wu WY. "Reducing medication errors and improving systems reliability using an electronic medication reconciliation system," *The Joint Commission Journal on Quality and Patient Safety*, 2009, Vol. 35(2), pp. 106-114.

Items Included in the Quality Measure

One data element will be included to calculate the measure. One data element will be collected to inform the internally consistency logic of the proposed measure.

Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge	
At the time of discharge to another provider, did your facility provide the patient’s current reconciled medication list to the subsequent provider?	
Enter Code <input type="checkbox"/>	0. No – Current reconciled medication list not provided to the subsequent provider 1. Yes – Current reconciled medication list provided to the subsequent provider

Route of Current Medication List Transmission

A2123. Route of Current Reconciled Medication List Transmission		
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider and/or patient/family/caregiver.		
Route of Transmission	1. To subsequent provider	2. To patient/family/ caregiver
	↓	↓
	Check all that apply	
A. Electronic Health Record	<input type="checkbox"/>	<input type="checkbox"/>
B. Health Information Exchange Organization	<input type="checkbox"/>	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>	<input type="checkbox"/>

Risk Adjustment

This measure is not risk-adjusted or stratified.

Quality Measure Calculation Steps

The following steps are used to calculate the measure:

1. Calculate the facility observed score (steps 1 through 3).

Step 1. Calculate the denominator count

Calculate the total number of patient stays with discharge to a subsequent provider based on the discharge location item in Section A.

Step 2. Calculate the numerator count

Calculate the total number of stays where a reconciled medication list was transferred:

A2121 = [1]

Step 3: Calculate the facility observed score

Divide the facility's numerator count by its denominator count to obtain the observed score; in other words, divide the results of Step 2 by the results of Step 1. Multiply by 100.

Quality Measure Coding Steps

The following steps are used to code the measure:

1. At discharge, code for the patient's discharge location.

Identify discharge location with item 44D.

2. At discharge, code for if the facility provided the reconciled medication list to the subsequent provider.

A valid response for item 44D would skip the coder into item A2121.

3. At discharge, code for the route of transmission.

A valid response for item A2121 [A2121 = 1] would skip the coder into item A2123. This item is used for measure consistency logic.

Section 3. Cross-Setting Proposed Measure: Transfer of Health Information to the Patient–Post-Acute Care Measure

Measure Description

This proposed measure assesses for and reports on the timely transfer of health information, i.e., a current reconciled medication list, to the patient/resident when discharged from their current setting of post-acute care to a private home/apartment, board and care home, assisted living, group home, transitional living, or home under the care of an organized home health service organization or hospice.

This proposed measure, developed under the intent of the IMPACT Act, has been developed for the IRF, LTCH, SNF, and HHA settings. This proposed measure is calculated by one standard data element that asks at the time of discharge did the facility provide the patient’s/resident’s current reconciled medication list to the patient, family, and/or caregiver. It also includes one data element that asks the route of transmission of the reconciled medication list (Appendix A). In order to track discharge to home, the IRF-PAI will be used to track discharge location status. The measure is conceptualized uniformly across the PAC settings. The measure is calculated using data from the IRF-PAI for IRF patients, the LCDS for LTCH patients, the MDS 3.0 assessment instrument for SNF residents, and the OASIS-D for HHA patients. Data are collected and calculated separately in each of the four settings using standardized data elements. The collection of this measure and the components tied to the standardized data element used to calculate this measure are in Appendix A.

The Reconciled Medication List

The guidance related to a reconciled medication list for purposes of this measure, and the information which may be included for the patient/resident and for each of the medications is provided in Chapter 1, Section 2. It is recommended that a reconciled medication list that is transferred to the patient, family, or caregiver use consumer-friendly terminology and plain language to ensure that the information provided to patients and caregivers is clear and understandable, promoting transparent access to medical record information.³⁸

Purpose/Rationale for the Quality Measure

In 2013, 22.3 percent of all acute hospital discharges were discharged to PAC settings, including 11 percent who were discharged to home under the care of a home health agency.³⁹ Of the Medicare FFS beneficiaries with an IRF stay in fiscal years 2016 and 2017, an estimated 51 percent were discharged home with home health services, 21 percent were discharged home with self-care, and .5 percent were discharged with home hospice services⁴⁰

The communication of health information, such as a reconciled medication list, is critical to ensuring safe and effective patient transitions from health care settings to home and/or other community settings. Incomplete or missing health information, such as medication information, increases the

³⁸ For an examples of plain language resources for healthcare information see: <https://www.plainlanguage.gov/resources/content-types/healthcare/>

³⁹ Tian, W. “An all-payer view of hospital discharge to postacute care,” May 2016. Available at: <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb205-Hospital-Discharge-Postacute-Care.jsp>.

⁴⁰ RTI International analysis of Medicare claims data for index stays in IRF 2016/2017. (RTI program reference: MM150).

likelihood of a patient safety risk, often life-threatening.^{41 42 43 44 45} Individuals who use PAC settings are particularly vulnerable to adverse health outcomes due to their higher likelihood of multiple comorbid chronic conditions, polypharmacy, and complicated transitions between care settings.^{46 47} Upon discharge to home, individuals in PAC settings may be faced with numerous medication changes, new medication regimes, and follow-up details.^{48 49 50} The efficient and effective communication and coordination of medication information may be critical to prevent potentially deadly adverse effects. When care coordination activities enhance care transitions, these activities can reduce duplication of care services and costs of care, resolve conflicting care plans, and prevent medical errors.^{51 52}

The transfer of a patient's medication information to the patient, family, or caregiver is common practice and supported by discharge planning requirements for participation in Medicare and Medicaid programs.^{53 54} However, there is limited information about the route or mode (for example, paper-based,

⁴¹ Kwan, J. L., Lo, L., Sampson, M., & Shojania, K. G., "Medication reconciliation during transitions of care as a patient safety strategy: a systematic review," *Annals of Internal Medicine*, 2013, Vol. 158(5), pp. 397-403.

⁴² Boockvar, K. S., Blum, S., Kugler, A., Livote, E., Mergenhagen, K. A., Nebeker, J. R., & Yeh, J., "Effect of admission medication reconciliation on adverse drug events from admission medication changes," *Archives of Internal Medicine*, 2011, Vol. 171(9), pp. 860-861.

⁴³ Bell, C. M., Brener, S. S., Gunraj, N., Huo, C., Bierman, A. S., Scales, D. C., & Urbach, D. R., "Association of ICU or hospital admission with unintentional discontinuation of medications for chronic diseases," *JAMA*, 2011, Vol. 306(8), pp. 840-847.

⁴⁴ Basey, A. J., Krska, J., Kennedy, T. D., & Mackridge, A. J., "Prescribing errors on admission to hospital and their potential impact: a mixed-methods study," *BMJ Quality & Safety*, 2014, Vol. 23(1), pp. 17-25.

⁴⁵ Desai, R., Williams, C. E., Greene, S. B., Pierson, S., & Hansen, R. A., "Medication errors during patient transitions into nursing homes: characteristics and association with patient harm," *The American Journal of Geriatric Pharmacotherapy*, 2011, Vol. 9(6), pp. 413-422.

⁴⁶ Brody, A. A., Gibson, B., Tresner-Kirsch, D., Kramer, H., Thraen, I., Coarr, M. E., & Rupper, R. "High prevalence of medication discrepancies between home health referrals and Centers for Medicare and Medicaid Services home health certification and plan of care and their potential to affect safety of vulnerable elderly adults," *Journal of the American Geriatrics Society*, 2016, Vol. 64(11), pp. e166-e170.

⁴⁷ Chhabra, P. T., Rattinger, G. B., Dutcher, S. K., Hare, M. E., Parsons, K., L., & Zuckerman, I. H., "Medication reconciliation during the transition to and from long-term care settings: a systematic review," *Res Social Adm Pharm*, 2012, Vol. 8(1), pp. 60-75.

⁴⁸ Brody, A. A., Gibson, B., Tresner-Kirsch, D., Kramer, H., Thraen, I., Coarr, M. E., & Rupper, R. "High prevalence of medication discrepancies between home health referrals and Centers for Medicare and Medicaid Services home health certification and plan of care and their potential to affect safety of vulnerable elderly adults," *Journal of the American Geriatrics Society*, 2016, Vol. 64(11), pp. e166-e170.

⁴⁹ Bell, C. M., Brener, S. S., Gunraj, N., Huo, C., Bierman, A. S., Scales, D. C., & Urbach, D. R., "Association of ICU or hospital admission with unintentional discontinuation of medications for chronic diseases," *JAMA*, 2011, Vol. 306(8), pp. 840-847.

⁵⁰ Sheehan, O. C., Kharrazi, H., Carl, K. J., Leff, B., Wolff, J. L., Roth, D. L., Gabbard, J., & Boyd, C. M., "Helping older adults improve their medication experience (HOME) by addressing medication regimen complexity in home healthcare," *Home Healthcare Now*, 2018, Vol. 36(1) pp. 10-19.

⁵¹ Mor, V., Intrator, O., Feng, Z., & Grabowski, D. C., "The revolving door of rehospitalization from skilled nursing facilities," *Health Affairs*, 2010, Vol. 29(1), pp. 57-64.

⁵² Starmer, A. J., Sectish, T. C., Simon, D. W., Keohane, C., McSweeney, M. E., Chung, E. Y., Yoon, C.S., Lipsitz, S.R., Wassner, A.J., Harper, M. B., & Landrigan, C. P., "Rates of medical errors and preventable adverse events among hospitalized children following implementation of a resident handoff bundle," *JAMA*, 2013, Vol. 310(21), pp. 2262-2270.

⁵³ CMS, "Revision to state operations manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.43, Discharge Planning" May 17, 2013. Available at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-32.pdf>.

⁵⁴ The State Operations Manual Guidance to Surveyors for Long Term Care Facilities (Guidance §483.21(c)(1) Rev. 11-22-17) for discharge planning. CMS, "Revision to state operations manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.43, Discharge Planning" May 17, 2013. Available at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-32.pdf>

verbal, and electronic) of transmission used by PAC providers to transfer health information. PAC provider health information exchange with patients, families and caregivers supports the goals of: high quality, personalized, and efficient healthcare; care coordination and person-centered care; and supports real-time, data driven, clinical decision making.

Most PAC electronic health record (EHR) systems generate a discharge medication list. Further, interventions to promote patient participation in medication management have been shown to be acceptable and potentially useful for improving patient outcomes and reducing costs^{55 56} and provision of a reconciled medication list to patients/residents and their caregivers can improve transitional care.⁵⁷

Some clinical practice guidelines state the importance of medication safety and communicating accurate medication information to the patient. For example, The Joint Commission's National Patient Safety Goals #4 and #5 for Home Care Accreditation (NPSG.03.06.01) include the following elements of performance with respect to medication information that is important to provide to the patient or family when discharging or transferring.⁵⁸

4. Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she leaves the organization's care (for example, name, dose, route, frequency, purpose).
5. Explain the importance of managing medication information to the patient.

The AHRQ Project Re-Engineered Discharge (RED) Toolkit includes a number of medication-related strategies (e.g., active medication reconciliation, medication teaching for patients and caregivers, development of medication list for patients and their health care providers).⁵⁹

Denominator

IRF Denominator

The denominator for this measure is the total number of IRF Medicare Part A and Medicare Advantage (Part C) patient stays ending in discharge to a private home/ apartment (apt.), board/care, assisted living, group home, transitional living or home under care of organized home health service organization or hospice. Discharge to one of these locations is determined based on response to the discharge location item, 44D, of the IRF-PAI assessment, shown below:

44D. Patient's discharge destination/living setting, using codes below: _____
(answer only if 44C = 1; if 44C = 0, skip to item 46)

(01. Home (e.g. private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements); 02. Short-term General Hospital; 03. Skilled Nursing Facility (SNF); 04. Intermediate care; 06. Home under care of organized home health service organization; 50. Hospice (home); 51. Hospice (medical facility); 61. Swing Bed; 62. Another Inpatient Rehabilitation Facility; 63. Long-Term Care Hospital (LTCH);

⁵⁵ Greene, J., & Hibbard, J. H. "Why does patient activation matter? An examination of the relationships between patient activation and health-related outcomes," *Journal of General Internal Medicine*, 2012, Vol. 27(5), pp. 520-526.

⁵⁶ Phatak A, Prusi R, Ward, B., Hansen, L. O., Williams, M. V., Vetter, E., Chapman, N., Postelnick, M., "Impact of pharmacist involvement in the transitional care of high-risk patients through medication reconciliation, medication education, and postdischarge call-backs (IPITCH Study)," *J Hosp Med.*, 2016, Vol. 11(1), pp. 39-44.

⁵⁷ Toles, M., Colon-Emeric, C., Naylor, M. D., Asafu-Adjei, J., Hanson, L. C., "Connect-home: transitional care of skilled nursing facility patients and their caregivers," *Am Geriatr Soc.*, 2017, Vol. 65(10), pp. 2322-2328.

⁵⁸ The Joint Commission. National Patient Safety Goals, Effective January 2018, Home Care Accreditation Program. Available at: https://www.jointcommission.org/assets/1/6/NPSG_Chapter_OME_Jan2018.pdf

⁵⁹ Re-Engineered Discharge (RED) Toolkit. Agency for Healthcare Research and Quality, Rockville, MD. Available at: <http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html>, Last accessed November, 28, 2018.

64. Medicaid Nursing Facility; 65. Inpatient Psychiatric Facility; 66. Critical Access Hospital (CAH); 99. Not Listed

Numerator

IRF Numerator: The numerator is the number of stays for which the IRF-PAI indicated that the following is true:

At the time of discharge, the facility provided a current reconciled medication list to the patient, family and/or caregiver (A2122= [1]).

Measure Time Window

The measure will be calculated quarterly. All IRF stays during the quarter will be included in the denominator and are eligible for inclusion in the numerator. For patients with multiple stay during the quarter, each stay is eligible for inclusion in the measure.

Items Included in the Quality Measure

One data element will be included to calculate the measure. One data element will be collected to inform the internally consistency logic of the proposed measure.

Provision of Current Reconciled Medication List to Patient at Discharge

A2122. Provision of Current Reconciled Medication List to Patient at Discharge	
At the time of discharge, did your facility provide the patient’s current reconciled medication list to the patient, family and/or caregiver?	
Enter Code <input type="checkbox"/>	0. No – Current reconciled medication list not provided to the patient, family and/or caregiver 1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver

Route of Current Medication List Transmission

A2123. Route of Current Reconciled Medication List Transmission		
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider and/or patient/family/caregiver.		
Route of Transmission	1. To subsequent provider	2. To patient/family/ caregiver
↓ Check all that apply ↓		
A. Electronic Health Record	<input type="checkbox"/>	<input type="checkbox"/>
B. Health Information Exchange Organization	<input type="checkbox"/>	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>	<input type="checkbox"/>

Risk Adjustment

This measure is not risk-adjusted or stratified.

Quality Measure Calculation Steps

The following steps are used to calculate the measure:

1. Calculate the facility observed score (steps 1 through 3).

Step 1. Calculate the denominator count

Calculate the total number of patient stays with discharge to home based on the discharge location item in Section A.

Step 2. Calculate the numerator count

Calculate the total number of stays where a reconciled medication list was transferred:

A2122 = [1]

Step 3: Calculate the facility observed score

Divide the facility's numerator count by its denominator count to obtain the observed score; in other words, divide the results of Step 2 by the results of Step 1. Multiply by 100.

Quality Measure Coding Steps

The following steps are used to code the measure:

1. At discharge, code for the patient's discharge location.

Identify discharge location with item 44D.

2. At discharge, code for if the facility provided the reconciled medication list to the patient, family and/or caregiver.

A valid response for item 44D would skip the coder into item A2122.

3. At discharge, code for the route of transmission.

A valid response for item A2122 [A2122 = 1] would skip the coder into item A2123. This item is used for measure consistency logic.

Section 4. Update to the Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) Measure

Measure Update

The Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) measure was adopted for the IRF QRP in the FY 2017 IRF Prospective Payment System (PPS) final rule (81 FR 52095 through 52103) to meet the requirement of the IMPACT Act. Measure specifications were first published in July 2016.⁶⁰ These draft specifications include a new proposed measure exclusion for baseline NF residents; there are no other changes to measure specifications.

Measure Description

This measure assesses successful discharge to the community from a PAC setting, with successful discharge to the community including no unplanned rehospitalizations and no death in the 31 days following discharge. Specifically, this measure reports an IRF’s risk-standardized rate of Medicare fee-for-service (FFS) patients who are discharged to the community following an IRF stay, and do not have an unplanned readmission to an acute care hospital or LTCH in the 31 days following discharge to community, and who remain alive during the 31 days following discharge to community. Community, for this measure, is defined as home/self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare FFS claim.^{61,62,63}

We adopted four discharge to community measures for IRF, LTCH, SNF, and HH settings, respectively. These measures are conceptualized uniformly across the PAC settings in terms of the definition of the discharge to community outcome, the approach to risk adjustment, and the measure calculation, with some differences where needed due to setting-specific considerations. It is important to note that each measure is specific to the particular PAC setting (i.e., IRF, LTCH, SNF, or HH); we do not pool PAC patients/residents across settings in the measure development and calculation.

Purpose/Rationale for the Measure

Discharge to a community setting is an important health care outcome for many patients/residents for whom the overall goals of PAC include optimizing functional improvement, returning to a previous level of independence, and avoiding institutionalization. Returning to the community is also an important outcome for many patients/residents who are not expected to make functional improvement during their PAC stay, and for patients/residents who may be expected to decline functionally due to their medical condition. By assessing whether patients remain alive in the community without acute complications for 31 days following discharge, the DTC–PAC IRF QRP measure is a meaningful, patient- and family-centered measure of successful community discharge.

⁶⁰ The original measure specifications are available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-IRF-QRP-Final-Rule.pdf>.

⁶¹ National Uniform Billing Committee Official UB-04 Data Specifications Manual 2018, Version 12, July 2017, Copyright 2017, American Hospital Association.

⁶² Patient discharge status codes 81 and 86 are intended for use on acute care claims only. However, since these codes have sometimes been reported on PAC claims, we include them in our definition of community to credit the PAC provider for discharging the patient to a community setting.

⁶³ This definition is not intended to suggest that group homes, foster care, or other residential care settings included in the definition of “community” for the purpose of this measure are the most integrated setting for any particular individual or group of individuals under the Americans with Disabilities Act (ADA) and Section 504.

In addition to being an important outcome from a patient/resident and family perspective, patients/residents discharged to community settings, on average, incur lower costs over the recovery episode, compared with those discharged to institutional settings.^{64,65} Given the high costs of care in institutional settings, encouraging PACs to prepare patients for discharge to community, when clinically appropriate, may have cost-saving implications for the Medicare program.⁶⁶ Also, providers have found that successful discharge to community was a major driver of their ability to achieve savings, where capitated payments for post-acute care were in place.⁶⁷ For patients/residents who require long-term care due to persistent disability, discharge to community could result in lower long-term care costs for Medicaid and for patients'/residents' out-of-pocket expenditures.⁶⁸

Analyses conducted by the Medicare Payment Advisory Commission (MedPAC) using 2013 PAC data demonstrates the substantially higher costs of institutional PAC stays compared with HH stays.⁶⁹ Average costs of HH stays ranged from \$1,790 to \$2,699 depending on the position of the HH stay in a sequence of PAC care. Average costs of institutional PAC stays (including IRF, LTCH, or SNF stays) ranged from \$13,948 to \$17,506, depending on the position of the institutional PAC stay in a sequence of PAC care.⁷⁰

Analyses conducted for the Assistant Secretary for Planning and Evaluation (ASPE) on PAC episodes, using a 5 percent sample of 2006 Medicare claims, revealed that relatively high average, unadjusted Medicare payments are associated with discharge to institutional settings from IRFs, SNFs, LTCHs or HHAs, as compared with payments associated with discharge to community settings.⁷¹ Average, unadjusted Medicare payments associated with discharge to community settings ranged from \$0 to \$4,017 for IRF discharges, \$0 to \$3,544 for SNF discharges, \$0 to \$4,706 for LTCH discharges, and \$0 to \$992 for HHA discharges. In contrast, payments associated with discharge to non-community settings were considerably higher, ranging from \$11,847 to \$25,364 for IRF discharges, \$9,305 to \$29,118 for SNF discharges, \$12,465 to \$18,205 for LTCH discharges, and \$7,981 to \$35,192 for HHA discharges.⁷² These expenditure estimates only include Medicare expenditures related to the immediate discharge destination following SNF, LTCH, IRF or HH care, and not expenditures related to any subsequent discharge destinations.

Measuring and comparing facility-level discharge to community rates is expected to help differentiate among facilities with varying performance in this important domain, and to help avoid disparities in care across patient/resident groups. Variation in discharge to community rates has been reported within and across post-acute settings; across a variety of facility-level characteristics, such as geographic location (for example, regional location, urban or rural location), ownership (for example, for-

⁶⁴ Dobrez D, Heinemann AW, Deutsch A, Manheim L, Mallinson T. Impact of Medicare's prospective payment system for inpatient rehabilitation facilities on stroke patient outcomes. *American journal of physical medicine & rehabilitation / Association of Academic Physiatrists*. 2010;89(3):198-204.

⁶⁵ Gage B, Morley M, Spain P, Ingber M. Examining Post Acute Care Relationships in an Integrated Hospital System. Final Report. RTI International; 2009.

⁶⁶ Ibid.

⁶⁷ Doran JP, Zabinski SJ. Bundled payment initiatives for Medicare and non-Medicare total joint arthroplasty patients at a community hospital: bundles in the real world. *The Journal of Arthroplasty*. 2015;30(3):353-355.

⁶⁸ Newcomer RJ, Ko M, Kang T, Harrington C, Hulett D, Bindman AB. Health Care Expenditures After Initiating Long-term Services and Supports in the Community Versus in a Nursing Facility. *Medical Care*. 2016 (54)3, 221-228.

⁶⁹ Medicare Payment Advisory Commission. Paying for sequential stays in a unified prospective payment system for post-acute care. In: Report to the Congress: Medicare and the Health Care Delivery System. June 2018. Available at: http://www.medpac.gov/docs/default-source/reports/jun18_ch4_medpacreport_sec.pdf?sfvrsn=0.

⁷⁰ Ibid.

⁷¹ Gage B, Morley M, Spain P, Ingber M. Examining Post Acute Care Relationships in an Integrated Hospital System. Final Report. RTI International; 2009.

⁷² Ibid.

profit or nonprofit), and freestanding or hospital-based units; and across patient-level characteristics, such as race and gender.^{73,74,75,76,77,78} Discharge to community rates in the IRF setting have been reported to range from about 60 to 80 percent.^{79,80,81,82,83,84} Longer-term studies show that rates of discharge to community from IRFs have decreased over time as IRF length of stay has decreased.^{85,86} In the IRF Medicare FFS population, using calendar year 2015-2016 national unadjusted data, we found that approximately 64 percent of patients were discharged to the community; facility-level observed discharges to community ranged from approximately 15 percent to 100 percent, with an interquartile range of 9.3 percentage points. Greater variation in discharge to community rates is seen in the SNF setting, with rates ranging from 31 to 65 percent.^{87,88,89,90} A multi-center study of 23 LTCHs demonstrated that 28.8 percent of 1,061 patients who were ventilator-dependent on admission were discharged to

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- 73 Reistetter TA, Karmarkar AM, Graham JE, et al. Regional variation in stroke rehabilitation outcomes. *Archives of physical medicine and rehabilitation*. 2014;95(1):29-38.
- 74 El-Solh AA, Saltzman SK, Ramadan FH, Naughton BJ. Validity of an artificial neural network in predicting discharge destination from a postacute geriatric rehabilitation unit. *Archives of physical medicine and rehabilitation*. 2000;81(10):1388-1393.
- 75 Medicare Payment Advisory Commission. March 2018 Report to the Congress: Medicare Payment Policy. 2018.
- 76 Bhandari VK, Kushel M, Price L, Schillinger D. Racial disparities in outcomes of inpatient stroke rehabilitation. *Archives of physical medicine and rehabilitation*. 2005;86(11):2081-2086.
- 77 Chang PF, Ostir GV, Kuo YF, Granger CV, Ottenbacher KJ. Ethnic differences in discharge destination among older patients with traumatic brain injury. *Archives of physical medicine and rehabilitation*. 2008;89(2):231-236.
- 78 Berges IM, Kuo YF, Ostir GV, Granger CV, Graham JE, Ottenbacher KJ. Gender and ethnic differences in rehabilitation outcomes after hip-replacement surgery. *American journal of physical medicine & rehabilitation / Association of academic physiatrists*. 2008;87(7):567-572.
- 79 Galloway RV, Granger CV, Karmarkar AM, et al. The Uniform Data System for Medical Rehabilitation: report of patients with debility discharged from inpatient rehabilitation programs in 2000-2010. *American journal of physical medicine & rehabilitation / Association of academic physiatrists*. 2013;92(1):14-27.
- 80 Morley MA, Coots LA, Forgues AL, Gage BJ. Inpatient rehabilitation utilization for Medicare beneficiaries with multiple sclerosis. *Archives of physical medicine and rehabilitation*. 2012;93(8):1377-1383.
- 81 Reistetter TA, Graham JE, Deutsch A, Granger CV, Markello S, Ottenbacher KJ. Utility of functional status for classifying community versus institutional discharges after inpatient rehabilitation for stroke. *Archives of physical medicine and rehabilitation*. 2010;91(3):345-350.
- 82 Gagnon D, Nadeau S, Tam V. Clinical and administrative outcomes during publicly-funded inpatient stroke rehabilitation based on a case-mix group classification model. *Journal of rehabilitation medicine*. 2005;37(1):45-52.
- 83 DaVanzo J, El-Gamil A, Li J, Shimer M, Manolov N, Dobson A. Assessment of patient outcomes of rehabilitative care provided in inpatient rehabilitation facilities (IRFs) and after discharge. Vienna, VA: Dobson DaVanzo & Associates, LLC; 2014.
- 84 Kushner DS, Peters KM, Johnson-Greene D. Evaluating Siebens Domain Management Model for Inpatient Rehabilitation to Increase Functional Independence and Discharge Rate to Home in Geriatric Patients. *Archives of physical medicine and rehabilitation*. 2015;96(7):1310-1318.
- 85 Galloway RV, Granger CV, Karmarkar AM, et al. The Uniform Data System for Medical Rehabilitation: report of patients with debility discharged from inpatient rehabilitation programs in 2000-2010. *American journal of physical medicine & rehabilitation / Association of Academic Physiatrists*. 2013;92(1):14-27.
- 86 Mallinson T, Deutsch A, Bateman J, et al. Comparison of discharge functional status after rehabilitation in skilled nursing, home health, and medical rehabilitation settings for patients after hip fracture repair. *Archives of physical medicine and rehabilitation*. 2014;95(2):209-217.
- 87 El-Solh AA, Saltzman SK, Ramadan FH, Naughton BJ. Validity of an artificial neural network in predicting discharge destination from a postacute geriatric rehabilitation unit. *Archives of physical medicine and rehabilitation*. 2000;81(10):1388-1393.
- 88 Hall RK, Toles M, Massing M, et al. Utilization of acute care among patients with ESRD discharged home from skilled nursing facilities. *Clinical journal of the American Society of Nephrology: CJASN*. 2015;10(3):428-434.
- 89 Stearns SC, Dalton K, Holmes GM, Seagrave SM. Using propensity stratification to compare patient outcomes in hospital-based versus freestanding skilled-nursing facilities. *Medical care research and review: MCRR*. 2006;63(5):599-622.
- 90 Wodchis WP, Teare GF, Naglie G, et al. Skilled nursing facility rehabilitation and discharge to home after stroke. *Archives of physical medicine and rehabilitation*. 2005;86(3):442-448.

home.⁹¹ A single-center study found that 31 percent of LTCH hemodialysis patients were discharged to home.⁹² One study noted that 64 percent of beneficiaries who were discharged from the HH episode did not use any other acute or post-acute services paid by Medicare in the 30 days after discharge.⁹³ However, significant numbers of patients were admitted to hospitals (29 percent) and lesser numbers to SNF (7.6 percent), IRF (1.5 percent), HH (7.2 percent) or hospice (3.3 percent).⁹⁴

Discharge to community is an actionable health care outcome, as targeted interventions have been shown to successfully increase discharge to community rates in a variety of post-acute settings.^{95,96,97,98,99} Many of these interventions involve discharge planning, communication and care coordination, specific rehabilitation strategies, such as addressing discharge barriers and improving medical and functional status, or community-based transitional care services and supports.^{100,101,102,103,104,105,106,107,108,109} The

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- ⁹¹ Scheinhorn DJ, Hassenpflug MS, Votto JJ, et al. Post-ICU mechanical ventilation at 23 long-term care hospitals: a multicenter outcomes study. *Chest*. 2007;131(1):85-93.
- ⁹² Thakar CV, Quate-Operacz M, Leonard AC, Eckman MH. Outcomes of hemodialysis patients in a long-term care hospital setting: a single-center study. *American journal of kidney diseases: the official journal of the National Kidney Foundation*. 2010;55(2):300-306.
- ⁹³ Wolff JL, Meadow A, Weiss CO, Boyd CM, Leff B. Medicare home health patients' transitions through acute and post-acute care settings. *Medical care*. 2008;46(11):1188-1193.
- ⁹⁴ Ibid.
- ⁹⁵ Kushner DS, Peters KM, Johnson-Greene D. Evaluating Siebens Domain Management Model for Inpatient Rehabilitation to Increase Functional Independence and Discharge Rate to Home in Geriatric Patients. *Archives of physical medicine and rehabilitation*. 2015;96(7):1310-1318.
- ⁹⁶ Wodchis WP, Teare GF, Naglie G, et al. Skilled nursing facility rehabilitation and discharge to home after stroke. *Archives of physical medicine and rehabilitation*. 2005;86(3):442-448.
- ⁹⁷ Berkowitz RE, Jones RN, Rieder R, et al. Improving disposition outcomes for patients in a geriatric skilled nursing facility. *Journal of the American Geriatrics Society*. 2011;59(6):1130-1136.
- ⁹⁸ Kushner DS, Peters KM, Johnson-Greene D. Evaluating use of the Siebens Domain Management Model during inpatient rehabilitation to increase functional independence and discharge rate to home in stroke patients. *PM&R: the journal of injury, function, and rehabilitation*. 2015;7(4):354-364.
- ⁹⁹ O'Brien SR, Zhang N. Association between therapy intensity and discharge outcomes in aged Medicare skilled nursing facilities admissions. *Archives of Physical Medicine and Rehabilitation*. 2018;99(1):107-115.
- ¹⁰⁰ Kushner DS, Peters KM, Johnson-Greene D. Evaluating Siebens Domain Management Model for Inpatient Rehabilitation to Increase Functional Independence and Discharge Rate to Home in Geriatric Patients. *Archives of physical medicine and rehabilitation*. 2015;96(7):1310-1318.
- ¹⁰¹ Wodchis WP, Teare GF, Naglie G, et al. Skilled nursing facility rehabilitation and discharge to home after stroke. *Archives of physical medicine and rehabilitation*. 2005;86(3):442-448.
- ¹⁰² Berkowitz RE, Jones RN, Rieder R, et al. Improving disposition outcomes for patients in a geriatric skilled nursing facility. *Journal of the American Geriatrics Society*. 2011;59(6):1130-1136.
- ¹⁰³ Kushner DS, Peters KM, Johnson-Greene D. Evaluating use of the Siebens Domain Management Model during inpatient rehabilitation to increase functional independence and discharge rate to home in stroke patients. *PM&R: the journal of injury, function, and rehabilitation*. 2015;7(4):354-364.
- ¹⁰⁴ Jung HY, Trivedi AN, Grabowski DC, Mor V. Does more therapy in skilled nursing facilities lead to better outcomes in patients with hip fracture? *Physical therapy*. 2016;96(1):81-89.
- ¹⁰⁵ Camicia M, Wang H, DiVita M, Mix J, Niewczyk P. Length of stay at inpatient rehabilitation facility and stroke patient outcomes. *Rehabilitation Nursing: The Official Journal of the Association of Rehabilitation Nurses*. 2016;41(2):78-90.
- ¹⁰⁶ Buttke D, Cooke V, Abrahamson K, et al. A Statewide Model for assisting nursing home residents to transition successfully to the community. *Geriatrics*. 2018;3(2):18.
- ¹⁰⁷ Logue MD, Drago J. Evaluation of a modified community based care transitions model to reduce costs and improve outcomes. *BMC Geriatrics*. 2013;13(1):94.
- ¹⁰⁸ Carnahan JL, Slaven JE, Callahan CM, Tu W, Torke AM. Transitions from skilled nursing facility to home: the relationship of early outpatient care to hospital readmission. *Journal of the American Medical Directors Association*. 2017;18(10):853-859.
- ¹⁰⁹ Rodakowski J, Rocco PB, Ortiz M, et al. Caregiver integration during discharge planning for older adults to reduce resource use: a metaanalysis. *J Am Geriatr Soc*. 2017;65(8):1748-1755.

effectiveness of these interventions suggests that improvement in discharge to community rates among post-acute care patients/residents is possible through modifying provider-led processes and interventions.

Denominator

The denominator for the discharge to community measure is the risk-adjusted expected number of discharges to community. This estimate includes risk adjustment for patient characteristics with the facility effect removed. The “expected” number of discharges to community is the predicted number of risk-adjusted discharges to community if the same patients were treated at the average facility appropriate to the measure.

The regression model used to calculate the denominator is developed using all non-excluded facility stays in the national data. The denominator is computed in the same way as the numerator, but the facility effect is set at the average. The descriptions of the discharge to community outcome, patient stays included in the measure, and numerator calculation are provided below.

Numerator

The measure does not have a simple form for the numerator and denominator—that is, the risk adjustment method does not make the *observed* number of community discharges the numerator, and a *predicted* number the denominator. The measure numerator is the *risk-adjusted estimate* of the number of patients who are discharged to the community, do not have an unplanned readmission to an acute care hospital or LTCH in the 31-day post-discharge observation window, and who remain alive during the post-discharge observation window. This estimate starts with the observed discharges to community and is risk-adjusted for patient characteristics and a statistical estimate of the facility effect beyond case mix.

The numerator uses a model estimated on full national data specific to the IRF setting; it is applied to the facility’s patient stays included in the measure and includes the estimated effect of that facility. The prediction equation is based on a logistic statistical model with a two-level hierarchical structure. The patient stays in the model have an indicator of the facility they are discharged from; the effect of the facility is measured as a positive or negative shift in the intercept term of the equation. The facility effects are modeled as belonging to a normal (Gaussian) distribution centered at 0 and are estimated along with the effects of patient characteristics in the model. Numerator details are provided below.

Numerator Details: Discharge to Community

Discharge to community is determined based on the “Patient Discharge Status Code” from the IRF claim. Discharge to community is defined as discharge to home/self-care with or without home health services.¹¹⁰ Table 1 below lists the Patient Discharge Status Codes used to define community.

**Table 1
Patient Discharge Status Codes Used to Determine Discharge to a Community Setting**

Discharge Status Codes Indicating Discharge to a Community Setting	
01	Discharged to home/self-care (routine discharge)
06	Discharged/transferred to home under care of organized home health service organization
81	Discharged to home or self-care with a planned acute care hospital readmission
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission

¹¹⁰ National Uniform Billing Committee Official UB-04 Data Specifications Manual 2018, Version 12, July 2017, Copyright 2017, American Hospital Association.

Patient discharge status codes 81 and 86 are intended for use on acute care claims only. However, since these codes have sometimes been reported on PAC claims, we include them in our definition of community to credit the PAC provider for discharging the patient to a community setting.

Numerator Details: Unplanned Readmissions in the 31-Day Post-Discharge Observation Window

A patient who is discharged to the community is not considered to have a successful discharge to community outcome for this measure if they have a subsequent unplanned readmission to an acute care hospital or LTCH in the post-discharge observation window, which includes the day of discharge and the 31 days following day of discharge. We only assess the first readmission encountered in the post-discharge window. Our definition of acute care hospital includes hospitals paid under the Inpatient PPS (IPPS), critical access hospitals (CAH), and psychiatric hospitals or units. Using acute care and LTCH claims, we identify unplanned readmissions based on the CMS planned readmissions algorithm¹¹¹ used in the following PAC readmission measures, endorsed by the National Quality Forum (NQF) and used in several CMS programs: (i) NQF #2510: Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM); (ii) NQF #2502: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities; (iii) NQF #2512: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals; and (iv) NQF #2380: Rehospitalization During the First 30 Days of Home Health.^{112,113,114,115} These readmission measures are based on the Hospital-Wide All-Cause Readmission Measure (HWR) (CMS/Yale) (NQF #1789),¹¹⁶ with some additions made for the SNF, IRF, and LTCH setting measures.¹¹⁷ The CMS planned readmission definition is based on the claim from the readmission having a code for a diagnosis or procedure that is considered planned; however, if a planned procedure is accompanied by a principal diagnosis in a specified list of acute diagnoses, the readmission is reclassified as unplanned. Readmissions to psychiatric hospitals or units are classified as planned readmissions. We use the most current available version of the CMS planned readmission algorithm from the HWR measure specifications for measure calculation and make necessary updates to the additions made for PAC settings to ensure the algorithm corresponds to our measurement period.

¹¹¹ Appendix E. Planned Readmission Algorithm Version 4.0 2018 (ICD-10). In: 2018 All-Cause Hospital Wide Measure Updates and Specifications Report: Hospital-Level 30-Day Risk-Standardized Readmission Measure – Version 7.0. Available at:

https://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228890804653&blobheader=multi part%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3DHospWide_Readmission_AUS_Report_2018_3-28.pdf&blobcol=urldata&blobtable=MungoBlobs or <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=OnetPublic%2FPAGE%2FOnetTier4&cid=1219069855841>.

¹¹² NQF #2510: Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM). www.qualityforum.org/QPS/2510

¹¹³ NQF #2502: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities. www.qualityforum.org/QPS/2502

¹¹⁴ NQF #2512: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long Term Care Hospitals. www.qualityforum.org/QPS/2512

¹¹⁵ NQF #2380: Rehospitalization During the First 30 Days of Home Health. www.qualityforum.org/QPS/2380

¹¹⁶ NQF #1789: Hospital-Wide All-Cause Readmission Measure (HWR) (CMS/Yale). www.qualityforum.org/QPS/1789

¹¹⁷ Table 2-9. AHRQ CCS Single Level Procedure Codes and ICD-9 Procedure Codes Added to Yale's Planned Readmission Algorithm, for the Post-Acute Care Setting. In: Measure Specifications for Measures Adopted in the FY 2017 IRF QRP Final Rule. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-IRF-QRP-Final-Rule.pdf>. Note: The ICD-9 codes listed in Table 2-9 were updated with ICD-10-CM codes for data starting October 1, 2015.

While this measure was developed with ICD-9-CM procedure and diagnosis codes, it has been transitioned using the ICD-9-CM to ICD-10-CM crosswalk.

Numerator Details: Death in the 31-Day Post-Discharge Observation Window

Patients who are discharged to the community are not considered to have a successful discharge to community outcome for this measure if they die in the post-discharge window, which includes the day of discharge and the 31 days following day of discharge. Death in the post-discharge window is identified based on date of death from Medicare eligibility files.

Target Population and Measure Exclusions

The target population for the measure is the group of Medicare FFS patients who are not excluded for the reasons listed below.

Measure Exclusions

Exclusions for the discharge to community measure are listed below, along with the rationale and data source for each exclusion. Baseline NF residence is based on data from the Minimum Data Set (MDS). All other measure exclusion criteria are determined by processing Medicare claims and eligibility data to determine whether the individual exclusion criteria are met. Only IRF stays that are preceded by a short-term acute care stay in the 30 days prior to the IRF admission date are included in the measure. Stays ending in transfers to the same level of care are excluded.

1) *Age under 18 years*

Rationale:

- a. There is limited literature on discharge destination outcomes in this age group;
- b. Patients in this age group represent a different cohort, likely living with their parents, and may be expected to have higher discharge to community rates compared with the rest of the Medicare population; and
- c. Patients in this age group represent a small proportion of the post-acute Medicare FFS population.

Data source: Birth date and IRF admission date from Inpatient Standard Analytic File (SAF).

2) *No short-term acute care stay within the 30 days preceding IRF admission*

Rationale: Acute care claims from the 30 days prior to IRF admission provide the principal diagnosis and other important patient data for risk adjustment. Patients without a short-term acute care discharge within the 30 days prior to PAC admission are excluded from the measure, because important risk adjustment data are missing.

Data source: Hospital discharge date in Inpatient SAF acute care claims in the 30 days before IRF admission.

3) *Discharges to psychiatric hospital*

Rationale: Patients discharged to psychiatric hospital are excluded from the measure because community living at the time of discharge may be potentially inappropriate or unsafe for them due to their mental health or psychiatric condition.

Data source: Patient discharge status code from Inpatient SAF IRF claim.

4) *Discharges against medical advice*

Rationale: Patients who discharge themselves against medical advice are excluded because their care plan may not have been fully implemented, and the discharge destination may not reflect the facility's discharge recommendation. Additionally, patients discharged against medical advice may potentially be at higher risk of post-discharge readmissions or death, depending on their medical condition, or due to potential non-adherence or non-compliance with care recommendations.

Data source: Patient discharge status code from Inpatient SAF IRF claim.

5) *Discharges to disaster alternative care sites or federal hospitals*

Rationale: Patients discharged to disaster alternative care sites are excluded because these discharges are likely influenced by external emergency conditions and may not represent discretionary discharges by the IRF provider. Discharges to federal hospitals are also excluded.

Data source: Patient discharge status code from Inpatient SAF IRF claim.

6) *Discharges to court/law enforcement*

Rationale: Patients who are discharged to court or law enforcement are likely ineligible for discharge to the community due to legal restrictions.

Data source: Patient discharge status code from Inpatient SAF IRF claim.

7) *Patients discharged to hospice or those with a hospice benefit in the 31-day post-discharge window*

Rationale:

- a. Patients discharged to hospice care and those with a hospice benefit in the post-discharge observation window are terminally ill and have very different goals of care compared with non-hospice patients. For non-hospice patients, the primary goal of post-acute care is to return to baseline, independent living in the community; death is an undesirable outcome in the non-hospice population. For patients on hospice, the goal is to provide them the opportunity to die comfortably, at home or in a facility.
- b. A large proportion of patients on hospice care die in the 31-day window following discharge from the post-acute setting.
- c. The hospice agency, not the post-acute care setting, makes the final decision of discharge to hospice-home or hospice-facility.

Data source: Discharge to hospice is determined based on the Inpatient SAF IRF claim. Post-discharge hospice benefit is determined based on hospice enrollment dates (start and termination dates) in the Enrollment Database (EDB).

8) *Patients not continuously enrolled in Part A FFS Medicare for the 12 months prior to IRF admission date, and at least 31 days after IRF discharge date*

Rationale: Patients not continuously enrolled in Part A FFS Medicare for the 12 months prior to the IRF admission date are excluded because risk adjustment for certain comorbidities requires information on acute inpatient bills for one year prior to IRF admission. Patients not continuously enrolled in Part A FFS Medicare for at least 31 days after IRF discharge are excluded because readmissions and death must be observable in the 31-day post-discharge period. Patients without Part A coverage or those who are enrolled in Medicare Advantage plans will not have complete inpatient claims in the system.

Data source: EDB and Denominator Files.

9) *Patients whose prior short-term acute care stay was for non-surgical treatment of cancer*

Rationale: Patients whose prior short-term acute care stay was for non-surgical treatment of cancer are excluded because they have a different trajectory for recovery after discharge, with a high mortality rate.¹¹⁸ Exclusion of these patients is consistent with the HWR and PAC readmission measures.

Data source: Diagnosis codes from the Inpatient SAF prior acute claim.

10) *IRF stays that end in transfer to the same level of care*

Rationale: IRF stays that end in transfer to the same level of care are excluded because their IRF episode has not ended. For an IRF episode that involves transfer to the same level of care, only the final IRF provider is included in the measure.

Data source: Patient discharge status code from Inpatient SAF IRF claim.

11) *IRF stays with claims data that are problematic (e.g., anomalous records for stays that overlap wholly or in part, or are otherwise erroneous or contradictory, stays not matched to the denominator or EDB files, claims not paid)*

Rationale: This measure requires accurate information from the IRF stay and prior short-term acute care stay in the elements used for risk adjustment. No-pay IRF stays involving exhaustion of Part A benefits are also excluded.

Data source: Inpatient SAF claims, EDB and denominator files.

12) *Planned discharges to an acute or LTCH setting*

Rationale: Planned discharges to an acute care hospital or LTCH are excluded because these patients had a planned return to higher level of care and discharge to community is not appropriate for these patients.

Data source: The planned readmission algorithm is applied to diagnosis and procedure codes found on the first acute care or LTCH claim, if any, on the day of or day after index IRF discharge.

13) *Medicare Part A benefits exhausted*

Rationale: Patients who have exhausted their Medicare Part A coverage during the IRF stay are excluded because the discharge destination decision may be related to exhaustion of benefits.

Data source: Inpatient SAF IRF claim

14) *Patients who received care from a facility located outside of the United States, Puerto Rico or a U.S. territory*

Rationale: Patients who received care from foreign facilities may not have complete inpatient claims in the system, and these facilities may not be subject to policy decisions related to this quality measure.

Data source: CMS Certification Number from the Inpatient SAF IRF claim.

¹¹⁸ NQF #1789: Hospital-Wide All-Cause Readmission Measure (HWR) (CMS/Yale).
www.qualityforum.org/QPS/1789

15) ***New proposed exclusion:*** Patients who had a long-term NF stay in the 180 days preceding their hospitalization and IRF stay, with no intervening community discharge between the long-term NF stay and qualifying hospitalization for measure inclusion (i.e., baseline NF residents)



Rationale: Baseline NF residents did not live in the community prior to their IRF stay and discharge to a community setting may not be a safe or expected outcome for these residents.

Data source: We examine historical MDS data in the 180 days preceding the qualifying prior acute care admission and index IRF stay. Presence of an OBRA-only¹¹⁹ assessment (not a SNF PPS assessment) with no intervening community discharge between the OBRA assessment and acute care admission date flags the index IRF stay as baseline NF resident.

Data Sources

This measure is based on Medicare FFS administrative claims and uses data in the Medicare eligibility files, inpatient claims, and MDS. The eligibility files provide information such as date of birth, date of death, sex, reasons for Medicare eligibility, periods of Part A coverage, and periods in the Medicare FFS program. The data elements from the Medicare FFS claims are those basic to the operation of the Medicare payment systems and include data such as date of admission, date of discharge, diagnoses, procedures, indicators for use of dialysis services, and indicators of whether the Part A benefit was exhausted. The inpatient claims data files contain patient-level PAC and other hospital records. Historical MDS data are used to identify baseline NF residents. No data beyond those submitted in the normal course of business are required from IRF providers for the calculation of this measure.

The following are the specific files used for measure calculation with links to their documentation:

- *Medicare Inpatient claims (SAF), Index PAC claims* - Documentation for the Medicare claims data is provided online by Research Data Assistance Center (ResDAC). The following web page includes data dictionaries for the Inpatient SAF (Inpatient Research Identifiable File (RIF)): <http://www.resdac.org/cms-data/files/ip-rif/data-documentation> 
- *Medicare Enrollment Database* - Information about the EDB may be found at: <http://aspe.hhs.gov/datacncl/datadir/cms.htm>
- *Medicare Denominator file* - Information and documentation are available at: <https://aspe.hhs.gov/report/data-health-and-well-being-american-indians-alaska-natives-and-other-native-americans-data-catalog/medicare-denominator-file> and [ftp://ftp.cdc.gov/pub/health_statistics/nchs/datalinkage/Denominator%20\(edited\).pdf](ftp://ftp.cdc.gov/pub/health_statistics/nchs/datalinkage/Denominator%20(edited).pdf)
- *Minimum Data Set (MDS)* - Documentation available at: <https://www.resdac.org/cms-data/files/mds-3.0> 

Measure Time Window

The measure is calculated using two years of data. All IRF stays during the two-year time window, except those that meet the exclusion criteria, are included in the measure. For patients with multiple stays during the two-year time window, each stay is eligible for inclusion in the measure. Data from CY 2012-2013 were used to develop this measure. The analyses in this document are based on CY 2015-2016 data.

Statistical Risk Model and Risk Adjustment Covariates

We used a hierarchical logistic regression method to predict the probability of discharge to community. Patient characteristics related to discharge and a marker for the specific discharging facility

¹¹⁹ OBRA = Omnibus Budget Reconciliation Act

are included in the equation. The equation is hierarchical in that both individual patient characteristics are accounted for, as well as the clustering of patient characteristics by facility. The statistical model estimates both the average predictive effect of the patient characteristics across all facilities, and the degree to which each facility has an effect on discharge to community that differs from that of the average facility. The facility effects are assumed to be randomly distributed around the average (according to a normal distribution). When computing the facility effect, hierarchical modeling accounts for the known predictors of discharge to community, on average, such as patient characteristics, the observed facility rate, and the number of facility stays eligible for inclusion in the measure. The estimated facility effect is determined mostly by the facility's own data if the number of patient discharges is relatively large (as the estimate would be relatively precise) but is adjusted toward the average if the number of patient discharges is small (as that would yield a less precise estimate).

We used the following model:

Let Y_{ij} denote the outcome (equal to 1 if patient i is discharged to community, 0 otherwise) for a patient i at facility j ; Z_{ij} denotes a set of risk adjustment variables. We assume the outcome is related to the risk adjusters via a logit function with dispersion:

$$\begin{aligned} \text{logit}(\text{Prob}(Y_{ij}=1)) &= \alpha_j + \beta * Z_{ij} + \varepsilon_{ij} \\ \alpha_j &= \mu + \omega_j; \omega_j \sim N(0, \tau^2) \end{aligned} \tag{1}$$

where $Z_{ij} = (Z_1, Z_2, \dots, Z_k)$ is a set of k patient-level risk adjustment variables; α_j represents the facility-specific intercept; μ is the adjusted average outcome across all facilities; τ^2 is the between-facility variance component; and $\varepsilon \sim N(0, \sigma^2)$ is the error term. The hierarchical logistic regression model is estimated using SAS software (PROC GLIMMIX: SAS/STAT User's Guide, SAS Institute Inc.).

The estimated equation is used twice in the measure. The sum of the probabilities of discharge to community of all patients in the facility measure, including both the effects of patient characteristics and the facility, is the "predicted number" of discharges to community after adjusting for the facility's case mix. The same equation is used without the facility effect to compute the "expected number" of discharges to community for the same patients at the average facility. The ratio of the predicted-to-expected number of discharges to community is a measure of the degree to which discharges to community are higher or lower than what would otherwise be expected. This standardized risk ratio (SRR) is then multiplied by the mean discharge to community rate for all facility stays for the measure, yielding the risk-standardized discharge to community rate for each facility. Please note that the estimation procedure is recalculated for each measurement period. Re-estimating the models for each measurement period allows the estimated effects of the patient characteristics to vary over time as patient case-mix and medical treatment patterns change.

Risk adjustment variable descriptions are provided below. See Appendix B, Table B-1 for the full list of variables in the risk adjustment models.

1. Age and sex groups.
2. End stage renal disease (ESRD) or disability as original reason for entitlement.
3. Principal diagnosis (Clinical Classifications Software (CCS) groups) from the prior acute stay in the past 30 days. The principal diagnosis codes from the prior acute claim are grouped clinically using the CCS groupings developed by the Agency for Healthcare Research and Quality (AHRQ).^{120,121}

¹²⁰ AHRQ CCS groupings of ICD-9 codes - Documentation available at: <http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp>

¹²¹ AHRQ CCS groupings of ICD-10 codes - Documentation available at: <https://www.hcup-us.ahrq.gov/toolssoftware/ccs10/ccs10.jsp>

4. IRF case-mix groups.
5. Surgical procedure categories (if present) based on the prior acute stay in the past 30 days. The procedures are grouped using the CCS groupings of procedures developed by AHRQ.¹²²
6. Indicator for ESRD status.
7. Dialysis in prior acute stay where ESRD not indicated.
8. Length of prior acute hospital stay in days for patients whose prior acute stay was in a non-psychiatric hospital (categorical variables are used to account for nonlinearity); indicator of prior psychiatric hospital stay for patients whose prior acute stay was in a psychiatric hospital.
9. Comorbidities based on prior acute stay in the past 30 days or based on a one year look back, depending on the specific comorbidity. Comorbidities are clustered using the Hierarchical Condition Categories [HCC] groups used by CMS.¹²³
10. Number of prior acute hospital discharges in the past year, not including the hospitalization in the 30 days prior to the IRF stay.

Measure Calculation Algorithm

The following steps describe the calculation algorithm/measure logic for the discharge to community measures:

- Step 1:* Identify patients meeting the criteria for the target population, after applying measure exclusions.
- Step 2:* Identify patients meeting the numerator criteria, i.e., discharge to community, no unplanned readmissions on the day of discharge or in the 31 days following discharge, and no death on the day of discharge or in the 31 days following discharge.
- Step 3:* Identify presence or absence of risk adjustment variables for each patient.
- Step 4:* Calculate the predicted and expected number of discharges to community for each facility using the hierarchical logistic regression model.

The predicted number of discharges to community for each facility is calculated as the sum of the predicted probability of discharge to community for each patient discharged from the facility and included in the measure, including the facility-specific effect.

To calculate the predicted number of discharges to community, $pred_j$, for index facility stays at facility_j, we used the following equation:

$$pred_j = \sum \text{logit}^{-1}(\mu + \omega_i + \beta * Z_{ij}) \quad (2)$$

where the sum is over all stays in facility_j, and ω_i is the random intercept.

To calculate the expected number exp_j , we used the following equation:

¹²² *Ibid*

¹²³ CMS-HCC Mappings of ICD-9 and ICD-10 Codes: Mappings are included in the software at the following website: <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Risk-Adjustors.html>

$$\text{exp}_j = \Sigma \text{logit}^{-1} (\mu + \beta * Z_{ij}) \quad (3)$$

Step 5: Calculate the SRR for each facility, as the ratio of the predicted to expected number of discharges to community.

To calculate the facility-wide SRR, SRR_j , we used the following equation:

$$\text{SRR}_j = \text{pred}_j / \text{exp}_j \quad (4)$$

Step 6: Calculate the risk-standardized discharge to community rate for each facility.

To aid interpretation, the facility-wide SRR_j , obtained from equation (4) is then multiplied by the overall national raw discharge to community rate for all facility stays, \bar{Y} , to produce the facility-wide risk-standardized discharge to community rate (RSR_j).

To calculate the risk-standardized discharge to community rate for each facility, we used the following equation:

$$\text{RSR}_j = \text{SRR}_j * \bar{Y} \quad (5)$$

NOTE: Because the statistic described in Step 6 is a complex function of parameter estimates, re-sampling using bootstrapping may be necessary to derive a confidence interval estimate for the final risk-standardized rate, to characterize the uncertainty of the estimate.

See **Appendix B** for risk adjustment model results and providers' observed and risk-standardized score distributions.

Chapter 2 Standardized Patient Assessment Data Elements

Section 1: Introduction

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires CMS to develop, implement, and maintain standardized patient assessment data elements (SPADEs) for post-acute care (PAC) settings. The four PAC settings specified in the IMPACT Act are home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs), and skilled nursing facilities (SNFs). The goals of implementing cross-setting SPADEs are to facilitate care coordination, interoperability, and improve Medicare beneficiary outcomes.

Existing PAC assessment instruments (i.e., OASIS for HHAs, IRF-PAI for IRFs, LCDS for LTCHs, and the MDS for SNFs) often collect data elements pertaining to similar concepts, but the individual data elements -- questions and response options -- vary by assessment instrument. With a few exceptions, the data elements collected in these assessment instruments are not currently standardized or interoperable, therefore, patient responses across the assessment instruments cannot be compared easily.

The IMPACT Act further requires that the assessment instruments described above be modified to include core data elements on health assessment categories and that such data be standardized and interoperable. Implementation of a core set of standardized assessment items across PAC settings has important implications for Medicare beneficiaries, families, providers, and policymakers. CMS is proposing standardized patient assessment data elements for five categories specified in the IMPACT Act. These categories are:

1. Cognitive function (e.g., able to express ideas and to understand normal speech) and mental status (e.g., depression and dementia)
2. Special services, treatments, and interventions (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
3. Medical conditions and co-morbidities (e.g., diabetes, heart failure, and pressure ulcers)
4. Impairments (e.g., incontinence; impaired ability to hear, see, or swallow)
5. Other categories as deemed necessary by the Secretary

Background

In the following sections, we present additional information on the SPADEs proposed in the FY 2020 IRF PPS proposed rule. We include detailed specifications of the proposed data elements along with a mockup of how the SPADE is proposed to appear in the IRF-PAI. We outline how each SPADE is relevant to the care of patients in the IRF, review its current use in existing PAC assessment item sets, and summarize any prior testing of the data elements. For SPADEs that were included in the National Beta Test, which was conducted by RAND between November 2017 and August 2018, we present detailed information on data element performance.

Evidence supporting the SPADEs proposed in the IRF PPS proposed rule comes from several sources including the Post-Acute Care Payment Reform Demonstration (PAC PRD), Minimum Data Set 3.0 (MDS 3.0) testing, and the National Beta Test. The most relevant metrics for evaluation of SPADE performance (i.e., feasibility and reliability) include the amount of missing data, time to administer the data element, and interrater reliability (IRR). Interrater reliability is the level of agreement between two raters; that is, the extent to which two different individuals would code the same response when presented with the same information. Typically, percent agreement and the kappa statistic – or weighted kappas, for ordinal data – are used to represent IRR. The kappa statistic is preferred in most cases because there are agreed-upon conventions for its interpretation and it corrects for chance agreement between raters.

However, kappa is sensitive to prevalence rates; when prevalence rates are extremely high or low, the resulting kappa statistic does not accurately convey the level of agreement.^{124 125 126 127} In those cases, percent agreement is preferred. The evidence offered for the SPADEs in the sections below follows standard conventions in reporting both percent agreement and kappas or weighted kappas to describe IRR.

Post-Acute Care Payment Reform Demonstration (PAC PRD)

Some prior evidence for the proposed SPADEs comes from the PAC PRD. The PAC PRD was mandated by the Deficit Reduction Act of 2005 to examine the relative costliness and outcomes of similar types of Medicare beneficiaries discharged to different PAC settings (i.e., HHAs, IRFs, LTCHs, and SNFs). To meet these aims, the study collected standardized assessment data, using the Continuity Assessment Record and Evaluation (CARE) across PAC settings to measure patient severity and case-mix across settings in over 200 providers in 11 geographically diverse markets. The standardized assessment data allowed cross-setting comparisons of the factors associated with costs and outcomes, as well as service substitution among post-acute providers, all else being equal about the patient. Further information on the design and methods of the PAC PRD can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

Testing of the Minimum Data Set 3.0 (MDS 3.0)

Additional testing information comes from the national testing of the MDS 3.0.¹²⁸ During a six-year period starting in 2003, CMS engaged in a national project to create an improved version of the MDS 2.0. A joint RAND/Harvard team employed an iterative development process that culminated in the national testing of the MDS 3.0 in 2006-2007. The national validation and evaluation testing of the MDS 3.0 included 71 community nursing homes (3,822 residents) and 19 Veterans Health Administration nursing homes (764 residents), distributed throughout the regions of the United States. The evaluation was designed to test and analyze interrater reliability, validity of key items, response rates for interview items, feedback on changes from participating nurses, and time to complete the MDS assessment. In addition, the national test design allowed comparison of item distributions between MDS 3.0 and MDS 2.0. Further information on the design and methods of MDS 3.0 testing can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReport.pdf>.

National Beta Test

Purpose and Goals

The National Beta Test was conducted to evaluate the reliability and validity of candidate SPADEs and to support the identification of data elements for standardization across PAC settings, in accordance with the mandates of the IMPACT Act. To test SPADE performance within each setting, sufficient numbers of patients/residents needed to be included in each of the four settings to enable setting-specific performance estimates. Further, the participating patients/residents needed to represent

¹²⁴ Cicchetti, D. V., Feinstein, A. R. (1990). High agreement but low kappa: II. Resolving the paradoxes. *Journal of Clinical Epidemiology*, 43(6):551-558.

¹²⁵ Xu, S., Lorber, M. F. (2014). Interrater agreement statistics with skewed data: Evaluation of alternatives to Cohen's kappa. *Journal of Consulting and Clinical Psychology*, 82(6):1219-1227.

¹²⁶ Byrt, T., Bishop, J., Carlin, J. B. (1993). Bias, prevalence and kappa. *Journal of Clinical Epidemiology*, 46(5):423-429.

¹²⁷ McHugh, M. L. (2002). Interrater reliability: the kappa statistic. *Biochemia Medica*, 22(3):276-282.

¹²⁸ Saliba, D., & Buchanan, J. (2008). Development and validation of a revised nursing home assessment tool: MDS 3.0. Santa Monica, CA: RAND Corporation. 2008. Available at <http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf>

adequate coverage of the clinical range of patients/residents receiving care nationally in each of the four PAC settings. To evaluate the suitability of the SPADEs for cross-setting use, sufficient numbers of facilities/agencies of each setting type needed to be included in the test. These facilities/agencies needed to reflect a reasonable range of geographic diversity relative to PAC settings nationally.

Many large national studies of patients and health conditions are designed to generate estimates and make comparisons of rates of conditions or severity of patients on one or more clinical characteristics (e.g., cognitive status). To do this, these studies seek to recruit a proportionally balanced representative sample, and employ casemix models and/or sampling weights to the data. In contrast, the National Beta Test was designed to generate valid and robust national SPADE performance estimates (i.e., time to complete and IRR), which fundamentally requires acceptable geographic diversity, sufficient sample size, and reasonable coverage of the range of clinical characteristics. To meet these requirements, the National Beta Test was carefully designed so that data could be collected from a wide range of environments, allowing for thorough evaluation of candidate SPADE performance in all PAC settings. These analyses included extensive checks on the sampling design (e.g., generating results by market and by urbanicity) to identify possible limitations to the generalizability of results. Results of these sensitivity analyses are not included in this document, but will be described in detail in the forthcoming volumes of the National Beta Test Final Report (see <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html>).

In order to help readers interpret evidence from the National Beta Test that is included for some SPADEs, we include an abridged description of the National Beta Test design and methods below. An in-depth technical discussion of the design and methods of the National Beta Test can be found in the document titled “Development and Evaluation of Candidate SPADEs_National Beta Test Background and Methods,” available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html>.

Design and Sampling

The National Beta Test included PAC providers in a total of 14 markets across the country. This number of markets was chosen to be similar to the design used for the PAC PRD. A multi-stage stratified random sampling plan was used to obtain the sample of 14 geographic/metropolitan areas, or “markets,” in the United States, and then a sample of eligible PAC facilities was compiled from those markets. To be eligible for selection, markets had to meet the following criteria:

- Sampled markets would yield a predefined number of PAC facilities/agencies of each type for the sample (12 SNFs, 10 HHAs, at least four LTCHs *or* IRFs, *and* at least one LTCH)
- The predefined number of facilities/agencies within the markets were expected to have flow rates large enough to obtain the targeted number of assessments per facility
- The predefined number of facilities/agencies had to be located within two hours of one another to facilitate completion of assessments in a timely manner

Of 306 markets in the U.S., 64 were deemed eligible. The random sampling of the 14 markets was stratified by U.S. Census division to enhance geographic representation yielding the following 14 markets: Boston, MA, Chicago, IL, Dallas, TX, Durham, NC, Fort Lauderdale, FL, Harrisburg, VA, Houston, TX, Kansas City, MO, Los Angeles, CA, Nashville, TN, Philadelphia, PA, Phoenix, AZ, St. Louis, MO, and San Diego, CA. Given these markets are a random sample, they are expected to be representative of the set of 64 eligible facilities and findings generalizable to the set of eligible facilities.

The target numbers of providers by setting within these 14 markets were 28 IRFs, 28 LTCHs, 84 SNFs, and 70 HHAs, totaling 210 PAC providers. The number of settings was determined based on

standard sample size calculations which included the numbers of facilities and patients rather than the proportions of the populations they represented. The power calculations indicated that 28 providers per setting type (two in each market) would yield sufficient numbers of admissions during the field period to obtain robust estimates of candidate SPADE performance. This minimum number was adopted as the recruitment target for IRFs and LTCHs; additional SNFs and HHAs were targeted so as to enhance sample diversity in light of the larger proportion of these setting types nationally. A total of 143 PAC facilities were successfully recruited across 14 U.S. markets (35 HHAs, 22 IRFs, 26 LTCHs, 60 SNFs) to participate in the National Beta Test. Although this number falls short of targets both overall and by setting, this shortfall was offset by extending the field period, allowing for the accrual of more eligible patient/resident admissions and discharges.

Eligibility

The National Beta Test SPADEs included in this proposed rule were evaluated for performance among a sample of communicative patients/residents (who could make themselves understood through any means). All communicative patients/residents who were admitted to a participating provider site during the field period and were Medicare beneficiaries covered under one of the PAC prospective payment systems were eligible for the admission assessment, and all those who completed an admission assessment and were discharged during the field period were eligible for the discharge assessment. National Beta Test enrollment of non-communicative patients/residents was not tied to an admission date so as to ensure availability of sufficient numbers within the field period for evaluation of three data elements developed specifically for non-communicative patients/residents (observational assessments of cognitive status, mood, and pain). Although this ensured availability of sufficient numbers of non-communicative patients/residents for testing of the non-communicative data elements, it precluded assessing these patients/residents with non-interview SPADEs at admission. The three data elements developed specifically for non-communicative patients/residents are not included in this proposed rule, thus the non-communicative sample from the National Beta Test is not described further here.

Section 1557 of the Patient Protection and Affordable Care Act¹²⁹ states that facilities that deliver PAC services under Medicare are required to provide qualified interpreters to their patients/residents with limited English proficiency. Facilities have discretion in how they furnish qualified interpreters, including the use of remote interpreters (i.e., high-quality telephone or video services). As described above, the focus of the National Beta Test was to establish the feasibility and validity of the data elements within and across PAC settings. Including limited English proficiency patients/residents in the sample would have required the Beta test facilities to engage or involve translators during the test assessments. In planning the National Beta Test, we anticipated that this would have added undue complexity to what facilities/agencies were being asked to do, and would have undermined the ability of facility/agency staff to complete the requested number of assessments within the assessment window (e.g., Admission Days 3-7) and within the study field period. In light of the strong existing evidence for the feasibility of all patient/resident interview SPADEs included in this proposed rule (BIMS, Pain Interference, PHQ) when administered in other languages, either through standard PAC workflow (e.g., as tested and currently collected in the MDS 3.0) and/or through rigorous translation and testing (e.g., PHQ), the performance of translated versions of these patient/resident interview SPADEs did not need to be further evaluated. In addition, because their exclusion did not threaten our ability to achieve acceptable geographic diversity, sufficient sample size, and reasonable coverage of the range of PAC patient/resident clinical characteristics, the exclusion of limited English proficiency patients/residents was not considered a limitation to interpretation of the National Beta Test results.

¹²⁹ <https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html>

Data Collection

Admission assessments were completed between admission days 3-7; discharge assessments could be completed from two days prior to discharge through the discharge date. Trained research nurses and/or staff at participating PAC facilities/agencies administered all assessments. A subset of the admission assessments was completed by research nurse/facility staff assessor pairs to allow for evaluation of interrater reliability. Power analyses indicated that reliability estimates required a minimum of 194 paired assessments, time to complete estimates could be compared across settings for detection of small effect sizes with a minimum of 274 assessments per setting, and as few as 460 assessments would be sufficient to evaluate aspects of validity (e.g., group differences, associations with other clinical variables, etc.) with small to moderate effect sizes. Therefore, average assessment contributions per participating facility/agency were calculated for each of these goals (i.e., paired assessments, assessments completed by facility/agency staff, total admission assessments) and communicated throughout the study period to guide the data collection and track progress. These minimums were more easily attainable in SNFs and HHAs due to the larger number of participating facilities/agencies. However, participating LTCHs and IRFs were able to collectively meet these targets by the end of the field period. The total number of admission assessments is shown in Appendix C, Table 1.1. This table also shows the number of assessments from which completion times were estimated, and the number of assessments that were conducted by paired raters and contributed to evaluation of interrater reliability (IRR). In addition to meeting the minimum sample size requirements, the data collection yielded very small rates of missing data, speaking to the overall feasibility of the proposed SPADEs. Table 1.2 in Appendix C shows completion rates by Beta protocol module. Module completion rates ranged from 93.8 to 98.2 percent, and nearly 90 percent of the communicative admission sample completed all assessment modules. More information on the design and methods of the National Beta Test can be found in the document titled “Development and Evaluation of Candidate SPADEs_National Beta Test Background and Methods,” available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html>.

Section 2: Cognitive Function

Impairments in cognitive function can result from many underlying conditions, including dementia, Alzheimer’s Disease, stroke, brain injury, side effects of medication, metabolic and/or endocrine imbalances, and delirium.¹³⁰ Cognitive impairments may affect a patient or resident’s ability to recover from illness or injury, or they may be a sign of an acute condition (e.g., hypoxia) that requires immediate intervention. Cognitive impairment that manifests with behavioral symptoms—or that impairs a patient’s ability to communicate, prompting behavioral disturbances—may put the patient or resident or others in the care setting at risk for injury or assault, or may signal unmet patient or resident needs (e.g., pain management). Screening for the presence of impairment can help ensure appropriate and timely intervention.

A substantial proportion of PAC patients and residents experience cognitive impairment, delirium, communication impairment, or behavioral distress. Testing from the PAC PRD found that about one-third of patients and residents in PAC settings were classified as having moderately or severely impaired cognitive function.^{131 132} About one-third exhibited disorganized thinking and altered level of consciousness, and about one-half exhibited inattention. Fewer than 7 percent of patients and residents exhibited signs and symptoms of behavioral distress in the PAC PRD.

Therapeutic interventions can improve patient outcomes, and evidence suggests that treatment (e.g., drugs, physical activity) can stabilize or delay symptom progression in some patients, thereby improving quality of life.^{133 134 135} In addition, assessments help PAC providers to better understand the needs of their patients by establishing a baseline for identifying changes in cognitive function and mental status (e.g., delirium), elucidating the patient’s ability to understand and participate in treatments during their stay, highlighting safety needs (e.g., to prevent falls), and identifying appropriate support needs at the time of discharge. The standardized assessment of patient or resident cognition supports clinical decision-making, early clinical intervention, person-centered care, and improved care continuity and coordination. The use of valid and reliable standardized assessments can aid in the communication of information within and across providers, enabling the transfer of accurate health information.

CMS has identified several data elements as applicable for cross-setting use in standardized assessment of cognitive impairment. The proposed data elements comprise:

1. The Brief Interview for Mental Status (BIMS);
2. The Confusion Assessment Method (CAM)

¹³⁰ National Institute on Aging. (2013). “Assessing Cognitive Impairment in Older Patients: A Quick Guide for Primary Care Physicians.” Available at <https://www.nia.nih.gov/alzheimers/publication/assessing-cognitive-impairment-older-patients>

¹³¹ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. 2012. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

¹³² This estimate is based on responses to the Brief Interview for Mental Status (BIMS) in a study of patient/residents in the Post-Acute Care Payment Reform Demonstration (Gage et al., 2012).

¹³³ Casey, D. A., Antimisiaris, D., & O’Brien, J. (2010). “Drugs for Alzheimer’s disease: are they effective?” *Pharmacy and Therapeutics* 35(4): 208.

¹³⁴ Bherer, L., Erickson, K. I., & Liu-Ambrose, T. (2013). “A review of the effects of physical activity and exercise on cognitive and brain functions in older adults.” *Journal of Aging Research*. 2013.

¹³⁵ Langa, K. M., & Levine, D. A. (2014). “The diagnosis and management of mild cognitive impairment: a clinical review.” *JAMA* 312(23): 2551-2561.

The data elements proposed involve different aspects of cognition (e.g., short term memory, comprehension), types of data (e.g., interview, performance-based), and are collected by various modes (e.g., clinician assessed, patient reported).

Brief Interview for Mental Status (BIMS)

The Brief Interview for Mental Status (BIMS) is a performance-based cognitive assessment developed to be a brief cognition screener with a focus on learning and memory. The BIMS evaluates repetition, recall with and without prompting, and temporal orientation.

Relevance to IRFs

The BIMS is currently included in the IRF-PAI assessment on admission. Assessing cognitive functioning is critical in IRF settings, as cognitive impairments are common among IRF patients. Although more comprehensive cognitive assessment is commonplace in IRFs (e.g., instruments incorporated in speech therapy or administered by neuropsychologists), standardized assessment tools can provide comparable baseline information if uniformly administered to all patients and standardized across provider types. An estimated 22.2 percent of IRF patients are moderately impaired, and 11.6 percent are severely impaired, as assessed by the BIMS in the PAC PRD.¹³⁶ Patients with brain injury and stroke are commonly transferred to IRFs for intensive post-acute care: approximately 21 percent of IRF patients have a primary diagnosis of stroke, and approximately 8 percent have a primary diagnosis of brain injury.¹³⁷ In addition, cognitive impairments are associated with engagement in rehabilitation therapies,¹³⁸ and individuals with severe cognitive impairment as measured by BIMS at IRF admission are more likely to be readmitted after discharge.¹³⁹ Cognitive impairment has significant implications for patient resource utilization, ability to participate in rehabilitation therapies, and care planning in IRFs. The standardized assessment of cognitive function using the BIMS would provide important information for care planning, care transitions, patient safety, and resource use in IRFs.

Proposed Data Elements for the Assessment of Cognitive Function: The BIMS

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?	
Attempt to conduct interview with all patients.	
Enter Code <input type="checkbox"/>	0. No (patient is rarely/never understood) → <i>Skip to XXXX</i> 1. Yes → <i>Continue to C0200, Repetition of Three Words</i>
Brief Interview for Mental Status (BIMS)	
C0200. Repetition of Three Words	

¹³⁶ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. (2012). Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

¹³⁷ Medicare Payment Advisory Commission. (2016). Report to the Congress: Medicare Payment Policy. Chapter 9 Inpatient rehabilitation facility services. Retrieved from <http://www.medpac.gov/-documents-/reports>

¹³⁸ E.J. Lenze, M.C. Munin, M.A. Dew, et al. (2004). Adverse effects of depression and cognitive impairment on rehabilitation participation and recovery from hip fracture. *Int J Geriatr Psychiatry* 19: 472–478

¹³⁹ Gage B., Morley M., Smith L., et al. (2012). Post-Acute Care Payment Reform Demonstration (Final report, Volume 4 of 4). Research Triangle Park, NC: RTI International.

Enter Code <input type="checkbox"/>	Ask patient: <i>“I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue and bed. Now tell me the three words.”</i> Number of words repeated after first attempt 0. None 1. One 2. Two 3. Three After the patient’s first attempt, repeat the words using cues (<i>“sock, something to wear; blue, a color; bed, a piece of furniture”</i>). You may repeat the words up to two more times.
C0300. Temporal Orientation (orientation to year, month, and day)	
Enter Code <input type="checkbox"/>	Ask patient: <i>“Please tell me what year it is right now.”</i> A. Able to report correct year 0. Missed by > 5 years or no answer 1. Missed by 2-5 years 2. Missed by 1 year 3. Correct
Enter Code <input type="checkbox"/>	Ask patient: <i>“What month are we in right now?”</i> B. Able to report correct month 0. Missed by > 1 month or no answer 1. Missed by 6 days to 1 month 2. Accurate within 5 days
Enter Code <input type="checkbox"/>	Ask patient: <i>“What day of the week is today?”</i> C. Able to report correct day of the week 0. Incorrect or no answer 1. Correct
C0400. Recall	
Enter Code <input type="checkbox"/>	Ask patient: <i>“Let’s go back to an earlier question. What were those three words that I asked you to repeat?”</i> If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. A. Able to recall “sock” 0. No - could not recall 1. Yes, after cueing (“something to wear”) 2. Yes, no cue required
Enter Code <input type="checkbox"/>	B. Able to recall “blue” 0. No - could not recall 1. Yes, after cueing (“a color”) 2. Yes, no cue required
Enter Code <input type="checkbox"/>	C. Able to recall “bed” 0. No - could not recall 1. Yes, after cueing (“a piece of furniture”) 2. Yes, no cue required
C0500. BIMS Summary Score	
Enter Score <input type="text"/> <input type="text"/>	Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if the patient was unable to complete the interview

Current use

The BIMS data elements are currently used in the MDS and the IRF-PAI.

Prior evidence supporting use of the BIMS

The BIMS data elements were tested in the PAC PRD, where they showed substantial to almost perfect reliability of 0.71 to 0.91 (weighted kappas) when used across all four PAC settings. The lowest agreement was on the “repetition of three words” memory data element, with a kappa of 0.71, which still falls within the range of substantial agreement. PAC PRD testing also demonstrated feasibility of the BIMS for use in IRFs and found evidence of strong reliability of the BIMS data elements in the IRF setting. In addition, the BIMS data elements were found to be predictive of higher patient cost.¹⁴⁰ The BIMS data elements were also included in the national MDS 3.0 test in nursing homes and showed almost perfect reliability.¹⁴¹ Agreement ranged from 0.86 to 0.99 (standard kappa). The BIMS data elements were found to be highly correlated (0.906) with a gold-standard measure of cognitive function, the Modified Mini-Mental Status (3MS) exam.¹⁴²

Evidence supporting use of the BIMS from the National Beta Test

Assessing impairment: In the Beta testing, the BIMS was administered at admission to 646 patients/residents in the HHA setting, 786 in IRF, 496 in LTCH, and 1,134 in SNF (n = 3,062 overall). Overall, 5 percent of patients/residents met criteria for being severely impaired, 18 percent moderately impaired, and 76 percent intact. In the IRF setting, 3 percent were severely impaired, 15 percent moderately impaired, and 82 percent intact. Patients in the IRF setting showed similar impairment levels to those in an HHA and somewhat lower impairment than those in an LTCH or SNF. Setting-specific admission frequencies for BIMS data elements and the overall impairment category at admission are shown in Appendix C, Table 2.1.1.

Missing data: In general, there were low rates of missing data for BIMS items. Overall, item-level missing data ranged from 0.4 to 1.7 percent and ranged from 0.3 to 0.9 percent in the IRF setting. For all settings, missing data rates were slightly higher for recall of current day of the week. In general, the low rate of missing data indicates feasibility of administration.

Time to complete: To assess feasibility of administration, the length of time to administer the BIMS was assessed among 445 patients/residents in HHA, 537 in IRF, 332 in LTCH, and 494 in SNF (n = 1,808 overall). Overall mean time to complete the BIMS was 2.2 minutes (SD = 1.2 minutes). Time to complete in the IRF setting was 1.8 minutes (SD = 0.9 minutes).

Interrater reliability: The interrater reliability (IRR) was excellent for the BIMS as measured by kappa and percent agreement of paired raters (n = 966 paired assessments across settings; n = 259 paired assessments in IRF). Across all settings, the kappa for the BIMS Impairment Category classification (based on the BIMS total score) was 0.91; in the IRF setting, the kappa was 0.85. The kappas for individual items within the BIMS ranged from 0.83 to 0.93 across all settings and ranged from 0.81 to

¹⁴⁰ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. 2012. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

¹⁴¹ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at : <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>.

¹⁴² Saliba, D., Buchanan, J., Edelen, M. O., Streim, J., Ouslander, J., Berlowitz, D., & Chodosh, J. (2012). “MDS 3.0: Brief interview for mental status.” *Journal of the American Medical Directors Association* 13(7): 611-617.

0.91 in the IRF setting. Overall kappa values were not estimated for two items within the BIMS because the proportion of patients across settings with correct responses was out of range for a stable kappa estimate. Similarly, in the IRF setting, kappa was not estimated for three BIMS items. Percent agreement for the BIMS Impairment Category classification was 96 percent across all settings and 95 percent in the IRF setting. Percent agreement for the individual items ranged from 94 to 98 percent across settings and from 94 to 99 percent in IRFs. Please refer to Table 2.1.2 in Appendix C for kappa and percent agreement statistics for all BIMS items.

Confusion Assessment Method (CAM©)

The Confusion Assessment Method (CAM) is a widely used delirium screening tool.¹⁴³ Delirium, when undetected or untreated, can increase the likelihood of complications, rehospitalization, and death compared to patients/residents without delirium.¹⁴⁴

Although multiple versions of the CAM have been developed, CMS is proposing that the Short version be adopted for standardized patient assessment data elements. The Short CAM contains only four items (i.e., items 1 to 4) from the original Confusion Assessment Method (Long CAM). These items focus on an acute change in mental status, inattention, disorganized thinking, and altered level of consciousness.

Relevance to IRFs

The IRF-PAI does not include items to assess signs and symptoms of delirium, although delirium is common among IRF populations. In PAC PRD testing using the CAM, high proportions of IRF patients demonstrated signs and symptoms of delirium: 57.3 percent showed inattention, 44.1 percent showed disorganized thinking, and 21.4 percent showed altered level of consciousness.¹⁴⁵ Delirium may also interfere with functional recovery and a patient's ability to actively participate in intensive rehabilitation therapies,^{146 147} which is required by IRFs. In addition, presence of delirium has implications for administering and interpreting cognitive assessments,^{148 149} which has implications for assessing recovery and anticipated benefits of cognitive rehabilitation for IRF patients. As such, assessing IRF patients for signs and symptoms of delirium is critical for care planning and decision making in IRF settings, and for ensuring that IRF patients can maximally benefit from rehabilitation therapies.

The standardized assessment of delirium and reversible confusion using the Short CAM would provide important information for care planning, care transitions, patient safety, and resource use in IRFs.

¹⁴³ De, J., & Wand, A. P. (2015). Delirium screening: a systematic review of delirium screening tools in hospitalized patients. *The Gerontologist*, 55(6), 1079-1099.

¹⁴⁴ Marcantonio, E. R., Kiely, D. K., Simon, S. E., John Orav, E., Jones, R. N., Murphy, K. M., & Bergmann, M. A. (2005). Outcomes of older people admitted to postacute facilities with delirium. *Journal of the American Geriatrics Society*, 53(6): 963-969.

¹⁴⁵ Unpublished data from the PAC PRD Public Comments sample, 2008-2010.

¹⁴⁶ Marcantonio, E. R., Simon, S. E., Bergmann, M. A., et al. (2003). Delirium symptoms in postacute care: Prevalent, persistent, and associated with poor functional recovery. *Journal of the American Geriatrics Society*, 51:4e9.

¹⁴⁷ Kiely, D. K., Jones, R. N., Bergmann, M. A., et al. (2006). Association between delirium resolution and functional recovery among newly admitted postacute facility patients. *Journal of Gerontol A Biol Sci Med Sci*. 61:204e208.

¹⁴⁸ Landi, F., Liperoti, R., Bernabei, R. (2011). Postacute rehabilitation in cognitively impaired patients: comprehensive assessment and tailored interventions. *Journal of the American Medical Association* 12:395e397.

¹⁴⁹ McCusker, J., Cole, M., Dendukuri, N., et al. (2001). Delirium in older medical inpatients and subsequent cognitive and functional status: A prospective study. *Canadian Medical Association Journal* 165:575e583.

Proposed Data Elements for the Assessment of Cognitive Function: CAM

C1310. Signs and Symptoms of Delirium (from CAM©)							
Code after completing Brief Interview for Mental Status or Staff Assessment and reviewing medical record.							
A. Acute Onset Mental Status Change							
Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	Is there evidence of an acute change in mental status from the patient's baseline? 0. No 1. Yes						
Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)	<div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 5px;">↓ Enter Code in Boxes</div> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px; vertical-align: top;"><input style="width: 30px; height: 20px;" type="checkbox"/></td> <td style="padding: 5px;">B. Inattention - Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?</td> </tr> <tr> <td style="padding: 5px; vertical-align: top;"><input style="width: 30px; height: 20px;" type="checkbox"/></td> <td style="padding: 5px;">C. Disorganized thinking - Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?</td> </tr> <tr> <td style="padding: 5px; vertical-align: top;"><input style="width: 30px; height: 20px;" type="checkbox"/></td> <td style="padding: 5px;">D. Altered level of consciousness - Did the patient have altered level of consciousness as indicated by any of the following criteria? <ul style="list-style-type: none"> ▪ vigilant- startled easily to any sound or touch ▪ lethargic - repeatedly dozed off when being asked questions, but responded to voice or touch ▪ stuporous- very difficult to arouse and keep aroused for the interview ▪ comatose - could not be aroused </td> </tr> </table>	<input style="width: 30px; height: 20px;" type="checkbox"/>	B. Inattention - Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?	<input style="width: 30px; height: 20px;" type="checkbox"/>	C. Disorganized thinking - Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?	<input style="width: 30px; height: 20px;" type="checkbox"/>	D. Altered level of consciousness - Did the patient have altered level of consciousness as indicated by any of the following criteria? <ul style="list-style-type: none"> ▪ vigilant- startled easily to any sound or touch ▪ lethargic - repeatedly dozed off when being asked questions, but responded to voice or touch ▪ stuporous- very difficult to arouse and keep aroused for the interview ▪ comatose - could not be aroused
<input style="width: 30px; height: 20px;" type="checkbox"/>	B. Inattention - Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?						
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<input style="width: 30px; height: 20px;" type="checkbox"/>	D. Altered level of consciousness - Did the patient have altered level of consciousness as indicated by any of the following criteria? <ul style="list-style-type: none"> ▪ vigilant- startled easily to any sound or touch ▪ lethargic - repeatedly dozed off when being asked questions, but responded to voice or touch ▪ stuporous- very difficult to arouse and keep aroused for the interview ▪ comatose - could not be aroused 						
Confusion Assessment Method. © 1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Used with permission.							

Current use

The Short CAM data elements are currently collected in the MDS and the LCDS, and the scoring is based on staff observations of signs and symptoms of delirium. While the Short CAM data elements are used in both assessment tools, the response options currently differ. The current version of the LCDS includes two response options (yes/no, indicating that the behavior is present or not present), whereas the MDS offers three response options (behavior continuously present, does not fluctuate; behavior present, fluctuates; behavior not present). The LCDS and MDS versions of the CAM also differ slightly in wording and criteria for the “Altered Level of Consciousness” item.

Prior evidence supporting use of the CAM

A version of the CAM, with the addition of an item to assess psychomotor retardation, was tested in the national MDS 3.0 test in nursing homes. Reliabilities were substantial or almost perfect. Overall

average kappa ranged from 0.85 to 0.89 and items ranged from 0.78 to 0.90 (standard kappa).¹⁵⁰ Based on a meta-analysis of diagnostic accuracy in nine studies, the CAM demonstrated moderate sensitivity (82 percent, 95 percent confidence interval [CI]: 69–91 percent) and high specificity (99 percent, 95 percent CI: 87–100 percent), respectively, using a delirium diagnosis (Diagnostic and Statistical Manual of Mental Disorders IV) as the standard.¹⁵¹

Evidence supporting use of the CAM from the National Beta Test

Assessing impairment: In the Beta testing, we administered the version of the CAM that is currently collected in the MDS 3.0, that is, the version with three response options. The CAM was administered at admission to 630 patients/residents in HHA, 771 in IRF, 471 in LTCH, and 1,101 in SNF (n = 2,973 overall). Overall, 5 percent of patients/residents had evidence of mental status change from baseline, 12 percent had difficulty focusing (3 percent continuously), 6 percent had disorganized thinking (1 percent continuously), and 4 percent had altered consciousness (1 percent continuously). In the IRF setting specifically, 6 percent of patients/residents had evidence of mental status change from baseline, 14 percent had difficulty focusing (3 percent continuously), 7 percent had disorganized thinking (2 percent continuously), and 4 percent had altered consciousness (1 percent continuously). Setting-specific frequencies for CAM data elements at admission are shown in Appendix C, Table 2.2.1.

Missing data: Overall, there were very low rates of missing data for the CAM. Across all settings, item level missing data did not exceed 0.4 percent for any of the four CAM items. Similarly, in the IRF setting item level missing data did not exceed 0.4 percent. For all settings, missing data rates were slightly higher for the change in mental status from baseline item (0.4 percent missing). In general, the low rate of missing data indicates feasibility of administration.

Time to complete: To assess feasibility of administration, time to complete was assessed for 375 patients/residents in HHA, 472 in IRF, 284 in LTCH, and 405 in SNF (n = 1,536 overall). Overall mean time to complete the CAM was 1.4 minutes (SD = 0.7 minutes) across settings. In the IRF setting, mean time to complete the CAM was 1.3 minutes (SD = 0.6 minutes).

Interrater reliability: The interrater reliability (IRR) was good for the CAM as measured by kappa and percent agreement of paired raters (n = 914 paired assessments across settings; n = 245 paired assessments in IRF). The kappa for the focusing attention item was good (0.66) across settings and moderate in the IRF setting (0.55). Across all settings, kappa was not estimated for the other three items within the CAM because the proportion of patients across settings with correct responses was out of range for a stable kappa estimate. In IRFs, however, the evidence of change in mental status from baseline item did yield a kappa of 0.60, reflecting moderate IRR. Percent agreement for the CAM across settings was high for all four CAM items: evidence of change of mental status from baseline (96 percent), whether the patient had difficulty focusing attention (91 percent), had disorganized thinking (94 percent), and had altered consciousness (96 percent). Percent agreement in the IRF setting was similarly high for the four CAM items (93 percent, 89 percent, 93 percent, and 97 percent, respectively). Please refer to Table 2.2.2 in Appendix C for kappa and percent agreement statistics for all CAM items.

Mental Status (Depressed Mood)

Depression is the most common mental health condition in older adults, yet under-recognized and thus under-treated. Existing data show that depressed mood is relatively common in patients and residents receiving PAC services. The PAC PRD found that about nine percent of individuals in PAC were

¹⁵⁰ Saliba, D., & Buchanan, J. (2008). Development and validation of a revised nursing home assessment tool: MDS 3.0 Appendices. Santa Monica, CA: RAND Corporation. Available at: <https://www.cms.gov/Medicare/QualityInitiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>.

¹⁵¹ Shi, Q., Warren, L., Saposnik, G., & MacDermid, J. C. (2013). Confusion assessment method: a systematic review and meta-analysis of diagnostic accuracy. *Neuropsychiatric Disease and Treatment*, 9, 1359.

classified as having likely depression.¹⁵² The prevalence varied from a low of seven percent of beneficiaries in SNFs to a high of 11 percent in IRFs.¹⁵³ Almost half of nursing home residents in the United States with an active diagnosis of depression at the time of admission are not receiving psychiatric treatment (medication or psychological therapy) for the condition.¹⁵⁴

Older adults with depression may exhibit different symptoms than younger adults, including fatigue, insomnia, irritable mood, confusion, and lack of focus.¹⁵⁵ Some medications and medical conditions, such as heart disease, stroke, or cancer, may also cause depressive symptoms in older adults.²⁶ Diagnosis and treatment of depression can lead to significant improvement of symptoms, as measured on depression assessment scales. Depressive symptoms improve in 60 to 80 percent of elderly patients taking an antidepressant medication.¹⁵⁶ Psychosocial treatments of depression in older adults have been shown to be more effective than no treatment, based on self-rated and clinician-rated measures of depression.¹⁵⁷

Assessments of the signs and symptoms of depression help PAC providers to better understand the needs of their patients and residents by prompting further evaluation (i.e., to establish a diagnosis of depression); elucidating the patient's or resident's ability to participate in therapies for conditions other than depression during their stay; and identifying appropriate ongoing treatment and support needs at the time of discharge. The standardized assessment of depression among PAC patients and residents supports clinical decision-making, early clinical intervention, person-centered care, and improved care continuity and coordination. The use of valid and reliable standardized assessments can aid in the communication of information within and across providers, further enabling the transfer of accurate health information.

Standardized Data Elements to Assess Depressed Mood

CMS has identified the Patient Health Questionnaire-2 to 9 (PHQ-2 to 9) data elements for standardized assessment of depressed mood.

Patient Health Questionnaire-2 to 9 (PHQ-2 to 9)

The Patient Health Questionnaire-2 to 9 (PHQ-2 to 9) data elements use a summed item scoring approach to first screen for signs and symptoms of depressed mood in patients and residents by assessing

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- ¹⁵² This estimate is based on patient responses to a question about being sad in the two weeks prior to the assessment interview in a study of patient/residents in the PAC PRD (Gage et al., 2012). If they responded "often" or "always," they were considered to have depression.
- ¹⁵³ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. 2012. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.
- ¹⁵⁴ Ulbricht, C. M., Rothschild, A. J., Hunnicutt, J. N., & Lapane, K. L. (2017). Depression and cognitive impairment among newly admitted nursing home residents in the USA. *International Journal of Geriatric Psychiatry*, 32(11), 1172-1181.
- ¹⁵⁵ National Institute on Aging. (2011). Depression and Older Adults. Retrieved from <https://www.nia.nih.gov/health/depression-and-older-adults>
- ¹⁵⁶ Lebowitz, B. D., Pearson, J. L., Schneider, L. S., Reynolds, C. F., Alexopoulos, G. S., Bruce, M. L., ... & Mossey, J. (1997). Diagnosis and treatment of depression in late life: Consensus statement update. *Journal of the American Medical Association*, 278(14): 1186-1190.
- ¹⁵⁷ Scogin, F., & McElreath, L. (1994). Efficacy of psychosocial treatments for geriatric depression: a quantitative review. *Journal of Consulting and Clinical Psychology*, 62(1):69-74.
- ¹⁵⁸ Wei, W., Sambamoorthi, U., Olfson, M., Walkup, J. T., & Crystal, S. (2005). Use of psychotherapy for depression in older adults. *American Journal of Psychiatry*, 162(4), 711-717.

the two cardinal criteria for depression: depressed mood and anhedonia (inability to feel pleasure).¹⁵⁹ At least one of the two must be present for a determination of probable depression, which signals the need for continued assessment of the additional seven PHQ symptoms. The interview is concluded if a respondent screens negative for the first two symptoms.

Relevance to IRFs

The PHQ-2 to 9 would provide valuable patient information for use in IRFs. The IRF-PAI does not currently assess the signs and symptoms of depression, though depression is common among IRF patients. In PAC PRD, 11.3 percent of IRF patients screened positive for depressive symptoms as assessed by the PHQ-2, more than the other three PAC settings.¹⁶⁰ This highlights the importance of screening for depressed mood among patients in IRF settings. Depressed mood may influence patient participation in rehabilitation therapies and may affect the validity of cognitive assessments,^{161 162} and therefore has significant implications for monitoring and supporting progress toward rehabilitation goals among IRF patients. The PHQ-2 demonstrated high reliability in IRF settings in PAC PRD testing.¹⁶³

The standardized assessment of the signs and symptoms of depression using the PHQ-2 to 9 would provide important information for care planning, care transitions, and resource use in IRFs.

¹⁵⁹ American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Third Edition. Washington, DC: American Psychiatric Association; 1980.

¹⁶⁰ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. (2012). Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

¹⁶¹ E.J. Lenze, M.C. Munin, M.A. Dew, et al. (2004). Adverse effects of depression and cognitive impairment on rehabilitation participation and recovery from hip fracture. *International Journal Geriatrics Psychiatry* 19: 472–478

¹⁶² Lequerica AH, Kortte K. (2010). Therapeutic engagement: a proposed model of engagement in medical rehabilitation. *American journal of physical medicine & rehabilitation* 89(5):415-22.

¹⁶³ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. (2012). Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

Proposed Data Elements for the Assessment of Cognitive Function: PHQ-2 to 9

D0150. Patient Mood Interview (PHQ-2 to 9)			
<p>Say to patient: "Over the last 2 weeks, have you been bothered by any of the following problems?"</p> <p>If symptom is present, enter 1 (yes) in column 1, Symptom Presence. If yes in column 1, then ask the patient: "About how often have you been bothered by this?" Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.</p>			
1. Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2) 9. No response (leave column 2 blank)	2. Symptom Frequency 0. Never or 1 day 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) 3. 12-14 days (nearly every day)	1. Symptom Presence	2. Symptom Frequency
		↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things		<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling down, depressed, or hopeless		<input type="checkbox"/>	<input type="checkbox"/>
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview and SKIP to next section.			
C. Trouble falling or staying asleep, or sleeping too much		<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy		<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating		<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down		<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television		<input type="checkbox"/>	<input type="checkbox"/>
H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual		<input type="checkbox"/>	<input type="checkbox"/>
I. Thoughts that you would be better off dead, or of hurting yourself in some way		<input type="checkbox"/>	<input type="checkbox"/>
D0160. Total Severity Score			
Enter Score <input type="text"/>	Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)		

Current use

The PHQ-2 data elements are currently in use in the OASIS. The PHQ-9 data elements, which include the two questions used in the PHQ-2 plus additional items, are in use in MDS.

Prior evidence supporting use of PHQ-2 and PHQ-9

The PHQ-2 is a brief, reliable screening tool for assessing signs and symptoms of depression. Among studies conducted in primary care centers with large samples of adults, the PHQ-2 has performed well as both a screening tool for identifying depression and to assess depression severity.^{164 165} It has also been shown to be sensitive to changes in a patient's mood. Across 15 studies that assessed the diagnostic accuracy of the PHQ-2 against a recognized gold-standard instrument for the diagnosis of major depression in adults, sensitivity estimates (based on the summed-item approach to scoring and a cutoff score of 3) have varied, ranging between 39 percent and 97 percent (median value = 77 percent); specificity estimates (based on the summed-item approach to scoring and a cutoff score of three) have been higher and more stable (kappas ranged from 0.74 to 0.91).¹⁶⁶ It is thus a viable option for standardization, with the benefits of the shorter assessment counterbalancing the limitation of the lower sensitivity.

The PHQ-9 was also tested in the national MDS 3.0 test in nursing homes. For the two presence items in the PHQ-2 (little interest in doing things; feeling down, depressed or hopeless), kappa statistics were almost perfect and ranged from 0.98 to 0.99.¹⁶⁷ The PHQ-9 was also found to have agreement with the Modified Schedule for Affective Disorders and Schizophrenia (m-SADS), a gold-standard measure for mood disorder, in residents without severe cognitive impairment (weighted kappa=0.69) and with the Cornell Depression Scale, a gold-standard measure for mood disorder, in residents with severe cognitive impairment (correlation = 0.63).¹⁶⁸ In addition, the Staff Time and Resource Intensity Verification (STRIVE) study conducted in a national sample of nursing homes by CMS concluded the PHQ-9 used in the MDS 3.0 was the "best measure" for identifying individuals with higher wage-weighted staff time, defined as the time that nursing home staff spent caring for residents.¹⁶⁹

Evidence supporting use of PHQ-2 to 9 from the National Beta Test

Assessing depressed mood: The PHQ-2 to 9 was administered to assess depressed mood in Beta testing. As a hybrid measure, the PHQ-2 to 9 uses the first two elements (PHQ-2) as a gateway item for the longer PHQ-9. The assessor only administers the full PHQ-9 if the initial score on the PHQ-2 passes a threshold indicating possible depression. A patient/resident who did not evidence possible depression based on the PHQ-2 would not receive the seven additional elements contained in the PHQ-9. In Beta testing, the PHQ-2 to 9 was administered to 646 patients/residents in the HHA setting, 786 in IRF, 496 in LTCH, and 1,134 in SNF settings (n = 3,062 overall).

Across settings, 38 percent of patients/residents reported having little interest in doing things and 43 percent reported feeling down, depressed, or hopeless at some point in the last 14 days. Among IRF patients, 39 percent reported having little interest in doing things, and 43 percent reported feeling down, depressed, or hopeless. About 1 in 10 IRF patients experienced little interest in doing things and 1 in 12

¹⁶⁵ Löwe, B., Kroenke, K., & Gräfe, K. (2005). Detecting and monitoring depression with a two-item questionnaire (PHQ-2). *Journal of Psychosomatic Research*, 58(2): 163-171.

¹⁶⁶ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. 2012. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

¹⁶⁷ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>.

¹⁶⁸ *Ibid.*

¹⁶⁹ Centers for Medicare & Medicaid Services. (2013). Analyses of data collected in CMS national nursing home time study used to establish RUG-IV model. Retrieved from <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/TimeStudy.html>

IRF patients experienced feeling down, depressed or hopeless nearly every day over the past two weeks. Similarly, about 1 in 10 IRF patients experienced these symptoms, on half or more of the days.

Over one in four patients/residents (28 percent) across settings passed the PHQ-2 to 9 threshold based on one or both of these symptoms, and continued to complete the remaining seven data elements. This positive screen rate was similar in the IRF setting (27 percent). Detailed symptom endorsement and frequency for the PHQ – 2 to 9 is shown in Appendix C Table 3.1.1. The average PHQ-2 only score across settings was 2.4 (SD = 1.7), and 2.3 (SD = 1.7) in the IRF setting. The average full PHQ-9 score across settings was 11.9 (SD = 5.3), and 11.8 (SD = 5.3) in the IRF setting. The PHQ-9 has thresholds to indicate the severity of probable depression.¹⁷⁰ Both across settings and in IRFs, the largest group of patients/residents screening positive on the PHQ-2 and continuing on to complete the full PHQ-9 was classified in the mild (31percent and 36 percent in IRF) or moderate (32 percent and 32 percent in IRF) severity group. The mean scores and severity threshold proportions are shown in Table 3.1.1 of Appendix C.

Missing data: Overall, there were low rates of missing data for the PHQ-2 to 9. Across all settings, item level missing data did not exceed 5.2 percent for any of the items. Similarly, in the IRF setting, item level missing data did not exceed 4.8 percent for any of the items. Missing data rates, overall and in IRFs, were greatest for the moving and speaking slowly item. In general, the low rate of missing data indicates feasibility of administration.

Time to complete: Time to complete was examined among 428 assessments in HHA, 515 in IRF, 305 in LTCH, and 479 in SNF (n = 1,727 overall). Among patients/residents who only received the PHQ-2, time to complete was an average of 1.7 minutes (SD = 1.1) overall. Average time to complete the PHQ-2 in the IRF setting was 1.5 minutes (SD = 0.9). Among patients receiving the full PHQ-9, time to complete was an average of 4.0 minutes (SD = 1.2). In the IRF setting, time to complete the PHQ-9 was 3.7 minutes on average (SD = 1.2). Without regard for PHQ-2 versus PHQ-9 stratification, the mood data elements took an average of 2.3 minutes (SD = 1.5) to complete across settings, and 2.0 minutes (SD = 1.3) in the IRF setting.

Interrater reliability: Interrater reliability was assessed for 196 patients/residents in HHA, 254 in IRF, 231 in LTCH, and 267 in SNF (n = 948 overall). IRR for all symptom presence and frequency items was excellent: kappas ranged from 0.95 – 1.00 for the four settings combined, and 0.87-1.00 in IRF. IRR regarding eligibility for the full PHQ-9 based on PHQ-2 responses was nearly perfect: kappa for whether to continue from the PHQ-2 to the full PHQ-9 was 0.98 across settings, and 0.98 in IRF. Finally, for patients/residents who received the full PHQ-9, the IRR for sum of symptom frequencies was nearly perfect (0.96 overall, and 0.95 in IRF).

Percent agreement was also nearly perfect, ranging from 97 percent to 100 percent overall, and 93 percent to 100 percent in IRF. For eligibility to complete the full PHQ-9, percent agreement was 99 percent across settings, and 99 percent in IRF. For the sum of symptom frequencies, percent agreement was 95 percent across settings and 94 percent in IRF. Please refer to Table 3.1.2 in Appendix C for kappa and percent agreement statistics for all PHQ items.

¹⁷⁰ Kroenke, K., Spitzer, R., & Williams, J. (2001). The PHQ-9 validity of a brief depression severity measure. *Journal of General Internal Medicine*, Available from. 16, 606–13.

Section 3: Special Services, Treatments, and Interventions (Including Nutritional Approaches)

Some medical conditions require complex clinical care, consisting of special services, treatments, and interventions. The implementation of these interventions typically indicates conditions of a more serious nature and can be life-sustaining. Patients and residents who need them may have few clinical alternatives. Conditions requiring the use of special services, treatments, and interventions can have a profound effect on an individual's health status, self-image, and quality of life. Providers should be aware of the patient or resident's clinical needs in order to plan the provision of these important therapies and to ensure the continued appropriateness of care and support care transitions. The assessment of special services, treatments, and interventions may also help to identify resource use intensity by capturing the medical complexity of patients/residents.

Standardized Data Elements to Assess for Special Services, Treatments, and Interventions

CMS has identified data elements for cross-setting standardization of assessment for special services, treatments, and interventions in the areas of cancer, respiratory, and other treatments, as well as nutritional approaches and high-risk medications. The proposed data elements are:

1. Chemotherapy (IV, Oral, Other);
2. Radiation;
3. Oxygen therapy (Intermittent, Continuous, High-concentration oxygen delivery system);
4. Suctioning (Scheduled, As needed);
5. Tracheostomy Care;
6. Non-invasive Mechanical Ventilator (Bilevel Positive Airway Pressure [BiPAP]; Continuous Positive Airway Pressure [CPAP]);
7. Invasive Mechanical Ventilator;
8. Intravenous (IV) Medications (Antibiotics, Anticoagulation, Vasoactive Medications, Other);
9. Transfusions;
10. Dialysis (Hemodialysis, Peritoneal dialysis);
11. Intravenous (IV) Access (Peripheral IV, Midline, Central line);
12. Parenteral/IV Feeding;
13. Feeding Tube;
14. Mechanically Altered Diet;
15. Therapeutic Diet; and
16. High-Risk Drug Classes: Use and Indication.

Chemotherapy (IV, Oral, Other)

Chemotherapy is a type of cancer treatment that uses medications to destroy cancer cells. Receipt of this treatment indicates that a patient has a malignancy (cancer) and therefore has a serious, often life-threatening or life-limiting condition. Both intravenous (IV) and oral chemotherapy have serious side effects, including nausea/vomiting, extreme fatigue, risk of infection (due to a suppressed immune system), anemia, and an increased risk of bleeding (due to low platelet counts). Oral chemotherapy can be as potent as chemotherapy given by IV but can be significantly more convenient and less resource-intensive to administer. Because of the toxicity of these agents, special care must be exercised in handling and transporting chemotherapy drugs. IV chemotherapy may be given by peripheral IV but is more

commonly given via an indwelling central line, which raises the risk of bloodstream infections. The need for chemotherapy predicts resource intensity, both because of the complexity of administering these potent, toxic drug combinations following specific protocols and because of what the need for chemotherapy signals about the patient's underlying medical condition. Furthermore, the resource intensity of IV chemotherapy is higher than for oral chemotherapy, as the protocols for administration and the care of the central line (if present) require significant resources.

Relevance to IRFs

Chemotherapy (either in general or specific routes of administration) is not assessed at present in the IRF-PAI. Patients in the rehabilitation setting with cancer and who are receiving chemotherapy may be different than other patients in terms of their rehabilitation stay requirements, their potential for rehabilitation functional gains, and their risk of return to the acute care setting. In addition, these patients may require more intensive medical care and monitoring than some other populations of patients (e.g., lab work, nursing care). Individuals impaired by cancer or chemotherapy treatments have been shown to make functional gains in the IRF setting.^{171 172} Some cancer patients can benefit from 3 hours of therapy per day and benefit from multi-modal types of therapy to address heterogeneous needs that can include neurologic issues, orthopedic problems, general conditioning, pain management, and lymphedema management.^{173 174} However, cancer patients in an inpatient rehabilitation unit are at risk of transfer back to the acute care setting at rates ranging from 17 percent to of 35 percent.^{175 176} Receipt of chemotherapy has implications for care planning, assessing functional gains, and estimating patient length of stay and resource utilization in IRF setting.

Given the resource intensity of administering chemotherapy and the side effects and potential complications of these highly-toxic medications, assessing whether the patient is receiving chemotherapy would provide important information for care planning, clinical decision making, and resource use in IRFs.

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- ¹⁷¹ Marciniak, C. M., Sliwa, J. A., Spill, G., Heinemann, A. W., & Semik, P. E. (1996). Functional outcome following rehabilitation of the cancer patient. *Archives of physical medicine and rehabilitation*, 77(1): 54-57. Available at <http://www.sciencedirect.com/science/article/pii/S0003999396902208>
- ¹⁷² McKinley, W. O., Huang, M. E., & Tewksbury, M. A. (2000). Neoplastic vs. traumatic spinal cord injury: an inpatient rehabilitation comparison. *American journal of physical medicine & rehabilitation*, 79(2): 138-144. Available at http://journals.lww.com/ajpmr/Abstract/2000/03000/Neoplastic_vs_Traumatic_Spinal_Cord_Injury_An.5.aspx
- ¹⁷³ Fialka-Moser, V., Crevenna, R., Korpan, M., & Quittan, M. (2003). CANCER REHABILITATION. *Journal of rehabilitation medicine*, 35(4): 153-162. Available at <https://www.medicaljournals.se/jrm/content/abstract/10.1080/16501970306129>
- ¹⁷⁴ Hewitt, M., Maxwell, S., & Vargo, M. M. (2007). Policy issues related to the rehabilitation of the surgical cancer patient. *Journal of surgical oncology*, 95(5): 370-385. Available at <http://onlinelibrary.wiley.com/doi/10.1002/jso.20777/pdf>
- ¹⁷⁵ Guo, Y., Persyn, L., Palmer, J. L., & Bruera, E. (2008). Incidence of and risk factors for transferring cancer patients from rehabilitation to acute care units. *American Journal of Physical Medicine & Rehabilitation*, 87(8): 647-653. Available at http://journals.lww.com/ajpmr/Abstract/2008/08000/Incidence_of_and_Risk_Factors_for_Transferring.6.aspx
- ¹⁷⁶ Asher, A., Roberts, P. S., Bresee, C., Zabel, G., Riggs, R. V., & Rogatko, A. (2014). Transferring inpatient rehabilitation facility cancer patients back to acute care (TRIPBAC). *PM&R*, 6(9): 808-813. Available at <http://www.sciencedirect.com/science/article/pii/S1934148214000240>.

Proposed Data Elements for the Assessment of Special Services, Treatments, and Interventions: Chemotherapy

00110. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that apply on admission.	
↓ Check all that apply	
Cancer Treatments	
<input type="checkbox"/>	A1. Chemotherapy
	<input type="checkbox"/> A2. IV <input type="checkbox"/> A3. Oral <input type="checkbox"/> A10. Other

Current use

Chemotherapy is currently assessed in the MDS. It first assesses whether the resident received chemotherapy while not a resident of the assessing facility and within the last 14 days, and then whether the resident has received chemotherapy while a resident and within the last 14 days while a resident. The MDS data element does not assess the route of chemotherapy.

Prior evidence supporting use of Chemotherapy (IV, Oral, Other)

An IV Chemotherapy data element was found to be feasible for cross-setting use in the PAC PRD.¹⁷⁷ In nursing homes, a checkbox for chemotherapy during the last 5 days was shown to have perfect agreement (100 percent) among rater pairs in the national MDS 3.0 test.¹⁷⁸

Evidence supporting use of Chemotherapy (IV, Oral, Other) from the National Beta Test

Assessing Chemotherapy: One item assessed whether Chemotherapy was performed during the assessment period. If indicated, three follow-up items assessed whether the Chemotherapy was administered via intravenous (IV), oral, or other route. In Beta testing, the data elements were administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall). Across settings, the overwhelming majority of patients/residents (99 percent) did not receive Chemotherapy. In the IRF setting, specifically, only three percent of patients had Chemotherapy treatment noted. More detailed rates of Chemotherapy implementation across settings is shown in Appendix C, Table 4.1.1.

Missing data: Overall, there were very low rates of missing responses for the Chemotherapy items. Across all settings, missingness did not exceed 0.7 percent for each of the four items. In the IRF setting missingness was 0.5 percent for each of the four items. The low rate of missing data indicates feasibility of administration.

¹⁷⁷ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. 2012. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

¹⁷⁸ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>.

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554 overall). Average time to complete the Chemotherapy items was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: The IRR was excellent for the Chemotherapy data element as measured by percent agreement of paired raters (n = 882 paired assessments across settings; n = 236 paired assessments in IRF). Kappas were not estimated for the Chemotherapy sub-elements because the proportion of patients and residents receiving chemotherapy was out of range for stable kappa estimates. Percent agreement was perfect (100 percent) for all four Chemotherapy items across settings as well as in the IRF setting. Please refer to Table 4.1.2 in Appendix C for percent agreement statistics for the Chemotherapy items.

Radiation

Radiation is a type of cancer treatment that uses high-energy radiation to shrink tumors and kill cancer cells by damaging their DNA. However, it can also damage normal cells, leading to side effects such as fatigue, skin irritation or damage, hair loss, nausea, and delayed side effects such as fibrosis (scar tissue formation), damage to the bowels if radiation was delivered to the abdominal region, memory loss, and infrequently, a second cancer due to radiation exposure. Radiation is a mainstay of cancer treatment; about half to two-thirds of all patients with cancer receive radiation therapy at some point in their treatment course.^{179 180} The indications range from early-stage cancer treated with curative intent to palliative radiation therapy, such as to treat metastatic cancer; tumors that are pressing on the spine or growing within bones, causing severe pain; or shrinking a tumor near the esophagus, which can inhibit swallowing. There are many types of radiation, such as external-beam radiation therapy and internal radiation therapy (brachytherapy that is delivered from sources placed inside or on the body), and systemic radiation therapy (in which the patient swallows or receives an injection of a radioactive substance).

Relevance to IRFs

As noted above, individuals impaired by cancer, or its treatments, including chemotherapy or radiation, have been shown to make functional gains in the IRF setting, and cancer patients can benefit from intensive rehabilitation therapies. In particular, patients with brain tumors who are receiving concurrent radiation during an IRF stay make greater functional gains compared to those who are not.^{181 182} However, cancer patients in an inpatient rehabilitation unit are at risk of transfer back to the acute care setting, at rates ranging from 17 percent to of 35 percent.^{183 184} Receipt of radiation therapy has

¹⁷⁹ Yamada, Y. Principles of Radiotherapy. In Cancer rehabilitation: principles and practice. Eds. Stubblefield Michael D. and O'Dell Michael W. 2009.

¹⁸⁰ National Cancer Institute. (2010). Radiation Therapy for Cancer. Available at <https://www.cancer.gov/about-cancer/treatment/types/radiation-therapy/radiation-fact-sheet>

¹⁸¹ Marciniak, C. M., Sliwa, J. A., Heinemann, A. W., & Semik, P. E. (2001). Functional outcomes of persons with brain tumors after inpatient rehabilitation. Archives of physical medicine and rehabilitation, 82(4): 457-463. Available at <http://www.sciencedirect.com/science/article/pii/S0003999301948294>.

¹⁸² McKinley, W. O., Huang, M. E., & Tewksbury, M. A. (2000). Neoplastic vs. traumatic spinal cord injury: an inpatient rehabilitation comparison. American Journal of Physical Medicine & Rehabilitation, 79(2): 138-144. Available at http://journals.lww.com/ajpmr/Abstract/2000/03000/Neoplastic_vs_Traumatic_Spinal_Cord_Injury_An.5.aspx

¹⁸³ Guo, Y., Persyn, L., Palmer, J. L., & Bruera, E. (2008). Incidence of and risk factors for transferring cancer patients from rehabilitation to acute care units. American Journal of Physical Medicine & Rehabilitation, 87(8): 647-653. Available at http://journals.lww.com/ajpmr/Abstract/2008/08000/Incidence_of_and_Risk_Factors_for_Transferring.6.aspx

¹⁸⁴ Asher, A., Roberts, P. S., Bresee, C., Zabel, G., Riggs, R. V., & Rogatko, A. (2014). Transferring inpatient rehabilitation facility cancer patients back to acute care (TRIPBAC). PM&R 6(9): 808-813. Available at <http://www.sciencedirect.com/science/article/pii/S1934148214000240>

implications for care planning, assessing functional gains, and estimating patient length of stay and resource utilization in IRF setting.

Therefore, assessing whether the patient is receiving Radiation would provide important information for care planning, clinical decision making, and resource use in IRFs.

**Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions:
Radiation**

00110. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that apply on admission.	
↓ Check all that apply	
Cancer Treatments	
<input type="checkbox"/>	B1. Radiation

Current use

Radiation is currently assessed in the MDS. It first assesses whether the resident received radiation while not a resident of the assessing facility and within the last 14 days, and then whether the resident received radiation while a resident and within the last 14 days.

Prior evidence supporting use of Radiation

In nursing homes, a checkbox for radiation during the last 5 days was shown to have perfect agreement (100 percent) among rater pairs in the national MDS 3.0 test.¹⁸⁵

Evidence supporting use of Radiation from the National Beta Test

Assessing Radiation: One item assessed whether Radiation was performed during the assessment period. In Beta testing, the data element was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall). Across settings, only 3 patients/residents (1 in SNF, 2 in HHA; zero percent after rounding) received radiation. Detailed Radiation data are shown in Appendix C, Table 4.2.1.

Missing data: Overall, there were very low rates of missing responses for the Radiation item. Across all settings, missingness was 0.7 percent. Similarly, in the IRF setting missingness was 0.5 percent. The low rate of missing data indicates feasibility of administration.

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554, overall). Average time to complete the Radiation item was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). Kappas are not reported for the Radiation data element because its proportion was out of range for a stable kappa estimate. Percent agreement for the Radiation data element was perfect, both across settings and in the IRF specifically. Please refer to Table 4.2.2 in Appendix C for percent agreement statistics for the Radiation items.

¹⁸⁵ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>.

Oxygen Therapy (Intermittent, Continuous, High-concentration oxygen delivery system)

Oxygen therapy provides a patient/resident with supplemental oxygen when medical conditions (e.g., chronic obstructive pulmonary disease [COPD], pneumonia, severe asthma) prevent the patient or resident from adequately oxygenating their bloodstream. Oxygen administration is a resource-intensive intervention, as it requires specialized equipment: a reliable source of oxygen, various delivery systems (e.g., oxygen concentrator, liquid oxygen containers, and high-pressure systems), and the patient interface (e.g., nasal cannula, various types of masks). Accessories are also required (e.g., regulators, filters, tubing, etc.). While the equipment is generally the same for both sub-elements of this data element (continuous vs. intermittent), the main differences between delivering oxygen intermittently versus continuously are the severity of the underlying illness (which often requires more hours per day of oxygen therapy), and the bedside nursing care to set up the oxygen delivery system if the patient is unable (whether physically or cognitively) to do so independently.

Relevance to IRFs

There are currently no items in IRF-PAI addressing oxygen use in the IRF setting. Use of oxygen is a marker of clinical complexity and medical risk, potential for functional gains, and resource use in the IRF setting. Stroke, spinal cord injury, brain injury, and other neurologic conditions are commonly addressed conditions in the IRFs; a subset of patients with these conditions are at risk of dysphagia and inability to handle oral secretions which could result in aspiration pneumonia and may require supplemental oxygen use. When pneumonia is present as a comorbidity among IRF patients, it can be associated with longer length of stay, lower discharge functional status ratings, and lower odds of home discharge.¹⁸⁶ In addition, patients with cardiac conditions (some of whom may require oxygen therapy) represent approximately 5 percent of IRF cases.¹⁸⁷ Patients' use of oxygen therapy has important implications for ability to participate in intensive rehabilitation therapies (3 hours per day, 5 days per week), and ability to make functional gains over the course of rehabilitation, which may affect length of stay. Assessing whether a patient is receiving Oxygen Therapy would provide important information for care planning, clinical decision making, care transitions, and resource use in IRFs.

¹⁸⁶ Ahmed, I., Graham, J. E., Karmarkar, A. M., Granger, C. V., & Ottenbacher, K. J. (2013). In-patient rehabilitation outcomes following lower extremity fracture in patients with pneumonia. *Respiratory Care* 58(4): 601-606. Available at <http://rc.rcjournal.com/content/58/4/601.short>

¹⁸⁷ Medicare Payment Advisory Commission. (2016). Report to the Congress: Medicare Payment Policy. Chapter 9 Inpatient rehabilitation facility services. Available at <http://www.medpac.gov/-documents-/reports>

**Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions:
Oxygen Therapy**

00110. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that apply on admission.	
↓ Check all that apply	
Respiratory Therapies	
<input type="checkbox"/>	C1. Oxygen Therapy
<input type="checkbox"/>	C2. Continuous
<input type="checkbox"/>	C3. Intermittent
<input type="checkbox"/>	C4. High-concentration

Current use

Oxygen Therapy is currently assessed in the MDS. It first assesses whether the resident received oxygen therapy while not a resident of the assessing facility and within the last 14 days, and then whether the resident has received oxygen therapy while a resident and within the last 14 days. The MDS data element does not assess the type of oxygen therapy.

Prior evidence supporting use of Oxygen Therapy (Continuous, Intermittent, High-concentration oxygen delivery system)

A related data element on high concentration oxygen use (FiO₂>40 percent) was used and found feasible for cross-setting use in the PAC PRD.¹⁸⁸ In nursing homes, a checkbox for oxygen therapy during the last five days was shown to have reliability ranging from 0.93 to 0.96 (kappas) in the national MDS 3.0 test.¹⁸⁹

Evidence supporting use of Oxygen Therapy from the National Beta Test

Assessing Oxygen Therapy: One item assessed whether Oxygen Therapy was performed during the assessment period. If indicated, three follow-up items assessed therapy type: Intermittent, Continuous, and use of a High-concentration Delivery System. In Beta testing, the data element Oxygen Therapy (Intermittent, Continuous, High-concentration Delivery System) was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall). Across settings, one in five patients/residents (20 percent) received Oxygen Therapy whereas in the IRF setting, 17 percent received Oxygen Therapy.

Across settings, the most common type of Oxygen Therapy was Intermittent Therapy (14 percent). Only 6 percent of patients/residents had Continuous Therapy, and 1 percent of patients/residents had High-concentration Delivery System. This pattern was similar in the IRF setting as well, where Intermittent Therapy was the most common (11 percent). Continuous Therapy (8 percent) and High-

¹⁸⁸ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. 2012. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

¹⁸⁹ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>.

concentration Delivery (1 percent) were less common. Detailed Oxygen Therapy implementation data are shown in Appendix C, Table 4.3.1.

Missing data: Overall, there were very low rates of missing responses for the Oxygen Therapy items. Across all settings, missingness was less than 0.9 percent. In the IRF setting specifically, missingness was less than 0.4 percent. The low rate of missing data indicates feasibility of administration.

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554, overall). Average time to complete the Oxygen Therapy data element was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). The kappa for implementation of Oxygen Therapy was substantial/good both overall (0.82) and in the IRF setting (0.80). Kappa for the Intermittent Therapy sub-data element was 0.81 overall and 0.76 in the IRF setting, and kappa for the Continuous Therapy sub-data element was 0.55 overall and 0.68 in the IRF setting. Kappas are not reported for the High Concentration Therapy sub-data element because its proportions were out of range for a stable kappa estimate. Percent agreement for the data elements was excellent/almost perfect. Across settings, percent agreement ranged from 93 to 99 percent. Percent agreement in the IRF setting was also excellent/almost perfect ranging from (94 to 100 percent). Please refer to Table 4.3.2 in Appendix C for kappa and percent agreement statistics for all Oxygen Therapy items.

Suctioning (Scheduled, As Needed)

Suctioning is used to clear secretions from the airway when a person cannot clear those secretions on his or her own due to a variety of reasons, including excess production of secretions from a pulmonary infectious process or neurological deficits that inhibit the ability to cough, swallow, etc. It is done by aspirating secretions through a catheter connected to a suction source.

Types of suctioning include oropharyngeal and nasopharyngeal suctioning, nasotracheal suctioning, and suctioning through an artificial airway such as a tracheostomy tube. Oropharyngeal and nasopharyngeal suctioning are a key part of many patients' care plans, both to prevent the accumulation of secretions that can lead to aspiration pneumonias (a common condition in patients with inadequate gag reflexes) and to relieve obstructions from mucus plugging during an acute or chronic respiratory infection, which often lead to desaturations and increased respiratory effort. Suctioning can be done on a scheduled basis if the patient is judged to clinically benefit from regular interventions; or can be done as needed, such as when secretions become so prominent that gurgling or choking is noted, or a sudden desaturation occurs from a mucus plug. As suctioning is generally performed by a care provider rather than independently, this intervention can be quite resource-intensive if it occurs every hour, for example, rather than once a shift. It also signifies an underlying medical condition that prevents patients from clearing their secretions effectively, which also means they need increased nursing care more generally (such as after a stroke or during an acute respiratory infection).

Relevance to IRFs

Pneumonia and dysphagia are two conditions that may occur in the IRF setting that may necessitate the use of suctioning of secretions. Stroke, spinal cord injury, brain injury, and other neurologic conditions are commonly addressed conditions and qualifying conditions for IRFs; a subset of patients with these conditions are at risk of dysphagia and inability to handle oral secretions, which could result in aspiration pneumonia and may require suctioning. As mentioned above, pneumonia, which in many cases could require suctioning of respiratory secretions, and when present as a comorbidity among IRF lower extremity fracture patients, is associated with longer length of stay, lower discharge functional

status ratings, and lower odds of home discharge.¹⁹⁰ Additionally, pneumonia (which in some cases could require suctioning) is a common reason for interruptions in rehabilitation programs and for short stay transfers to an acute care setting among several classes of IRF patients (e.g., bacterial pneumonia caused 26.4 percent of preventable short-stay transfers to an acute care setting among IRF patients with traumatic brain injury and 66.7 percent of preventable short-stay transfers to an acute setting among IRF patients with spinal cord injury).¹⁹¹ The need for suctioning may affect patients’ ability to full participate in the intensive rehabilitation program (3 hours per day, 5 days per week) in the IRF setting. Assessing whether Suctioning is being performed for a patient would provide important information for care planning, clinical decision making, care transitions, and resource use in IRFs.

**Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions:
Suctioning**

00110. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that apply on admission.	
↓ Check all that apply	
Respiratory Therapies	
<input type="checkbox"/>	D1. Suctioning
<input type="checkbox"/>	D2. Scheduled
<input type="checkbox"/>	D3. As Needed

Current use

Suctioning is currently assessed in the MDS. It first assesses whether the resident received suctioning while not a resident of the assessing facility and within the last 14 days, and then whether the resident received suctioning while a resident and within the last 14 days. The MDS data element does not assess whether the suctioning is scheduled or as needed.

Prior evidence supporting use of Suctioning (Scheduled, As Needed)

In the PAC PRD, suctioning was assessed as part of the Trach Tube with Suctioning data element, which evaluated whether patients or residents had a tracheostomy tube or needed suctioning. This related data element was found feasible for cross-setting use in the PAC PRD.¹⁹² In nursing homes, a

¹⁹⁰ Ahmed, I., Graham, J. E., Karmarkar, A. M., Granger, C. V., & Ottenbacher, K. J. (2013). In-patient rehabilitation outcomes following lower extremity fracture in patients with pneumonia. *Respiratory Care* 58(4): 601-606. Available at <http://rcjournal.com/content/58/4/601.short>

¹⁹¹ Middleton, A., Graham, J. E., Krishnan, S., & Ottenbacher, K. J. (2016). Program Interruptions and Short-Stay Transfers Represent Potential Targets for Inpatient Rehabilitation Care-Improvement Efforts. *American Journal of Physical Medicine & Rehabilitation* 95(11): 850-861. Available at http://journals.lww.com/ajpmr/Fulltext/2016/11000/Program_Interruptions_and_Short_Stay_Transfers.9.aspx

¹⁹² Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. 2012. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

checkbox for suctioning during the last 5 days was shown to have perfect agreement (100 percent) among rater pairs in the national MDS 3.0 test.¹⁹³

Evidence supporting use of Suctioning (Scheduled, As Needed) from the National Beta Test

Assessing Suctioning: One item assessed whether Suctioning was provided during the assessment period. If indicated, two follow-up items assessed therapy type: Scheduled or As Needed. In Beta testing, the data element Suctioning (Scheduled, As Needed) was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall).

Across settings, most patients/residents (99 percent) did not have Suctioning noted, and those that did noted As Needed Suctioning (1 percent). In the IRF setting, only 1 percent of patients/residents had Suctioning indicated, all of which were noted As Needed. Detailed Suctioning findings are shown in Appendix C, Table 4.4.1.

Missing data: Overall, there were very low rates of missing responses for the Suctioning items. Across all settings, missingness was less than 0.9 percent. In the IRF setting specifically, missingness for any Suctioning item was less than 0.4 percent. The low rate of missing data indicates feasibility of administration.

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554 overall). Average time to complete the Suctioning items was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). The IRR was excellent for the Suctioning data element as measured by percent agreement of paired raters. Kappas were not estimated for the Suctioning data element because the proportion of patients and residents receiving suctioning was out of range for stable kappa estimates. Percent agreement for the data elements ranged from 98 to 99 percent across settings and 99 to 100 percent in the IRF setting. Please refer to Table 4.4.2 in Appendix C for kappa and percent agreement statistics for all Suctioning items.

Tracheostomy Care

A tracheotomy is a surgical procedure that consists of making a direct airway opening (tracheostomy) into the trachea (windpipe). Tracheostomies are created primarily for reasons such as to bypass an obstructed upper airway; in chronic cases, to enable the removal of secretions from the airway; and to deliver oxygen to the patient's lungs. For example, patients with a need for long-term ventilation (such as those in a persistent vegetative state or those who require long-term ventilator weaning but are alert and oriented); patients with tumors of the upper airway; patients with severe neck, mouth, or chest wall injuries; patients with degenerative neuromuscular diseases such as amyotrophic lateral sclerosis (ALS); patients with spinal cord injuries; and patients with airway burns are some of the examples of the indications for a tracheostomy. Generally, in all of these cases we note that suctioning is necessary to ensure that the tracheostomy is clear of secretions, which can inhibit successful oxygenation of the individual. Often, individuals with tracheostomies are also receiving supplemental oxygenation. The presence of a tracheostomy, permanent or temporary, warrants careful monitoring and immediate intervention should the tracheostomy become occluded, or in the case of a temporary tracheostomy, the devices used become dislodged.

¹⁹³ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>.

For patients with a tracheostomy, tracheostomy care, which primarily consists of cleansing, dressing changes, and replacement of the tracheostomy cannula (tube), is a critical part of their care plans. Regular cleansing is important to prevent infection, such as pneumonia, and to prevent any occlusions with which there are risks for inadequate oxygenation. While in rare cases the presence of a tracheostomy is not associated with increased care demands (and in some of those instances, the care of the tracheostomy is performed by the patient), in general the presence of such a device is associated with increased patient risk, and clinical care services will necessarily include close monitoring to ensure that no life-threatening events occur because of the tracheostomy.

Relevance to IRFs

Patients with deficits in respiratory drive or in respiratory muscle strength may require prolonged mechanical ventilation that would require a tracheostomy; such deficits may be present in patients with stroke, traumatic brain injury, spinal cord injury, or other neurologic conditions that serve as IRF qualifying conditions. In addition, the presence of a tracheostomy tube itself may be a marker of resource use and functional gains among key populations of IRF patients. For example, stroke patients admitted to IRFs with medical tubes, including tracheostomies, have been found to have longer lengths of stay, lower admission and discharge FIM scores, and more medical complications.¹⁹⁴ Tracheostomy care may also affect a patient’s capacity to participate in intensive rehabilitation therapies. As such, it is important to assess tracheostomy care in IRF settings for purposes of care planning and determining resource use. Assessing whether Tracheostomy Care is being performed for a patient would provide important information for care planning, clinical decision making, care transitions, and resource use in IRFs.

**Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions:
Tracheostomy Care**

00110. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that apply on admission.	
↓ Check all that apply	
<input type="checkbox"/>	E1. Tracheostomy Care

Current use

Tracheostomy Care is currently assessed in the MDS. It first assesses whether the resident received tracheostomy care while not a resident of the assessing facility and within the last 14 days, and then whether the resident received tracheostomy care while a resident and within the last 14 days.

Prior evidence supporting use of Tracheostomy Care

In nursing homes, a checkbox for tracheostomy care during the last 5 days was shown to have perfect agreement (100 percent) among rater pairs in the national MDS 3.0 test.¹⁹⁵

Evidence supporting use of Tracheostomy Care from the National Beta Test

Assessing Tracheostomy Care: One item assessed whether Tracheostomy Care was performed during the assessment period. In Beta testing, the data element was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall). Across

¹⁹⁴ Roth, E. J., Lovell, L., Harvey, R. L., Bode, R. K., & Heinemann, A. W. (2002). Stroke rehabilitation. *Stroke* 33(7): 1845-1850. Available at <http://stroke.ahajournals.org/content/33/7/1845.short>

¹⁹⁵ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>.

settings, 1 percent of patients received Tracheostomy Care. In the IRF setting specifically, 1 percent had Tracheostomy Care noted. Detailed Tracheostomy Care findings across settings are shown in Appendix C, Table 4.5.1.

Missing data: Overall, there were very low rates of missing responses for the Tracheostomy Care item. Across all settings, missingness was 1.2 percent. Similarly, in the IRF setting missingness was 0.5 percent. The low rate of missing data indicates feasibility of administration.

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554 overall). Average time to complete the Tracheostomy Care item was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). The IRR was excellent for the Tracheostomy Care data element as measured by percent agreement of paired raters. Kappa was not estimated for the Tracheostomy Care data element because the proportion of patients and residents receiving tracheostomy care was out of range for a stable kappa estimate. Percent agreement for the data element was 100 percent across settings and in the IRF setting. Please refer to Table 4.5.2 in Appendix C for percent agreement statistics for the Tracheostomy Care item.

Non-invasive Mechanical Ventilation (Bilevel Positive Airway Pressure [BiPAP], Continuous Positive Airway Pressure [CPAP])

BiPAP and CPAP are respiratory support devices that prevent the airways from closing by delivering slightly pressurized air through a mask continuously or via electronic cycling throughout the breathing cycle. A BiPAP/CPAP mask provides breathing support through the provision of positive airway pressure that prevents airways from collapsing down during the respiratory cycle. Non-invasive mechanical ventilation differs from invasive mechanical ventilation because the interface with the patient is a mask rather than an endotracheal tube that is passed into the windpipe. BiPAP and CPAP have a variety of clinical indications, from obstructive sleep apnea, to acute respiratory infections, to progressive neuromuscular decline leading to respiratory failure. The key difference between BiPAP and CPAP is that BiPAP, as the name implies, delivers two different pressure levels, a higher pressure to support inhalation and a lower pressure to prevent the airways from collapsing during exhalation while CPAP delivers the same amount of positive airway pressure throughout the breathing cycle. These interventions signify underlying medical conditions in the patient who requires their use.

Relevance to IRFs

BiPAP and CPAP use are not currently assessed in IRF-PAI. Many populations of patients admitted to IRFs are at increased risk of sleep-disordered breathing that could require use of CPAP or BIPAP, including stroke patients (about 21 percent of IRF patients), individuals with neurological conditions (about 20 percent of IRF patients), and cardiac patients (about 5 percent of IRF patients).¹⁹⁶ For example, sleep disordered breathing has been identified as common in stroke patients, and is a risk-factor for stroke itself and stroke recurrence; treatment of stroke patients with OSA with CPAP has been

¹⁹⁶ Medicare Payment Advisory Commission. (2016). Report to the Congress: Medicare Payment Policy. Chapter 9 Inpatient rehabilitation facility services. Retrieved from <http://www.medpac.gov/-documents-reports>

associated with improved functional motor outcomes.^{197 198 199 200} In addition, neurological conditions and spinal cord injuries, which are qualifying conditions for admission to an IRF, can be associated with respiratory muscle weakness, which could require non-invasive mechanical ventilation (i.e., CPAP, BiPAP). Noninvasive mechanical ventilation may improve outcomes in patients admitted to IRFs for cardiac or pulmonary rehabilitation, and may improve pulmonary rehabilitation outcomes in patients with interstitial lung disease and COPD patients.^{201 202} Use of noninvasive mechanical ventilation may also have implications for daytime energy, and patient motivation to actively participate in intensive rehabilitation therapies in the IRF setting, as well as being a marker of clinical complexity and resource use. As such, use of noninvasive mechanical ventilation is important to assess in IRF settings for purposes of care planning and resource use.

**Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions:
Non-invasive Mechanical Ventilation**

00110. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that apply on admission.	
↓ Check all that apply	
<input type="checkbox"/>	G1. Non-invasive Mechanical Ventilator
<input type="checkbox"/>	G2. BiPAP
<input type="checkbox"/>	G3. CPAP

Current use

Non-Invasive Mechanical Ventilation is currently assessed in the LCDS and the MDS. The LCDS uses a checklist format, including an item asking if the patient has non-invasive ventilator (BIPAP, CPAP) treatment at admission. The MDS first assesses whether the resident received non-invasive mechanical ventilation while not a resident of the assessing facility and within the last 14 days, and then whether the resident received non-invasive mechanical ventilation while a resident and within the last 14

¹⁹⁷ Brooks, D., Davis, L., Vujovic-Zotovic, N., Boulias, C., Ismail, F., Richardson, D., & Goldstein, R. S. (2010). Sleep-disordered breathing in patients enrolled in an inpatient stroke rehabilitation program. *Archives of Physical Medicine and Rehabilitation* 91(4): 659-662. Available at <http://www.sciencedirect.com/science/article/pii/S0003999310000298>

¹⁹⁸ Brown, D. L. (2006). Sleep disorders and stroke. Copyright© 2006 by Thieme Medical Publishers, Inc., 333 Seventh Avenue, New York, NY 10001, USA. *Seminars in Neurology* 26(1): 117-122 Available at <https://www.thieme-connect.com/products/ejournals/html/10.1055/s-2006-933315>

¹⁹⁹ Davis, A. P., Billings, M. E., Longstreth, W. T., & Khot, S. P. (2013). Early diagnosis and treatment of obstructive sleep apnea after stroke Are we neglecting a modifiable stroke risk factor? *Neurology: Clinical Practice* 3(3): 192-201. Available at <http://cp.neurology.org/content/3/3/192.short>

²⁰⁰ Ryan, C. M., Bayley, M., Green, R., Murray, B. J., & Bradley, T. D. (2011). Influence of continuous positive airway pressure on outcomes of rehabilitation in stroke patients with obstructive sleep apnea. *Stroke, STROKEAHA-110*. Available at <http://stroke.ahajournals.org/content/42/4/1062.short>

²⁰¹ Köhnlein, T., Schönheit-Kenn, U., Winterkamp, S., Welte, T., & Kenn, K. (2009). Noninvasive ventilation in pulmonary rehabilitation of COPD patients. *Respiratory medicine* 103(9): 1329-1336. Available at <http://www.sciencedirect.com/science/article/pii/S0954611109000997>

²⁰² Dreher, M., Ekkernkamp, E., Schmoor, C., Schönheit-Kenn, U., Winterkamp, S., & Kenn, K. (2015). Pulmonary rehabilitation and noninvasive ventilation in patients with hypercapnic interstitial lung disease. *Respiration* 89(3): 208-213. Available at <https://www.ncbi.nlm.nih.gov/pubmed/25677159>

days. The LCDS and MDS data elements do not assess whether the non-invasive mechanical ventilation is BiPAP or CPAP.

Prior evidence supporting use of Non-invasive Mechanical Ventilation (BiPAP, CPAP)

A checkbox item for Non-invasive Ventilation (CPAP) was tested in the PAC PRD and was found to be feasible for cross-setting use.²⁰³

Evidence supporting use of Non-invasive Mechanical Ventilation (BiPAP, CPAP) from the National Beta Test

Assessing Non-invasive Mechanical Ventilation: One item assessed whether a Non-invasive Mechanical Ventilator was noted during the assessment period. If indicated, two follow-up items assessed whether this Non-invasive Mechanical Ventilator was Bilevel Positive Airway Pressure (BiPAP) or Continuous Positive Airway Pressure (CPAP). In Beta testing, the data element was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall). Across settings overall, 5 percent of assessments noted use of a Non-invasive Mechanical Ventilator. In the IRF setting specifically, 6 percent noted a Non-invasive Mechanical Ventilator. With regard to specific Non-invasive Mechanical Ventilator, 2 percent of assessments across settings noted BiPAP and 3 percent noted CPAP. In IRF, CPAP was more common (6 percent) than BiPAP (1 percent). Detailed findings regarding non-invasive mechanical ventilator are shown in Appendix C, Table 4.7.1.

Missing data: Overall, there were very low rates of missing responses for the Non-Invasive Mechanical Ventilator items. Across all settings, missingness was less than 1.2 percent. In the IRF setting specifically, missingness was 0.5 percent or less. The low rate of missing data indicates feasibility of administration.

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554 overall). Average time to complete the Non-invasive Mechanical Ventilator items was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). Kappas for the Non-invasive Mechanical Ventilator items are not reported because their proportions were out of range for stable kappa estimates. Percent agreement for the data elements ranged from 97 to 98 percent across settings and from 98 to 100 percent in the IRF setting. Please refer to Table 4.7.2 in Appendix C for percent agreement statistics for all Non-invasive Mechanical Ventilator items across settings.

Invasive Mechanical Ventilator

Invasive mechanical ventilator includes any type of electrically or pneumatically powered closed-system mechanical support devices, to ensure adequate ventilation of the patient who is unable to support his or her own respiration. Patients receiving closed-system ventilation include those receiving ventilation via a tracheostomy, as well as those patients with an endotracheal tube (e.g., nasally or orally intubated). Depending on the patient's underlying diagnosis, clinical condition, and prognosis, he or she may or may not be a candidate for weaning off the ventilator. For instance, certain medical conditions such as lung infections are expected to improve or resolve to a point where the patient can support his or her own respiration, whereas chronic neurodegenerative diseases are likely to progress over time and therefore preclude the patient from weaning and eventually having the tube removed.

²⁰³ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. 2012. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

Ventilation in this manner is a resource-intensive therapy associated with life threatening conditions without which the patient would not survive. However, ventilator use has inherent risks requiring close monitoring, and failure to adequately care for the patient who is ventilator dependent can lead to iatrogenic events such as death, pneumonia, and sepsis. Mechanical ventilation further signifies the complexity of the patient’s underlying medical and/or surgical condition.

Relevance to IRFs

Although the frequency of patients receiving invasive mechanical ventilation varies widely across IRF settings, IRF patients who are ventilator dependent can participate and benefit from intensive rehabilitation programs,²⁰⁴ and early initiation of rehabilitation for such patients may be associated with improved outcomes. Invasive mechanical ventilation is associated with high daily and aggregate costs. In a national study of mechanical ventilation use in the United States, the estimated aggregated costs were \$27 billion, 12 percent of all hospital costs.²⁰⁵ Assessment of whether the patient is on Invasive Mechanical Ventilation would provide important information for care planning, clinical decision making, care transitions, and resource use in IRFs.

**Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions:
Invasive Mechanical Ventilator**

00110. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that apply on admission.	
↓ Check all that apply	
Respiratory Therapies	
<input type="checkbox"/>	F1. Invasive Mechanical Ventilator (ventilator or respirator)

Current use

Invasive mechanical ventilator is currently assessed in the LCDS and MDS. The MDS first assesses whether the resident received invasive mechanical ventilation while not a resident of the assessing facility and within the last 14 days, and then whether the resident received invasive mechanical ventilation while a resident and within the last 14 days. The LCDS includes an item that assesses use and type of invasive mechanical ventilator support (e.g., weaning or non-weaning).

²⁰⁴ Make B, Gilmartin M, Brody JS, Snider GL. (1984). Rehabilitation of ventilator-dependent subjects with lung disease. The concept and initial experience. *Chest* 86:358-65.

²⁰⁵ Wunsch, H., Linde-Zwirble, W. T., Angus, D. C., Hartman, M. E., Milbrandt, E. B., & Kahn, J. M. (2010). The epidemiology of mechanical ventilation use in the United States. *Critical Care Med* 38(10): 1947-1953.

Prior evidence supporting use of Invasive Mechanical Ventilator

Checkbox items for ventilator (weaning and non-weaning) were tested in the PAC PRD and were found to be feasible for cross-setting use.²⁰⁶ A version of the item was tested in the MDS 3.0 National Evaluation Study and had perfect agreement (100 percent).²⁰⁷

Evidence supporting use of Invasive Mechanical Ventilator from the National Beta Test

Assessing Invasive Mechanical Ventilator: One item assessed whether an Invasive Mechanical Ventilator was noted during the assessment period. In Beta testing, the data element was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1087 in SNF settings (n = 2,926 overall). Across settings overall, only 13 assessments (zero percent after rounding) noted use of an Invasive Mechanical Ventilator. One of these 13 patients was in the IRF setting (twelve were in an LTCH). Detailed Invasive Mechanical Ventilator findings across settings are shown in Appendix C, Table 4.6.1.

Missing data: Overall, there were very low rates of missing responses for the Invasive Mechanical Ventilator item. Across all settings, missingness was 1.2 percent for the item. In the IRF setting specifically, missingness was 0.5 percent. The low rate of missing data indicates feasibility of administration.

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554, overall). Average time to complete the Invasive Mechanical Ventilator item was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). The IRR was excellent for the Invasive Mechanical Ventilator data element as measured by percent agreement of paired raters. Kappa was not estimated for the Invasive Mechanical Ventilator data element because the proportion was out of range for a stable kappa estimate. Percent agreement for the data element was 100 percent across settings and in the IRF setting. Please refer to Table 4.6.2 in Appendix C for percent agreement statistics for the Invasive Mechanical Ventilator item across all settings.

IV Medications (Antibiotics, Anticoagulation, Vasoactive Medications, Other)

Intravenous (IV) medications are drugs or biologics that are administered via intravenous push (bolus), single, intermittent, or continuous infusion through a tube placed into the vein, including one that allows the fluids to enter the circulation through one of the larger heart vessels or more peripherally through a vein, e.g., commonly referred to as central midline, or peripheral ports.

This data element is important to collect, as IV medications are more resource intensive to administer than oral medications and signify a higher patient complexity (and often higher severity of illness). The clinical indications for each of the sub-types of IV medications proposed (antibiotics, anticoagulants, vasoactive, and other) are very different. IV antibiotics are used for severe infections when a) the bioavailability of the oral form of the medication would be inadequate to kill the pathogen; b) an oral form of the medication does not exist; or c) the patient is unable to take the medication by mouth. Due to growing concern about antimicrobial resistance, antibiotic stewardship initiatives are aimed at

²⁰⁶ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. 2012. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

²⁰⁷ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>.

increasing evidence-based antibiotic prescribing and decreasing antibiotic overuse. While data on the antibiotic(s) would not be collected, collecting data on the use of IV antibiotics overall in the four PAC settings would assist with monitoring the implementation of evidence-based prescribing guidelines moving forward.

IV anticoagulants refer to anti-clotting medications (“blood thinners”) often used for the prevention and treatment of deep vein thrombosis and other thromboembolic complications. IV anticoagulants are commonly used in patients with limited mobility (either chronically or acutely, in the post-operative setting), who are therefore at risk of deep vein thrombosis, or patients with certain cardiac arrhythmias such as atrial fibrillation. When a patient is on an IV anticoagulant, they require frequent monitoring of laboratory values to ensure appropriate anticoagulation status.

Vasoactive medications affect blood pressure and/or heart rate by causing dilation or constricting of the blood vessels. Vasoactive medications are used to treat septic shock, cardiac arrest, and other cardiac function issues. Continuous infusions of vasoactive medications require close observation of the patient, including constant monitoring of blood pressure and heart rate, in order to respond quickly to any changes.

Relevance to IRFs

IRF-PAI does not currently assess delivery of IV Medications nor subtypes thereof. Several classes of patients with IRF-Qualifying Conditions are at risk of infections that could require intravenous antibiotics (e.g., post-operative infections in patients admitted after a lower extremity fracture or joint replacement; urinary tract infections among catheterized patients or those with urinary retention, which is common among those with neurological conditions, stroke, debility, brain injury or spinal cord injury; aspiration pneumonia among the same population of patients with neurological or debility related conditions that could impair ability to swallow). Several groups of patients with IRF qualifying conditions are at increased risk of venous thromboembolism (i.e., deep venous thrombosis or pulmonary embolism) that could require initiation of intravenous anticoagulation, including those admitted after lower extremity fracture, lower extremity joint replacement, major multiple trauma, spinal cord injury, traumatic brain injury patients, stroke patients, and other patients whose mobility has been limited due to other neurologic conditions. For example, incidence of DVT varies from 16.4 percent to 100 percent among stroke, spinal cord injury, or traumatic brain injury patients not receiving prophylaxis, and incidence remains high when prophylactic measures (e.g., pneumatic compression, compression stockings, mobilization, medication) are used.²⁰⁸ In addition, use of IV antibiotics could represent a medical complication or comorbidity that places key classes of IRF patients at risk of a program interruption or transfer to an acute care setting. Of preventable program interruptions among IRF patients, among the most frequent included urinary tract infections among patients with stroke and traumatic brain injury (28.2 percent and 42.9 percent of preventable program interruptions, respectively). Infection is among the most common admitting diagnosis for short-stay transfers from IRFs to acute care setting for patients with stroke, traumatic brain injury, and spinal cord injury. Thus, given the increased risk for IV medication use among patients with IRF-qualifying conditions and its association with the interruption of rehabilitation therapies, and the fact that it is a marker of clinical complexity and resource use, it is important to assess IV medication use in IRFs. The standardized assessment of IV Medications, including the type of medications, would provide important information for care planning, clinical decision making, patient safety, care transitions, and resource use in IRFs.

²⁰⁸ Akman, M. N., Cetin, N., Bayramoglu, M., Isiklar, I., & Kilinc, S. (2004). Value of the D-dimer test in diagnosing deep vein thrombosis in rehabilitation inpatients. *Archives of Physical Medicine and Rehabilitation* 85(7): 1091-1094. Available at <http://www.sciencedirect.com/science/article/pii/S0003999304000255>

Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions: IV Medications

00110. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that apply on admission.	
↓ Check all that apply	
<input type="checkbox"/>	H1. IV Medications
<input type="checkbox"/>	H2. Vasoactive medications
<input type="checkbox"/>	H3. Antibiotics
<input type="checkbox"/>	H4. Anticoagulation
<input type="checkbox"/>	H10. Other

Current use

The item IV Medications is currently assessed in the LCDS and MDS. The LCDS uses a checklist format, including an item asking if the patient is being administered any IV Medications at admission. The MDS first assesses whether the resident received IV medications while not a resident of the assessing facility and within the last 14 days, and then whether the resident received IV medications while a resident and within the last 14 days. The MDS data element does not assess the type of IV medications.

Prior evidence supporting use of IV Medications

A similar but more focused data element, IV Vasoactive Medications, was tested in the PAC PRD and found to be feasible across PAC settings. This data element was specific to the IV administration of vasoactive drugs (e.g., pressors, dilators, continuous medication for pulmonary edema) that increase or decrease blood pressure and/or heart rate.

In nursing homes, a checkbox for IV medications during the last five days was shown to have reliability of 0.95 (kappa) in the national MDS 3.0 test.²⁰⁹

Evidence supporting use of IV Medications from the National Beta Test

Assessing IV Medications: One item assessed whether IV Medications were noted during the assessment period. If indicated, three follow-up items assessed specific types of IV Medications (Antibiotics, Anticoagulation, or Other). In Beta testing, the data element was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall).

Across settings, one in four assessments (25 percent) had IV Medications noted. For specific types of IV Medication, 16 percent had Antibiotics noted, 8 percent had Anticoagulation noted, and 7 percent had other IV Medications noted. In IRF, 17 percent noted IV Medications. For the specific types of IV Medication, 8 percent had antibiotics noted, 6 percent had anticoagulation noted, and 5 percent had other IV Medications noted. Detailed IV Medications findings across settings are shown in Appendix C, Table 4.8.1.

²⁰⁹ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>.

Missing data: Overall, there were very low rates of missing responses for the IV Medications items. Across all settings, missingness was less than 0.9 percent. In the IRF setting specifically, missingness for the IV Medication items did not exceed 0.9 percent. The low rate of missing data indicates feasibility of administration.

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554, overall). Average time to complete the IV Medications items was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). With the exception of the Anticoagulation sub-element, the IRRs were fair to good for the IV Medications data element as measured by kappa and percent agreement of paired raters. The kappa for the overarching IV Medications data element was 0.70 across settings and 0.61 in the IRF setting. The kappa for the Antibiotics sub-element was 0.88 across settings. The kappa for the Anticoagulation sub-element was 0.13 across settings, placing it in the “slight/poor” range. Consultation with assessors suggested that this low kappa was likely due to inconsistent interpretation of the coding instructions, which will be improved in the future with more comprehensive guidance. The kappa for the Other sub-element was 0.46 across settings. In the IRF setting, kappa was not estimated for the type of IV Medication data elements because the proportions were out of range for stable kappa estimates. Percent agreement for the data element ranged from 88 to 96 percent across settings and from 91 to 98 percent in the IRF setting. Please refer to Table 4.8.2 in Appendix C for IRR statistics for all IV Medications items.

Transfusions

Transfusions are the administration of blood or blood products (e.g., platelets, synthetic blood products) into the bloodstream. Blood transfusions are highly protocolized, with multiple safety checks and monitoring required during and after the infusion to avoid adverse events. Coordination with the facility’s blood bank is necessary, as well as documentation by clinical staff to ensure compliance with regulatory requirements. In addition, the need for transfusions signifies underlying patient complexity that is likely to require additional nursing staff and care coordination, and impacts planning for transitions of care, as transfusions are not performed in all PAC settings. Receipt of transfusions is also important to assess for case mix adjustment due to the need for added resources and to the extent that receipt of transfusions indicates a more medically complex patient.

Relevance to IRFs

Data regarding blood transfusions are not currently collected in the IRF-PAI. Key populations of IRF patients may benefit from blood transfusions during their rehabilitation stay. For example, patients with fractures of the lower extremity and major joint replacements of the lower extremity are IRF qualifying conditions and represent approximately 12 percent and approximately 8 percent of IRF cases annually, respectively.²¹⁰ As in other settings, blood transfusions are resource-intensive, requiring laboratory testing, coordination with the blood bank, intensive bedside nursing care and monitoring, and can be associated with adverse reactions. Because need for and receipt of a blood transfusion can be a marker of clinical complexity and resource use, assessment of receipt of transfusions is warranted in the IRF setting. The standardized assessment of patients’ receipt of transfusions would provide important information for care planning, clinical decision making, patient safety, care transitions, and resource use in IRFs.

²¹⁰ Medicare Payment Advisory Commission. (2016). Report to the Congress: Medicare Payment Policy. Chapter 9 Inpatient rehabilitation facility services. Retrieved from <http://www.medpac.gov/-documents/-reports>

**Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions:
Transfusions**

O0110. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that apply on admission.	
↓ Check all that apply	
Other	
<input type="checkbox"/>	I1. Transfusions

Current use

Transfusions are currently assessed in the MDS. It first assesses whether the resident received transfusions while not a resident of the assessing facility and within the last 14 days, and then whether the resident received transfusions while a resident and within the last 14 days.

Prior evidence supporting use of Transfusions

In nursing homes, a checkbox for transfusions in the past five days was shown to have reliability of 0.67 (kappa) in the national MDS 3.0 test.²¹¹

Evidence supporting use of Transfusions from the National Beta Test

Assessing Transfusions: One item assessed whether Transfusions were performed during the assessment period. In Beta testing, the data element was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall). Across settings, only 14 patient/resident assessments (zero percent after rounding) noted Transfusions. Five of these 14 patients (1 percent) were in the IRF setting specifically. Detailed Transfusion findings across settings are shown in Appendix C, Table 4.9.1.

Missing data: Overall, there were very low rates of missing responses for the Transfusions item. Across all settings, missingness was 1.0 percent for the item. In the IRF setting specifically, missingness was 0.9 percent. The low rate of missing data indicates feasibility of administration.

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554, overall). Average time to complete the Transfusion item was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). Kappas are not reported for the Transfusions data element because the proportion was out of range for a stable kappa estimate. Percent agreement for the Transfusions data element was perfect overall (100 percent), and nearly perfect in the IRF specifically (99 percent). Please refer to Table 4.9.2 in Appendix C for setting-specific percent agreement statistics for the Transfusion item.

²¹¹ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>.

Dialysis (Hemodialysis, Peritoneal dialysis)

Dialysis is used primarily in the case of end stage kidney failure. It is a process by which waste, salt, and excess water are removed from the body and key electrolytes such as sodium, potassium, and bicarbonate are maintained at a safe level. Hemodialysis is conducted using an artificial kidney, an external hemodialyzer, which filters the blood. During peritoneal dialysis, the dialysate is injected into the peritoneal (abdominal) cavity, excess fluid and waste products are drawn out of the blood and into the dialysate, and the fluid is then drained. Hemodialysis sessions are typically performed three times a week and last up to four hours each. Peritoneal dialysis can be performed continuously overnight or intermittently during the day.

Both forms of dialysis (hemodialysis and peritoneal dialysis) are resource intensive, not only during the actual dialysis process but before, during, and following. Patients who need and undergo dialysis procedures are at high risk for physiologic and hemodynamic instability from fluid shifts and electrolyte disturbances as well as infections that can lead to sepsis. Further, patients receiving hemodialysis are often transported to a different facility, or, at a minimum, to a different part of the facility if the IRF is adjacent to a dialysis center or provides dialysis services onsite. Close monitoring for fluid shifts, blood pressure abnormalities, and other adverse effects is required prior to, during, and following each dialysis session. Nursing staff typically perform peritoneal dialysis at the bedside, and, as with hemodialysis, close monitoring is required.

Relevance to IRFs

IRF-PAI does not presently collect data regarding receipt of dialysis, or the type thereof. In PAC PRD 2.1 percent of IRF patients received hemodialysis.²¹² There is a paucity of information about the impact of end-stage renal disease (ESRD) and receipt of dialysis in the IRF setting. However, some studies have found dialysis patients in IRFs to have longer lengths of stay²¹³ and poorer function performance outcomes.²¹⁴ ESRD and receipt of dialysis has been found to be related to functional outcomes in geriatric patients. For example, routine dialysis can lead to fatigue on non-dialysis days, which may result in decreased physical activity and impede participation in therapies for some patients.²¹⁵ Finally, ESRD patients are at increased risk of amputations, which is a qualifying condition among Medicare IRF patients (3 to 4 percent of IRF cases).²¹⁶ Dialysis is a time intensive service that requires coordination with specialists and close monitoring of vital signs and laboratory studies and carries with it risks of complications and infections. Accordingly, dialysis may impact patients' ability to participate in an intensive rehabilitation program, resource use, and functional gains, and assessment of receipt of dialysis services in the IRF setting is warranted for resource use and care planning purposes. Assessing Dialysis (Hemodialysis, Peritoneal dialysis) would provide important information for care planning, clinical decision making, patient safety, care transitions, and resource use in IRFs.

²¹² Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. (2012). Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

²¹³ Forrest, G. P. (2004). Inpatient rehabilitation of patients requiring hemodialysis. *Archives of Physical Medicine and Rehabilitation* 85(1): 51-53. Available at <http://www.sciencedirect.com/science/article/pii/S0003999303003666>

²¹⁴ Cowen, T. D., Huang, C. T., Lebow, J., Devivo, M. J., & Hawkins, L. N. (1995). Functional outcomes after inpatient rehabilitation of patients with end-stage renal disease. *Archives of physical medicine and rehabilitation* 76(4): 355-359. Available at <http://www.sciencedirect.com/science/article/pii/S000399939580661X>

²¹⁵ Farragher, J., & Jassal, S. V. (2012). Rehabilitation of the geriatric dialysis patient. Blackwell Publishing Ltd. In *Seminars in Dialysis* 25(6): 649-656. Available at <http://onlinelibrary.wiley.com/doi/10.1111/sdi.12014/full>

²¹⁶ Medicare Payment Advisory Commission. (2016). Report to the Congress: Medicare Payment Policy. Chapter 9 Inpatient rehabilitation facility services. Retrieved from <http://www.medpac.gov/-documents/-reports>

**Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions:
Dialysis**

O0110. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that apply on admission.	
↓ Check all that apply	
Other	
<input type="checkbox"/>	J1. Dialysis
<input type="checkbox"/>	J2. Hemodialysis
<input type="checkbox"/>	J3. Peritoneal dialysis

Current use

The data element Dialysis is currently assessed in the LCDS and MDS. The LCDS uses a checklist format, including an item asking if the patient receives dialysis as part of the patient’s treatment plan. The MDS first assesses whether the resident received dialysis while not a resident of the assessing facility and within the last 14 days, and then whether the resident received dialysis while a resident and within the last 14 days. The LCDS and MDS data elements do not assess the type of dialysis.

Prior evidence supporting use of Dialysis (Hemodialysis, Peritoneal dialysis)

In nursing homes, a data element assessing dialysis in the past five days was tested in the national MDS 3.0 test and shown to have almost perfect reliability (kappas of 0.91 to 0.93).²¹⁷

Evidence supporting use of Dialysis (Hemodialysis, Peritoneal dialysis) from the National Beta Test

Assessing Dialysis: One item assessed whether Dialysis was noted during the assessment period. If indicated, two follow-up items assessed whether the Dialysis was Hemodialysis or Peritoneal Dialysis. In Beta testing, the data element was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall). Across settings overall, 5 percent of assessments noted use of Dialysis. In the IRF setting specifically, Dialysis was noted for 5 percent of patients. With regard to specific forms of Dialysis, the vast majority of noted Dialysis was Hemodialysis. Only seven assessments overall, and three in IRF (both zero percent after rounding) indicated Peritoneal Dialysis. Detailed findings regarding Dialysis are shown in Appendix C, Table 4.10.1.

Missing data: Overall, there were very low rates of missing responses for the Dialysis items. Across all settings, missingness was less than 1 percent. In the IRF setting specifically, missingness did not exceed 0.9 percent. The low rate of missing data indicates feasibility of administration.

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554, overall). Average time to complete the Dialysis item was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). The majority of kappas are not reported for the

²¹⁷ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>.

Dialysis data element because the proportions both overall and for each setting were out of range for a stable kappa estimate. Percent agreement for Dialysis was nearly perfect overall and in the IRF specifically (98 percent). The same was true for the two types of dialysis across settings (98 percent and 100 percent, respectively), and also in the IRF (98 percent and 100 percent, respectively). Please refer to Table 4.10.2 in Appendix C for percent agreement statistics for all Dialysis items.

IV Access (Peripheral IV, Midline, Central line)

Intravenous (IV) access refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication treatment, hemodialysis, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or in some instances the measurement of central venous pressure.

The sub-elements associated with IV Access distinguish between peripheral access and central access. Further, different types of central access are specified. The rationale for distinguishing between a peripheral IV and central IV access is that central lines confer higher risks associated with life threatening events such as pulmonary embolism, infection, and bleeding. Patients with central lines, including those peripherally inserted or who have subcutaneous central line “port” access, always require vigilant nursing care to ensure patency of the lines and importantly to ensure that such invasive lines are free from any potentially life-threatening events such as infection, air embolism, as well as bleeding from an open lumen.

Relevance to IRFs

The presence of intravenous access is not currently assessed in IRF-PAI, nor are specific subtypes of intravenous access. The need for IV access in IRFs is common: in PAC PRD, 7.2 percent of IRF patients received central line management.²¹⁸ Presence of IV access and type is a marker of clinical complexity (i.e., need for a medication that can be administered through the IV route and nursing care need), and accordingly represents a marker of resource use and an important consideration for care planning. Assessing IV Access would provide important information for care planning, clinical decision making, patient safety, care transitions, and resource use in IRFs.

²¹⁸ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. (2012). Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports-Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

Proposed Data Elements for the Assessment of Special Services, Treatments, and Interventions: IV Access

00110. Special Treatments, Procedures, and Programs	
Check all of the following treatments, procedures, and programs that apply on admission.	
↓ Check all that apply	
Other	
<input type="checkbox"/>	O1. IV Access
	<input type="checkbox"/> O2. Peripheral <input type="checkbox"/> O3. Midline <input type="checkbox"/> O4. Central (e.g., PICC, tunneled, port)

Current use

The IV Access data element is not currently included in any of the PAC assessments.

Prior evidence supporting use of IV Access

The IV Access data element was not tested in the PAC PRD but that study did test a related data element, Central Line Management, which was found feasible for cross-setting use.

Evidence supporting use of IV Access from the National Beta Test

Assessing IV Access: One item assessed whether Intravenous (IV) Access was noted during the assessment period. If indicated, four follow-up items assessed whether the IV was a Peripheral Line, Midline Catheter, Central Line, or Other form of IV. In Beta testing, the data elements were administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall). Across settings, 24 percent of assessments noted use of IV Access. The rate in the IRF specifically was 22 percent. For the specific type of IV Access noted, a Central Line was most common across settings (13 percent) followed closely with Peripheral IV (11 percent). Midline Catheter (2 percent) and Other (1 percent) were less common. In the IRF setting, a Peripheral IV was most common (14 percent), followed by a Central Line (6 percent), Other IV (2 percent), and Midline Catheter (1 percent). Detailed findings regarding IV Access are shown in Appendix C, Table 4.11.1.

Missing data: Overall, there were very low rates of missing responses for the IV Access items. Across all settings, missingness was less than 1.4 percent. In the IRF setting specifically, missingness was less than 0.8 percent. The low rates of missing data indicate feasibility of administration.

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554, overall). Average time to complete the IV Access item was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). IRR was excellent across settings for the IV Access item (kappa = 0.90) as well as for type of access Peripheral (kappa=0.81) and Central (kappa=0.85). Similarly, IRR was substantial/good in the IRF specifically for the IV Access item (0.81) and type of access Peripheral (kappa=0.81). Percent agreement for the data element was almost perfect. Across settings, percent agreement was 96 percent for IV Access generally, as well as the subsequent types of IV Access (96 to 98 percent). In the IRF specifically, percent agreement was 94 percent for the general IV

Access item, and the subsequent types were also excellent or almost perfect (96 to 99 percent). Please refer to Table 4.11.2 in Appendix C for kappa and percent agreement statistics for all IV Access items.

Parenteral/IV Feeding

Patients can be fed parenterally (i.e., intravenously) to bypass the usual process of eating and digestion. The person receives nutritional formulas containing salts, glucose, amino acids, lipids, and added vitamins. Parenteral/IV feeding is often used following surgery, when feeding by mouth or digestive system is not possible, when a patient's digestive system cannot absorb nutrients due to chronic disease, or if a patient's nutritional requirement cannot be met by tube feeding and supplementation. The need for parenteral/IV feeding indicates a clinical complexity that prevents the patient from meeting his/her nutritional needs enterally. Overall, parenteral/IV feeding is a form of nutritional support that can be used to prevent or address malnutrition.²¹⁹ Without treatment, malnutrition can lead to a host of negative consequences, including a decline in health, poorer physical and cognitive function, increased use of health care services, earlier institutionalization, and increased risk of death.²²⁰

Malnutrition is prevalent among older adults, a population commonly served in PAC settings. A study showed that 58.3 percent of hospitalized patients diagnosed with malnutrition in the U.S. in 2010 were over age 65.²²¹ Additionally, as mentioned above, parenteral/IV feeding is often used to provide nutrition for patients with specific diseases. For example, parenteral/IV feeding can be utilized for individuals with inflammatory bowel disease, a condition which is common in older adults.^{222 223 224}

Parenteral/IV feeding is more resource intensive than other forms of nutrition, as it often involves monitoring of blood chemistries and maintenance of a central line. Therefore, assessing a patient's need for parenteral feeding is important for care planning and case mix adjustment. In addition to the risks associated with central and peripheral intravenous access, parenteral/IV feeding is associated with significant risks such as embolism and sepsis.

Relevance to IRFs

Parenteral feeding is jointly assessed with tube feeding at present in the IRF-PAI and is also assessed separately. As in other settings, parenteral nutrition indicates clinical complexity and resource use requiring frequent blood work, central venous access, risk of infection, and more intensive nursing care; these are important in the IRF setting for resource use and care planning. Need for parenteral or IV feeding also indicates the nutritional status of the patient, and accordingly could be an important marker for potential resource use and functional gains, particularly among key classes of IRF patients. For example, patients with severe malnutrition are at higher risk for a variety of complications.²²⁵ Among IRF patients with stroke, an IRF qualifying condition, malnutrition (which may or may not require

²¹⁹ National Collaborating Centre for Acute Care (UK). (2006). Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition. Methods, Evidence & Guidance. Retrieved from <https://www.nice.org.uk/guidance/cg32/evidence/full-guideline-194889853>

²²⁰ Evans, C. (2005). Malnutrition in the elderly: a multifactorial failure to thrive. *The Permanente Journal*, 9(3), 38.

²²¹ Corkins, M. R., Guenter, P., DiMaria-Ghalili, R. A., Jensen, G. L., Malone, A., Miller, S., ... & American Society for Parenteral and Enteral Nutrition. (2014). Malnutrition diagnoses in hospitalized patients: United States, 2010. *Journal of Parenteral and Enteral Nutrition*, 38(2), 186-195.

²²² Semrad, C. E. (2012). Use of parenteral nutrition in patients with inflammatory bowel disease. *Gastroenterology & hepatology*, 8(6), 393.

²²³ Mullady, D. K., & O'Keefe, S. J. (2006). Treatment of intestinal failure: home parenteral nutrition. *Nature Reviews Gastroenterology and Hepatology*, 3(9), 492.

²²⁴ Taleban, S., Colombel, J. F., Mohler, M. J., & Fain, M. J. (2015). Inflammatory bowel disease and the elderly: a review. *Journal of Crohn's and Colitis*, 9(6), 507-515.

²²⁵ Dempsey, D. T., Mullen, J. L., & Buzby, G. P. (1988). "The link between nutritional status and clinical outcome: can nutritional intervention modify it?" *American Journal of Clinical Nutrition* 47(2): 352-356.

parenteral/IV feeding) has been associated with poorer rehabilitation outcomes and has been found to be associated with length of stay and functional outcomes among stroke patients in some IRFs.²²⁶ As Parenteral/IV Feeding and nutritional state can be indicative of clinical complexity, resource use, potential ability to participate in an intensive rehabilitation program, and potential for functional gains, the standardized assessment Parenteral/IV Feeding would provide important information for IRFs.

**Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions:
Parenteral/IV Feeding**

K0520. Nutritional Approaches	
Check all of the following nutritional approaches that apply on admission.	
↓	Check all that apply
<input type="checkbox"/>	A. Parenteral/IV feeding

Current use

Different versions of the Parenteral/IV Feeding data element are currently collected in the OASIS, IRF-PAI, LCDS, and the MDS. The OASIS data element assesses whether the patient is receiving parenteral nutrition at home. The IRF-PAI includes a check box data element to assess total parenteral nutrition (TPN) with a 3-day look-back period. The LCDS includes a checklist to assess whether the patient receives TPN at admission. The MDS first assesses whether the patient received parenteral/IV feeding while not a resident of the assessing facility and within the last 7 days, and then whether the patient received parenteral/IV feeding while a resident and within the last 7 days.

Prior evidence supporting use of Parenteral/IV Feeding

A similar data element, the Total Parenteral Nutrition, was tested in the PAC PRD and found to be feasible across PAC settings. Parenteral/IV feeding in the last five days was shown to have almost perfect reliability (kappa of 0.95) in the national MDS 3.0 test in nursing homes.²²⁷

Evidence supporting use of Parenteral/IV Feeding from the National Beta Test

Assessing Parenteral/IV Feeding: The Parenteral/IV Feeding data element was included in the National Beta Test. This data element was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall). Across settings, only 1 percent of assessments indicated parenteral/IV feeding. In the IRF setting, 1 percent of assessments noted parenteral/IV feeding. Detailed Parenteral/IV Feeding implementation is shown in Appendix C, Table 5.1.1 for all four settings.

Missing data: Overall, there were very low rates of missing responses for the Parenteral/IV Feeding data element. Across all settings, missingness was 1.3 percent. In the IRF setting specifically, missingness was 0.8 percent. The low rates of missing data indicate feasibility of administering this data element across PAC provider settings.

²²⁶ Finestone, H. M., Greene-Finestone, L. S., Wilson, E. S., & Teasell, R. W. (1996). Prolonged length of stay and reduced functional improvement rate in malnourished stroke rehabilitation patients. *Archives of Physical Medicine and Rehabilitation* 77(4): 340-345. Available at <https://www.ncbi.nlm.nih.gov/pubmed/8607756>

²²⁷ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554, overall). Average time to complete the Parenteral/IV Feeding item was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). Kappas are not reported for the parenteral/IV feeding data element because its proportion was too low for a stable kappa estimate. Percent agreement was perfect at 100 percent for the Parenteral/IV feeding data element in the four settings combined as well as in the IRF setting specifically. Please refer to Table 5.1.2 in Appendix C for setting-specific percent agreement statistics for the Parenteral/IV Feeding item.

Feeding Tube

The Feeding Tube data element refers to enteral nutrition, which is the delivery of a nutritionally complete diet containing protein, carbohydrate, fat, water, minerals, and vitamins directly into the stomach, duodenum, or jejunum. It is typically used for patients/residents who have a functional gastrointestinal tract but are unable to maintain an adequate or safe oral intake. This data element assesses if the patient/resident received enteral nutrition during the assessment period.

Enteral nutrition is a form of nutritional support that can be used to prevent or address malnutrition.²²⁸ Without treatment, malnutrition can lead to a host of negative consequences, including a decline in health, poorer physical and cognitive function, increased use of health care services, earlier institutionalization, and increased risk of death.²²⁹

Malnutrition is prevalent among older adults, a population commonly served in PAC settings. A study showed that 58.3 percent of hospitalized patients diagnosed with malnutrition in the U.S. in 2010 were over age 65.²³⁰ Additionally, enteral nutrition can be used to provide nutrition for patients with specific diseases. For example, tube feeding can be utilized for individuals with stroke²³¹ and those with head and neck cancer,²³² conditions which are common in older adults.^{233 234}

Assessing use of a feeding tube can inform resource utilization, care planning, and care transitions.

Relevance to IRFs

At present, tube feeding is jointly assessed in a single item with parenteral nutrition in IRF-PAI. Administration of tube feeding implies nutritional needs that cannot be met by standard oral feeds, either due to poor oral intake and inability to meet nutritional goals or due to aspiration risk. For IRF patients,

²²⁸ National Alliance for Infusion Therapy and the American Society for Parenteral and Enteral Nutrition Public Policy Committee and Board of Directors. (2010). Disease-related malnutrition and enteral nutrition therapy: a significant problem with a cost-effective solution. *Nutrition in Clinical Practice*, 25(5), 548-554.

²²⁹ Evans, C. (2005). Malnutrition in the elderly: a multifactorial failure to thrive. *The Permanente Journal*, 9(3), 38.

²³⁰ Corkins, M. R., Guenter, P., DiMaria-Ghalili, R. A., Jensen, G. L., Malone, A., Miller, S., ... & American Society for Parenteral and Enteral Nutrition. (2014). Malnutrition diagnoses in hospitalized patients: United States, 2010. *Journal of Parenteral and Enteral Nutrition*, 38(2), 186-195.

²³¹ Corrigan, M. L., Escuro, A. A., Celestin, J., & Kirby, D. F. (2011). Nutrition in the stroke patient. *Nutrition in Clinical Practice*, 26(3), 242-252.

²³² Raykher, A., Russo, L., Schattner, M., Schwartz, L., Scott, B., & Shike, M. (2007). Enteral nutrition support of head and neck cancer patients. *Nutrition in Clinical Practice*, 22(1), 68-73.

²³³ Centers for Disease Control and Prevention (CDC). (2012). Prevalence of stroke--United States, 2006-2010. *MMWR. Morbidity and Mortality Weekly Report*, 61(20), 379.

²³⁴ VanderWalde, N. A., Fleming, M., Weiss, J., & Chera, B. S. (2013). Treatment of older patients with head and neck cancer: a review. *Oncologist*, 18(5):568-78.

tube feeding can imply risk of aspiration and aspiration-related complications such as pneumonia, as well as additional equipment and nursing resources. There are specific groups of IRF patient for whom tube feeding can serve as a proxy for risk of dysphagia, ability to fully participate in an intensive rehabilitation program, clinical complexity, and nutritional status. As mentioned above, malnutrition, which may or may not require tube feeding, has been associated with poorer rehabilitation outcomes among geriatric stroke patients and has been found to be associated with length of stay and functional outcomes among stroke patients in some IRF Settings.^{235 236} Feeding tubes themselves also appear to have important implications: Stroke patients admitted to IRFs with medical tubes, including feeding tubes, have been found to have longer lengths of stay, lower admission and discharge FIM scores, and more medical complications and feeding tubes have been associated with greater functional improvements over the course of IRF stays for severe stroke patients.^{237 238} Because it can be indicative of clinical complexity, resource use, and potential functional gains, assessment of tube feeding in the IRF setting would provide important information for care planning, care transitions, and resource use in IRFs.²³⁹

**Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions:
Feeding Tube**

K0520. Nutritional Approaches	
Check all of the following nutritional approaches that apply on admission.	
↓ Check all that apply	
<input type="checkbox"/>	B. Feeding tube (e.g., nasogastric or abdominal (PEG))

Current use

A version of the Feeding Tube data element is currently assessed in three existing PAC assessments. The data element Enteral Nutrition is currently collected in the OASIS, with a question asking if the patient is receiving enteral nutrition at home. In the IRF-PAI, a Swallowing Status data element captures some information related to enteral nutrition through the response option “Tube/Parenteral Feeding.” The MDS data element, Feeding tube – nasogastric or abdominal (PEG), first assesses whether a resident used a feeding tube while not a resident of the assessing facility and within the last 7 days and then whether the resident used a feeding tube while a resident and within the last 7 days.

²³⁵ Finestone, H. M., Greene-Finestone, L. S., Wilson, E. S., & Teasell, R. W. (1996). Prolonged length of stay and reduced functional improvement rate in malnourished stroke rehabilitation patients. *Archives of Physical Medicine and Rehabilitation* 77(4): 340-345. Available at <https://www.ncbi.nlm.nih.gov/pubmed/8607756>

²³⁶ Aptaker, R. L., Roth, E. J., Reichhardt, G., Duerden, M. E., & Levy, C. E. (1994). Serum albumin level as a predictor of geriatric stroke rehabilitation outcome. *Archives of Physical Medicine and Rehabilitation* 75(1): 80-84. Available at <https://www.ncbi.nlm.nih.gov/pubmed/8291969>

²³⁷ James, R., Gines, D., Menlove, A., Horn, S. D., Gassaway, J., & Smout, R. J. (2005). Nutrition support (tube feeding) as a rehabilitation intervention. *Archives of Physical Medicine and Rehabilitation* 86(12): 82-92. Available at <http://www.sciencedirect.com/science/article/pii/S0003999305011421>

²³⁸ Roth, E. J., Lovell, L., Harvey, R. L., Bode, R. K., & Heinemann, A. W. (2002). Stroke rehabilitation. *Stroke* 33(7): 1845-1850. Available at <http://stroke.ahajournals.org/content/33/7/1845.short>

²³⁹ Dempsey, D. T., Mullen, J. L., & Buzby, G. P. (1988). “The link between nutritional status and clinical outcome: can nutritional intervention modify it?” *American Journal of Clinical Nutrition* 47(2): 352-356.

Prior evidence supporting use of Feeding Tube

In the national MDS 3.0 test in nursing homes, the Feeding Tube data element, collected for the last five days, was shown to have almost perfect reliability (kappa of 0.89).²⁴⁰

Evidence supporting use of Feeding Tube from the National Beta Test

Assessing Feeding Tube: The Feeding Tube data element was included in the National Beta Test. This data element was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall). Across settings, 3 percent of assessments indicated use of a Feeding Tube. In the IRF setting, 3 percent of assessments noted use of a Feeding Tube. Detailed Feeding Tube implementation is shown in Appendix C, Table 5.2.1 for all four settings.

Missing data: There were very low rates of missing data for the Feeding Tube data element both overall (1.3 percent) and in the IRF setting (0.8 percent).

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554 overall). Average time to complete the Feeding Tube item was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). Kappas are not reported for the Feeding Tube data element because its proportion was too low for a stable kappa estimate. Percent agreement was 100 percent across settings and in the IRF setting. Please refer to Table 5.2.2 in Appendix C for setting-specific percent agreement statistics for the Feeding Tube item.

Mechanically Altered Diet


A mechanically altered diet is one that is specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.


The provision of a mechanically altered diet is resource intensive, as it signifies difficulty swallowing/eating safely (dysphagia). Often, nurses are required to slowly feed patients meals consisting of a mechanically altered diet rather than having them eat independently. Dysphagia is frequently associated with various health conditions, including: nervous system-related diseases (e.g., cerebral palsy and Parkinson's disease); stroke; head injury; head, neck, and esophagus cancers; head, neck, and chest injuries; and dementia.²⁴¹ In the absence of treatment, swallowing disorders can lead to malnutrition, dehydration, aspiration pneumonia, poor overall health, chronic lung disease, choking, and death.²⁴² In addition, other consequences can include lack of interest and enjoyment related to eating or drinking, and embarrassment or isolation tied to social situations involving eating.²⁴³

The prevalence of dysphagia is high in older adults, a population commonly served in PAC settings. A study of a geriatric population living independently found that the lifetime prevalence of a

²⁴⁰ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>

²⁴¹ National Institute on Deafness and Other Communication Disorders. (2017). Dysphagia. Retrieved from <https://www.nidcd.nih.gov/health/dysphagia>

²⁴² American Speech-Language-Hearing Association. (Undated). Adult Dysphagia. Retrieved from <https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589942550§ion=Overview> 

²⁴³ American Speech-Language-Hearing Association. (Undated). Adult Dysphagia. Retrieved from <https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589942550§ion=Overview> 

swallowing disorder was 38 percent, and current prevalence of a swallowing disorder was 33 percent.²⁴⁴ Additionally, increasing age has been shown to be associated with a higher likelihood of swallowing problems in the previous year.²⁴⁵ Beyond general aging effects on swallowing physiology, age-related disease is the main risk factor for dysphagia in older adults.²⁴⁶ Stroke and dementia are examples of two conditions that are common among the elderly that may contribute to issues with swallowing.²⁴⁷

Furthermore, discharge to a PAC setting is more likely among those with dysphagia. A study examining burden among inpatients diagnosed with dysphagia found that individuals with dysphagia had a 33.2 percent higher likelihood of being discharged to a PAC facility compared to patients without dysphagia.²⁴⁸

Assessing whether a patient requires a mechanically altered diet is important in ensuring patient safety and can inform care planning, care transitions, and resource utilization.

Relevance to IRFs

Patients with severe malnutrition are at higher risk for a variety of complications.²⁴⁹ Use of a mechanically altered diet or supervision is currently assessed in the IRF-PAI. Mechanically altered diets are particularly relevant for many common populations of IRF patients including those with strokes, neurologic conditions, and brain injuries, which account for 19.5 percent, 13.1 percent and 8.7 percent of patients in IRFs in 2014 and are IRF qualifying conditions.²⁵⁰ Owing to neurological changes, these patients may be at risk of aspiration and related complications, and as such many benefit from the use of a mechanically altered diet with thickened liquids or pureed solids. As mechanically altered diets are a marker of dysphagia, they are a marker both of clinical complexity, complication risk, and resource use among key groups of IRF patients. Dysphagia commonly affects stroke patients, with rates varying widely in the literature from 37 percent to 78 percent depending upon the setting and screening instrument used.²⁵¹ This is a risk for malnutrition, which has been found to be common among stroke patients and associated with worse functional outcomes and more complications.²⁵² Dysphagia is also common among patients with traumatic brain injury, with an incidence as high as 93 percent among traumatic brain injury patients admitted to rehabilitation.²⁵³ Many other neurologic disorders, for which patients may be admitted to an IRF, may feature dysphagia that may benefit from a mechanically altered diet.²⁵⁴ Because

²⁴⁴ Roy, N., Stemple, J., Merrill, R. M., & Thomas, L. (2007). Dysphagia in the elderly: preliminary evidence of prevalence, risk factors, and socioemotional effects. *Annals of Otology, Rhinology & Laryngology*, 116(11), 858-865.

²⁴⁵ Bhattacharyya, N. (2014). The prevalence of dysphagia among adults in the United States. *Otolaryngology--Head and Neck Surgery*, 151(5), 765-769.

²⁴⁶ Sura, L., Madhavan, A., Carnaby, G., & Crary, M. A. (2012). Dysphagia in the elderly: management and nutritional considerations. *Clinical Interventions in Aging*, 7, 287.

²⁴⁷ *Ibid.*

²⁴⁸ Patel, D. A., Krishnaswami, S., Steger, E., Conover, E., Vaezi, M. F., Ciucci, M. R., & Francis, D. O. (2017). Economic and survival burden of dysphagia among inpatients in the United States. *Diseases of the Esophagus*, 31(1), dox131.

²⁴⁹ Dempsey, D. T., Mullen, J. L., & Buzby, G. P. (1988). "The link between nutritional status and clinical outcome: can nutritional intervention modify it?" *American Journal of Clinical Nutrition* 47(2): 352-356.

²⁵⁰ Medicare Payment Advisory Commission. (2016). Report to the Congress: Medicare Payment Policy. Chapter 9 Inpatient rehabilitation facility services. Retrieved from <http://www.medpac.gov/documents/reports>

²⁵¹ Martino, R., Foley, N., Bhogal, S., Diamant, N., Speechley, M., & Teasell, R. (2005). Dysphagia after stroke. *stroke* 36(12): 2756-2763. Available at <http://stroke.ahajournals.org/content/36/12/2756>.

²⁵² Finestone, H. M., & Greene-Finestone, L. S. (2003). Rehabilitation medicine: 2. Diagnosis of dysphagia and its nutritional management for stroke patients. *Canadian Medical Association Journal* 169(10): 1041-1044. Available at <http://www.cmaj.ca/content/169/10/1041.full>

²⁵³ Hansen, T. S., Engberg, A. W., & Larsen, K. (2008). Functional oral intake and time to reach unrestricted dieting for patients with traumatic brain injury. *Archives of Physical Medicine and Rehabilitation* 89(8): 1556-1562. Available at <http://www.sciencedirect.com/science/article/pii/S0003999308003237>

²⁵⁴ Buchholz, D. W. (1993). Dysphagia associated with neurological disorders. *Acta oto-rhino-laryngologica belgica* 48(2): 143-155. Available at <https://www.ncbi.nlm.nih.gov/pubmed/8209677>

it can be a marker of clinical complexity, resource use, and can be related to potential for functional rehabilitation gains, assessing whether an IRF patient requires a mechanically altered diet would provide important information for care planning, care transitions, patient safety, and resource use in IRF.

**Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions:
Mechanically Altered Diet**

K0520. Nutritional Approaches	
Check all of the following nutritional approaches that apply on admission.	
↓	Check all that apply
<input type="checkbox"/>	C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)

Current use

Mechanically Altered Diet is currently assessed in the MDS. It first assesses whether the resident received a mechanically altered diet while not a resident and within the last 7 days, and then whether the resident received a mechanically altered diet while a resident and within the last 7 days.

Prior evidence supporting use of Mechanically Altered Diet

In the national MDS 3.0 test in nursing homes, the Mechanically Altered Diet data element was shown to have almost perfect reliability (kappas from 0.90 to 0.96).²⁵⁵

Evidence supporting use of Mechanically Altered Diet from the National Beta Test

Assessing Mechanically Altered Diet: The Mechanically Altered Diet data element was included in the National Beta Test. The data element was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall). Across settings, 10 percent of assessments indicated Mechanically Altered Diet. In the IRF setting, 15 percent of assessments noted Mechanically Altered Diet. Detailed Mechanically Altered Diet implementation is shown in Appendix C, Table 5.3.1 for all four settings.

Missing data: There were very low rates of missing data for the Mechanically Altered Diet data element both overall (1.2 percent) and in the IRF setting (0.7 percent).

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554, overall). Average time to complete the Mechanically Altered Diet item was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). IRR for Mechanically Altered Diet data element was substantial/good across settings (0.65) and moderate in the IRF specifically (0.53). Percent agreement for the data element was 93 percent across settings and 89 percent in the IRF setting. Please refer to Table 5.3.2 in Appendix C for setting-specific kappa and percent agreement statistics for the Mechanically Altered Diet item.

²⁵⁵ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>

Therapeutic Diet

A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium). Therapeutic diets can include low cholesterol, renal, diabetic, and low salt diets,²⁵⁶ the latter of which are most commonly used.²⁵⁷

Certain conditions, including diabetes,²⁵⁸ chronic kidney disease,²⁵⁹ hypertension,²⁶⁰ and heart disease²⁶¹ are highly prevalent among older adults who may receive services in a PAC setting. For example, the percentage of adults with diabetes is 25.2 percent among individuals 65 years of age or older.²⁶² Additionally, 61.7 percent of adults aged 65 or older have hypertension.²⁶³ These conditions may be treated utilizing a therapeutic diet.

The Therapeutic Diet data element is important to collect in the IRF setting in order to distinguish therapeutic diet from various other nutritional approaches. It is less resource intensive from the bedside nursing perspective but does signify one or more underlying clinical conditions that preclude the patient from eating a regular diet. The communication among PAC settings of whether a patient is receiving a particular therapeutic diet is critical to ensure safe transitions of care.

Relevance to IRFs

Therapeutic diets are not currently assessed in IRF-PAI and data are lacking regarding the prevalence of therapeutic diets in the IRF setting. However, therapeutic diets are part of the treatment and lifestyle changes required for patients with chronic conditions, which are common in IRF populations. In 2013 and 2014, more than 5 percent of IRF cases were for cardiac conditions,²⁶⁴ many of which require therapeutic diets (e.g., fluid restriction, low-fat, low sodium) for successful management of that condition while the patient undergoes rehabilitation services. Similarly, diabetes, a condition which requires a carbohydrate controlled therapeutic diet, has been found to affect 23 percent of patients in IRFs after hip fracture and result in longer lengths of stay, lower functional status ratings, and reduced odds of discharge

²⁵⁶ Kamel, H. K., Louis, S., Malekgoudarzi, B., & Pahlavan, M. (2000). Inappropriate use of therapeutic diets in the nursing home. *Journal of the American Geriatrics Society*, 48(7), 856-857.

²⁵⁷ Crogan, N. L., Corbett, C. F., & Short, R. A. (2002). The minimum data set: predicting malnutrition in newly admitted nursing home residents. *Clinical Nursing Research*, 11(3), 341-353.

²⁵⁸ Centers for Disease Control and Prevention. (2017). *National Diabetes Statistics Report, 2017: Estimates of Diabetes and Its Burden in the United States*. Retrieved from <https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf>

²⁵⁹ Centers for Disease Control and Prevention. *Chronic Kidney Disease Issue Brief*. Retrieved from <https://www.cdc.gov/diabetes/pdfs/programs/CKDBrief.pdf>

²⁶⁰ Fang, J., Gillespie, C., Ayala, C., Loustalot, F. (2018). Prevalence of Self-Reported Hypertension and Antihypertensive Medication Use Among Adults Aged ≥18 Years — United States, 2011–2015. *MMWR Morbidity and Mortality Weekly Report*, 67, 219–224.

²⁶¹ Centers for Disease Control and Prevention. (2017). *National Center for Health Statistics: Older Persons' Health*. Retrieved from <https://www.cdc.gov/nchs/fastats/older-american-health.htm>

²⁶² Centers for Disease Control and Prevention. (2017). *National Diabetes Statistics Report, 2017: Estimates of Diabetes and Its Burden in the United States*. Retrieved from <https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf>

²⁶³ Fang J, Gillespie C, Ayala C, Loustalot F. (2018). Prevalence of Self-Reported Hypertension and Antihypertensive Medication Use Among Adults Aged ≥18 Years — United States, 2011–2015. *MMWR Morbidity and Mortality Weekly Report*, 67, 219–224.

²⁶⁴ Medicare Payment Advisory Commission. (2016). *Report to the Congress: Medicare Payment Policy*. Chapter 9 Inpatient rehabilitation facility services. Retrieved from <http://www.medpac.gov/documents-reports>

home.²⁶⁵ Diabetes has also been shown to affect 20 to 22 percent of IRF knee replacement patients and 28 percent of stroke patients.²⁶⁶ ²⁶⁷ Fractures of the lower extremity, major joint replacements of the lower extremity, and stroke accounted for 12.2 percent, 7.8 percent, and 19.5 percent of IRF cases in 2014, respectively.²⁶⁸ As therapeutic diets may be a common requirement of many key IRF populations and may be a marker of clinical complexity, the standardized assessment of Therapeutic Diets is warranted in the IRF setting.

**Proposed Data Element for the Assessment of Special Services, Treatments, and Interventions:
Therapeutic Diet**

K0520. Nutritional Approaches	
Check all of the following nutritional approaches that apply on admission.	
↓	Check all that apply
<input type="checkbox"/>	D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)

Current use

Therapeutic Diet is currently assessed in the MDS. It first assesses whether the resident received a therapeutic diet while not a resident and within the last 7 days, and then whether the resident received a therapeutic diet while a resident and within the last 7 days.

Prior evidence supporting use of Therapeutic Diet

In the national MDS 3.0 test in nursing homes, the Therapeutic Diet data element was shown to have substantial to almost perfect reliability (kappas from 0.89 to 0.93).²⁶⁹

Evidence supporting use of Therapeutic Diet from the National Beta Test

Assessing Therapeutic Diet: The Therapeutic Diet data element was included in the National Beta Test. This data element was administered to 629 patients/residents in the HHA setting, 762 in IRF, 448 in LTCH, and 1,087 in SNF settings (n = 2,926 overall).

Across settings, over half of assessments (52 percent) indicated Therapeutic Diet. In the IRF setting, 49 percent of assessments noted Therapeutic Diet. Detailed Therapeutic Diet implementation is shown in Appendix C, Table 5.4.1 for all four settings.

²⁶⁵Reistetter, T. A., Graham, J. E., Deutsch, A., Markello, S. J., Granger, C. V., & Ottenbacher, K. J. (2011). Diabetes comorbidity and age influence rehabilitation outcomes after hip fracture. *Diabetes Care* 34(6): 1375-1377. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3114361>

²⁶⁶DeJong, G., Hsieh, C. H., Gassaway, J., Horn, S. D., Smout, R. J., Putman, K., ... & Foley, M. P. (2009). Characterizing rehabilitation services for patients with knee and hip replacement in skilled nursing facilities and inpatient rehabilitation facilities. *Archives of Physical Medicine and Rehabilitation* 90(8): 1269-1283. Available at <http://www.sciencedirect.com/science/article/pii/S0003999309003025>

²⁶⁷Roth, E. J., Lovell, L., Harvey, R. L., Heinemann, A. W., Semik, P., & Diaz, S. (2001). Incidence of and risk factors for medical complications during stroke rehabilitation. *Stroke* 32(2): 523-529. Available at <http://stroke.ahajournals.org/content/32/2/523.short>

²⁶⁸Medicare Payment Advisory Commission. (2016). Report to the Congress: Medicare Payment Policy. Chapter 9 Inpatient rehabilitation facility services. Available at <http://www.medpac.gov/-documents-reports>

²⁶⁹Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>

Missing data: There were low levels of missing data for the Therapeutic Diet data element both in the four settings combined (0.6 percent) and in the IRF setting specifically (0.8 percent).

Time to complete: Time to complete was examined among 422 assessments in HHA, 457 in IRF, 244 in LTCH, and 431 in SNF (n = 1,554 overall). Average time to complete the Therapeutic Diet item was 0.22 minutes overall (SD = 0.1). Average time to complete in the IRF setting was 0.25 minutes (SD = 0.1).

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 236 in IRF, 203 in LTCH, and 256 in SNF (n = 882 overall). The kappa for the Therapeutic Diet data element was substantial/good at 0.60 across settings and substantial/good (0.70) in the IRF setting. Percent agreement for the data element was 80 percent across settings and 85 percent in the IRF setting. Please refer to Table 5.4.2 in Appendix C for setting-specific kappa and percent agreement statistics for the Therapeutic Diet item.

High-Risk Drug Classes: Use and Indication

Most patients receiving PAC services depend on short- and long-term medications to manage their medical conditions. However, medications are a leading cause of adverse events. A study by the U.S. Department of Health and Human Services found that 31 percent of adverse events that occurred in 2008 among hospitalized Medicare beneficiaries were related to medication.²⁷⁰ Adverse drug events may be caused by medication errors such as drug omissions, errors in dosage, and errors in dosing frequency.²⁷¹ In addition, approximately half of all hospital-related medication errors and 20 percent of ADEs occur during transitions within, admission to, transfer to, or discharge from a hospital.^{272 273 274} ADEs are more common among older adults, who make up most patients receiving PAC services. The rate of emergency department visits for ADEs is three times higher among adults 65 years of age and older compared to that among those younger than age 65.²⁷⁵

Some classes of drugs are associated with more risk than others.²⁷⁶ The six medication classes proposed as response options in the High-Risk Drug Classes: Use and Indication data element are anticoagulants; antiplatelets; hypoglycemics (including insulin); opioids; antipsychotics; and antibiotics. These drug classes are considered high-risk due to the adverse effects that may result from use. In particular, anticoagulants and antiplatelets are associated with bleeding risk;^{277 278} hypoglycemics are

²⁷⁰ U.S. Department of Health and Human Services. Office of Inspector General. Daniel R. Levinson. Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries. OEI-06-09-00090. November 2010.

²⁷¹ Boockvar, K. S., Liu, S., Goldstein, N., Nebeker, J., Siu, A., & Fried, T. (2009). Prescribing discrepancies likely to cause adverse drug events after patient transfer. *Quality and Safety in Health Care*, 18(1):32–6.

²⁷² Barnsteiner, J. H. (2005). Medication reconciliation: transfer of medication information across settings-keeping it free from error. *Journal of Infusion Nursing*, 28(2 Suppl):31-36.

²⁷³ Rozich, J., Roger, R. (2001). Medication safety: one organization's approach to the challenge. *Journal of Clinical Outcomes Management*, 2001(8):27-34.

²⁷⁴ Gleason, K. M., Groszek, J. M., Sullivan, C., Rooney, D., Barnard, C., & Noskin, G. A. (2004). Reconciliation of discrepancies in medication histories and admission orders of newly hospitalized patients. *American Journal of Health-System Pharmacy*, 61(16): 1689-1695

²⁷⁵ Shehab, N., Lovegrove, M. C., Geller, A. I., Rose, K. O., Weidle, N. J., & Budnitz, D. S. (2016). US emergency department visits for outpatient adverse drug events, 2013–2014. *Journal of the American Medical Association*, 316:2115–25.

²⁷⁶ *Ibid.*

²⁷⁷ Shoeb, M., & Fang, M. C. (2013). Assessing bleeding risk in patients taking anticoagulants. *Journal of Thrombosis and Thrombolysis*, 35(3):312–319.

²⁷⁸ Melkonian, M., Jarzebowski, W., & Pautas, E. (2017). Bleeding risk of antiplatelet drugs compared with oral anticoagulants in older patients with atrial fibrillation: a systematic review and meta-analysis. *Journal of Thrombosis and Haemostasis*, 15:1500–1510.

associated with fluid retention, heart failure, and lactic acidosis;²⁷⁹ opioids are associated with misuse;²⁸⁰ antipsychotics are associated with fractures and strokes;^{281 282} and antimicrobials, the category of medications that includes antibiotics, are associated with various adverse events such as central nervous systems effects and gastrointestinal intolerance.²⁸³ Moreover, some medications in the six drug classes in this group of data elements are included in the 2019 Updated Beers Criteria® list as potentially inappropriate medications for use in older adults.²⁸⁴ Although a complete medication list should record several important attributes of each medication (e.g., dosage, route, stop date), recording an indication for the drug is of crucial importance.²⁸⁵

Relevance to IRFs

Many patients treated in the IRF setting have one or more conditions that require treatment with a medication in a high-risk drug class. In a nationally representative sample of Medicare beneficiaries in IRFs in 2012, almost five percent of Medicare patients in IRFs experienced some type of medication-related adverse event over a one-month period, ranging in severity from a longer IRF stay to contributing to death.²⁸⁶ In the same study, over eight percent of patients in IRFs experienced a medication-related “temporary harm event” during the one-month period, defined as requiring medical intervention, but not causing lasting harm.²⁸⁷ Of all adverse and temporary harm events identified in IRFs, 46 percent were related to medication.²⁸⁸ The top three categories of adverse or temporary harm events related to medications in IRFs were delirium and other changes in mental status due to medication, hypoglycemic events related to medication, and hypotension secondary to medication.²⁸⁹

Assessing use of high-risk medications by IRF patients and indications for each medication would provide important information related to patient safety in IRFs and care transitions between IRFs and other settings. The IRF-PAI does not currently contain data elements that document the use of any medication or the indication or reason for the patient taking the medication. The standardized assessment of high-risk medication use and ensuring that indications are noted in the medical record are important steps toward overall medication safety within and between PAC provider settings.

²⁷⁹ Hamnvik, O. P., & McMahon, G. T. (2009). Balancing Risk and Benefit with Oral Hypoglycemic Drugs. *The Mount Sinai Journal of Medicine, New York*, 76:234–243.

²⁸⁰ Naples, J. G., Gellad, W. F., Hanlon, J. T. (2016). The Role of Opioid Analgesics in Geriatric Pain Management. *Clinics in Geriatric Medicine*, 32(4):725-735.

²⁸¹ Rigler, S. K., Shireman, T. I., Cook-Wiens, G. J., Ellerbeck, E. F., Whittle, J. C., Mehr, D. R., & Mahnken, J. D. (2013). Fracture risk in nursing home residents initiating antipsychotic medications. *Journal of the American Geriatrics Society*, 61(5):715–722.

²⁸² Wang, S., Linkletter, C., Dore, D. et al. (2012). Age, antipsychotics, and the risk of ischemic stroke in the Veterans Health Administration. *Stroke*, 43:28–31.

²⁸³ Faulkner, C. M., Cox, H. L., & Williamson, J. C. (2005). Unique aspects of antimicrobial use in older adults. *Clinical Infectious Diseases*, 40(7):997–1004.

²⁸⁴ American Geriatrics Society 2019 Beers Criteria Update Expert Panel. American Geriatrics Society 2019: Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. *Journal of the American Geriatrics Society*, 00:1-21.

²⁸⁵ Li, Y., Salmasian, H., Harpaz, R., Chase, H., & Friedman, C. (2011). Determining the reasons for medication prescriptions in the EHR using knowledge and natural language processing. *AMIA Annual Symposium Proceedings*, 768-76.

²⁸⁶ Levinson, D. R., “Adverse events in rehabilitation hospitals: national incidence among Medicare beneficiaries.” Washington, DC: U.S. Department of Health and Human Services, Office of the Inspector General, July 2016. Available at: <https://oig.hhs.gov/oci/reports/oci-06-14-00110.pdf>.

²⁸⁷ *Ibid.*

²⁸⁸ *Ibid.*

²⁸⁹ *Ibid.*

Proposed Data Element for the Assessment of High-risk Drug Classes: Use and Indication

N0415. High-Risk Drug Classes: Use and Indication		
1. Is taking Check if the patient is taking any medications in the following drug classes	1. Is taking	2. Indication noted
2. Indication noted If Column 1 is checked, check if there is an indication noted for all medications in the drug class	Check all that apply ↓	Check all that apply ↓
A. Antipsychotic	<input type="checkbox"/>	<input type="checkbox"/>
E. Anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>
F. Antibiotic	<input type="checkbox"/>	<input type="checkbox"/>
H. Opioid	<input type="checkbox"/>	<input type="checkbox"/>
I. Antiplatelet	<input type="checkbox"/>	<input type="checkbox"/>
J. Hypoglycemic (including insulin)	<input type="checkbox"/>	<input type="checkbox"/>

Current use

Medication classes received is currently assessed in the MDS. The number of days the resident received the following medications by pharmacological classification during the last seven days is assessed for: antipsychotic, antianxiety, antidepressant, hypnotic, anticoagulant, antibiotic, diuretic, and opioid medications.

Prior evidence supporting use of High-Risk Drug Classes: Use and Indication

The High-Risk Drug Classes: Use and Indication data element was not tested in prior demonstration efforts. However, the use of similar data elements in the MDS 3.0 speak to the feasibility of collecting data on patient medications in a standardized assessment.

Evidence supporting use of High-Risk Drug Classes: Use and Indication from the National Beta Test

Assessing High-Risk Drug Classes: Use and Indication: As part of the assessment of the Medication Reconciliation process, the National Beta Test included a data element that assesses whether the patient/resident was taking any medications in each of the six high-risk drug classes, and for each medication, whether there was a corresponding indication noted. The six classes include: anticoagulants, antiplatelets (excluding low-dose aspirin), hypoglycemics (including insulin), opioids, antipsychotics, and antimicrobials (excluding topicals). In Beta testing, the data element was administered to 627 patients/residents in the HHA setting, 769 in IRF, 459 in LTCH, and 1,096 in SNF settings (n = 2,951 overall).

In the four settings combined, the percent of patients/residents taking medications in each of the six classes ranged from 12 percent (Antipsychotics) to 51 percent (Opioids). In the IRF setting, these percentages ranged from 9 percent (Antipsychotics) to 61 percent (Anticoagulants). The presence of indications for noted medications in the various classes ranged from 45 percent (Anticoagulants and

Antiplatelets) to 92 percent (Opioids) in the four settings combined, and in the IRF setting the indication percentages ranged from 29 percent (Anticoagulants) to 91 percent (Opioids). The overall and setting-specific findings for each high-risk drug class are detailed in Table 6.1.1 in Appendix C.

Missing data: There were very low rates of missing responses for the medication use items. In the four settings combined, missingness rates did not exceed 4.2 percent for any of the six drug class items. Similarly, in the IRF setting missingness rates did not exceed 3.9 percent for the six drug class items. Missing data was also very low for indication items. Missingness rates did not exceed 1.2 percent in the four settings combined and did not exceed 2.1 percent in the IRF setting. In general, the low rate of missing data indicates feasibility of administration.

Time to complete: Time to complete was examined among 406 assessments in the HHA setting, 446 in the IRF setting, 271 in the LTCH setting, and 421 in the SNF setting (n = 1,544 overall). Average time to complete the high-risk drug classes: use and indication items was approximately 1.0 minute (SD = 0.6 minutes) in the four settings combined and 1.1 minutes (SD = 0.6 minutes) in the IRF setting.

Interrater reliability: Interrater reliability was examined for 187 assessments in HHA, 240 in IRF, 212 in LTCH, and 261 in SNF (n = 900 overall). Kappas were not estimated within or across settings for items assessing antipsychotic use and indication of opioids because the proportions were out of range for stable kappa estimates.

In the four settings combined, IRRs across settings ranged from substantial/good to excellent/almost perfect (kappas = 0.72 to 0.89) for medication use items. In the IRF setting, kappas for medication use were also substantial/good to excellent/almost perfect (kappas = 0.71 to 0.86). For indication items, kappas ranged from substantial/good to excellent/almost perfect, both in the four settings combined (kappa = 0.65 to 0.87) and in the IRF setting (0.62 to 1.00).

Percent agreement was very high for the medication use items, both in the four settings combined (92 to 95 percent) and in the IRF setting (91 to 95 percent). Similarly, percent agreement was generally high for indication items, both in the four settings combined (82 to 94 percent) and in the IRF setting (81 to 100 percent). More detailed IRR statistics are shown in Appendix C, Table 6.1.2.


Section 4: Medical Conditions and Co-Morbidities

Pain Interference

Pain is a highly prevalent medical condition in the United States. A CDC analysis of 2016 National Health Interview Study data found that 8 percent of Americans report high-impact chronic pain, that is, pain that limits life or work activities on most days or every day in the past 6 months.²⁹⁰ Pain in older adults occurs in conjunction with many acute and chronic conditions, such as osteoarthritis, leg pain during the night, cancer and associated treatment, neuralgia from diabetes mellitus, infections such as herpes zoster/shingles, and peripheral vascular disease.²⁹¹ Conditions causing pain in older adults may be associated with depression,²⁹² sleep disturbance,²⁹³ ²⁹⁴ and lower participation in rehabilitation activities.²⁹⁵ ²⁹⁶ ²⁹⁷

A substantial percentage of older adults receiving services in a PAC setting experience pain. Based on assessment testing performed in the PAC PRD, more than half of patients in the PAC settings reported having experienced “pain or hurting at any time during the last two days”, with 55 percent in LTCHs, 65 percent in SNFs, 68 percent in IRFs, and 70 percent of patients receiving HHA services responding “yes” to this question.²⁹⁸ Based on the 2009 Medicare Current Beneficiary Survey, the prevalence of moderate-to-severe pain²⁹⁹ among residents of skilled and non-skilled nursing facilities was 22 percent, while the prevalence of persistent pain – defined as the same or worse pain over time – was 65 percent.³⁰⁰

Pain in older adults can be treated with medications, complementary and alternative approaches, or physical therapy.³⁰¹ Treatment of pain in older adults may be complicated by issues such as dementia, high rates of polypharmacy, end-of-life care, and patient expectations, attitudes, and fears related to pain

²⁹⁰ Dahlhamer J, Lucas J, Zelaya, C, et al. Prevalence of Chronic Pain and High-Impact Chronic Pain Among Adults — United States, 2016. *MMWR Morb Mortal Wkly Rep* 2018;67:1001–1006. DOI: <http://dx.doi.org/10.15585/mmwr.mm6736a2> 

²⁹¹ American Geriatrics Society Panel on Pharmacological Management of Persistent Pain in Older Persons. (2009.) Pharmacological management of persistent pain in older persons. *Journal of the American Geriatrics Society*, 57(8), 1331.

²⁹² Sullivan-Singh, S. J., Sawyer, K., Ehde, D. M., Bell, K. R., Temkin, N., Dikmen, S., ... & Hoffman, J. M. (2014). Comorbidity of pain and depression among persons with traumatic brain injury. *Archives of Physical Medicine and Rehabilitation*, 95(6), 1100-1105.

²⁹³ Eslami, V., Zimmerman, M. E., Grewal, T., Katz, M., & Lipton, R. B. (2016). Pain grade and sleep disturbance in older adults: evaluation the role of pain, and stress for depressed and non-depressed individuals. *International Journal of Geriatric Psychiatry*, 31(5), 450-457.

²⁹⁴ Blytt, K. M., Bjordvatn, B., Husebo, B., & Flo, E. (2018). Effects of pain treatment on sleep in nursing home patients with dementia and depression: A multicenter placebo-controlled randomized clinical trial. *International Journal of Geriatric Psychiatry*, 33(4), 663-670.

²⁹⁵ Chin, R. P. H., Ho, C. H., & Cheung, L. P. C. (2013). Scheduled analgesic regimen improves rehabilitation after hip fracture surgery. *Clinical Orthopaedics and Related Research*, 471(7), 2349-2360.

²⁹⁶ Brenner, I. & Marsella, A. (2008). Factors influencing exercise participation by clients in long-term care. *Perspectives (Pre-2012)*, 32(4), 5.

²⁹⁷ Zanca, J. M., Dijkers, M. P., Hammond, F. M., & Horn, S. D. (2013). Pain and its impact on inpatient rehabilitation for acute traumatic spinal cord injury: analysis of observational data collected in the SCIRehab study. *Archives of Physical Medicine and Rehabilitation*, 94(4), S137-S144.

²⁹⁸ Gage, B. (2016). Data from the PAC PRD study, 2008-2010 [data file]. Available from Barbara Gage, August 16, 2016.

²⁹⁹ In this study, pain was measured based on two MDS items that assess pain frequency and intensity, with “moderate pain...defined as having daily mild to moderate pain” and “severe pain ... as having daily pain at times horrible or excruciating”.

³⁰⁰ Shen, X., Zuckerman, I. H., Palmer, J. B., & Stuart, B. (2015). Trends in prevalence for moderate-to-severe pain and persistent pain among Medicare beneficiaries in nursing homes, 2006–2009. *Journals of Gerontology Series A: Biomedical Sciences and Medical Sciences*, 70(5), 598-603.

³⁰¹ National Institute on Aging. (2018, February 28). *Pain: You Can Get Help*. Retrieved from <https://www.nia.nih.gov/health/pain-you-can-get-help>

treatment.³⁰² Untreated pain is an often-debilitating condition that is associated with a host of adverse physical consequences, including loss of function, poor quality of life, disruption of sleep and appetite, inactivity, and weakness, as well as psychological effects such as depression, anxiety, fear, and anger.³⁰³
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Relevance to IRFs

Many patients in the IRF setting report having pain and experiencing it often. From the 2018 National Beta Test, 79 percent of patients in the IRF setting reported having “pain or hurting.” Of those who reported pain, 64 percent experienced pain “frequently” or “almost constantly.”

Pain among IRF patients can interfere with rehabilitation and has potential secondary complications. The potential effects of pain on patient health are myriad, and it is critical to assess pain during hospitalization and post discharge. Assessing pain in IRF patients during their stay can lead to appropriate treatment and improved quality of life, can reduce complications associated with immobility such as skin breakdown and infection, and can facilitate rehabilitation efforts and the ability to return to community settings. Pain assessment post-discharge can also be used to plan appropriate treatment and may potentially reduce readmissions.

Proposed Data Elements for Assessment of Pain Interference

J0510. Pain Effect on Sleep	
Enter Code <input type="checkbox"/>	Ask patient: “Over the past 5 days, how much of the time has pain made it hard for you to sleep at night? ” 0. Does not apply – I have not had any pain or hurting in the past 5 days → Skip to XXXX 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost Constantly 9. Unable to answer
J0520. Pain Interference with Therapy Activities	
Enter Code <input type="checkbox"/>	Ask patient: “Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain? ” 0. Does not apply – I have not received rehabilitation therapy in the past 5 days 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost Constantly 9. Unable to answer
J0530. Pain Interference with Day-to-Day Activities	

³⁰² Molton, I. R., & Terrill, A. L. (2014). Overview of persistent pain in older adults. *American Psychologist*, 69(2), 197.

³⁰³ Institute of Medicine (IOM). (2011). *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. Washington, DC, The National Academies Press.

³⁰⁴ American Geriatrics Society Panel on Pharmacological Management of Persistent Pain in Older Persons. (2009). Pharmacological management of persistent pain in older persons. *Journal of the American Geriatrics Society*, 57(8), 1331.

Enter Code <input type="checkbox"/>	<p>Ask patient: “Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?”</p> <ol style="list-style-type: none"> 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost Constantly 9. Unable to answer
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Current use

Data elements on the topic of pain are currently assessed in OASIS and MDS. The OASIS assesses the frequency of pain interfering with patient’s activity or movement. A pain assessment interview is included in MDS and includes questions on whether pain has made it hard for the resident to sleep at night and if pain has limited day-to-day activities.

Prior evidence supporting use of Pain Interference data elements

Two interview-based data elements, pain effect on sleep and pain effect on activities, were included in the PAC PRD testing of interrater reliability, and showed strong interrater reliability (weighted kappas of 0.836 and 0.789, respectively).³⁰⁵

In a national test to develop and validate the MDS 3.0, two items (pain made it hard to sleep, pain limited day-to-day activities) were validated for measuring the effect of pain on function.³⁰⁶

Evidence supporting use of Pain from the National Beta Test

Assessing Pain: In Beta testing, three pain interference data elements were assessed, including Effect of Pain on Sleep, Pain Interference with Rehabilitation Therapies (If Applicable), and Pain Interference with Daily Activities. A total of 489 patients/residents in HHA, 618 in IRF, 375 in LTCH, and 872 in SNF settings (n = 2,354 overall) reported experiencing any pain and were administered the three pain interference items. Setting-specific frequencies are shown in Appendix C, Table 7.1.1.

Across settings, among the 78 percent of patients/residents who reported experiencing any pain, pain interfered with sleep more often than rarely for two of three patients/residents (65 percent); 37 percent of patients/residents with pain had pain that made it difficult to sleep “frequently” or “almost constantly.” In the IRF setting, among the 79 percent of patients who reported experiencing any pain, pain interfered with sleep more than rarely for two of three patients (68 percent); 39 percent of patients with pain in the IRF experienced pain that interfered with sleep “frequently” or “almost constantly.”

Among the patients/residents who reported experiencing any pain, most had been offered rehabilitation therapies (e.g., physical therapy, occupational therapy, speech therapy), both across settings (89 percent) and in the IRF (98 percent). Among these patients/residents overall, 73 percent reported that pain rarely interfered with rehabilitation. Within the IRF setting, 76 percent of these patient of IRF patients who had pain and were offered therapy reported that pain rarely interfered with rehabilitation;

³⁰⁵ Gage, B., Smith, L., Ross, J., Coots, L., Kline, T., Shamsuddin, K., , ... & Gage-Croll, Z. (2012). The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on Reliability Testing. Volume 2 of 3. Research Triangle Park, NC: RTI International. Retrieved from <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/The-Development-and-Testing-of-the-Continuity-Assessment-Record-and-Evaluation-CARE-Item-Set-Final-Report-on-Reliability-Testing-Volume-2-of-3.pdf>

³⁰⁶ Saliba, D., & Buchanan, J. (2008). Development and validation of a revised nursing home assessment tool: MDS 3.0. Santa Monica, CA: RAND Corporation. 2008. Available at <http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf>

about one in fourteen (7 percent) had pain that interfered with therapy “frequently” or “almost constantly.”

Among those who reported experiencing any pain, fifty-five percent of patients/residents across settings reported limiting their daily activities (not including rehabilitation) more often than “rarely or not at all.” About one in three of these patients/residents (33 percent) had pain that limited activities “frequently” or “almost constantly.” In the IRF setting, 45 percent of patients with pain had pain that interfered more often than rarely. About one of four IRF patients with pain (27 percent) had limited activities “frequently” or “almost constantly” due to pain.

Fifty-five percent of patients/residents across settings reported limiting their daily activities (not including rehabilitation) more often than “rarely or not at all.” About one in three patients/residents (33 percent) had pain that limited activities “frequently” or “almost constantly.” In the IRF setting, 45 percent of patients had pain that interfered more often than rarely. About one of four IRF patients (27 percent) had limited activities “frequently” or “almost constantly.”

Missing data: Overall, there were low rates of missing data for pain data elements. Across all settings, missing data did not exceed 2.4 percent for any data element. Similarly, in the IRF setting, missing data did not exceed 2.6 percent for any data element. In general, the low rate of missing data indicates feasibility of administration.

Time to complete: The length of time to administer the pain data elements was examined as another indicator of feasibility among 440 patients/residents in HHA, 533 in IRF, 321 in LTCH, and 483 in SNF (n = 1,777 overall). Across settings, the average time to complete the three interference items was 1.3 minutes (SD = 0.6). In the IRF setting, time to complete was similar at 1.2 minutes (SD = 0.5).

Interrater reliability: IRR was assessed for 197 patients/residents in HHA, 256 in IRF, 232 in LTCH, and 268 in SNF (n = 953 overall). IRR statistics were generally excellent/perfect, indicating high levels of agreement in responses to the data elements across assessment staff. For the pain interference data elements across settings, kappas were excellent/almost perfect, with values of either 0.97 or 0.98. The same was true in the IRF setting, where excellent/almost perfect kappas ranged from 0.96 to 0.98. Percent agreement was similarly high, with nearly perfect or perfect agreement, 98 percent for all items in the four settings combined and in IRF specifically. More detailed IRR statistics are shown in Appendix C, Table 7.1.2.

Section 5: Impairments

Hearing and Vision Impairments

Hearing and vision impairments are common conditions that, if unaddressed, affect patients’ and residents’ activities of daily living, communication, physical functioning, rehabilitation outcomes, and overall quality of life. Sensory limitations can lead to confusion in new settings, increase isolation, contribute to mood disorders, and impede accurate assessment of other medical conditions such as cognition. Hearing impairments may cause difficulty in communication of important information concerning the patient’s or resident’s condition, preferences, and care transitions; vision impairments have been associated with increased risk of falls. Both types of impairment can also interfere with comprehension of and adherence to discharge plans. Onset of hearing and vision impairments can be gradual, so accurate screening tools and follow-up evaluations are essential to determining which patients and residents need hearing- or vision-specific medical attention or assistive devices, and to ensuring that person-directed care plans are developed to accommodate a patient or resident’s needs during post-acute care and at discharge.

Assessments pertaining to sensory status aids PAC providers in better understanding the needs of their patients and residents by establishing a diagnosis of hearing or vision impairment, elucidating the patient or resident’s ability and willingness to participate in treatments or use assistive devices during

their stay, and identifying appropriate ongoing therapy and support needs at the time of discharge. The standardized assessment of vision impairment among PAC patients and residents supports clinical decision-making, early clinical intervention, person-centered care, and improved care continuity and coordination. The use of valid and reliable standardized assessments can aid in the communication of information within and across providers, further enabling the transfer of accurate health information.

Standardized Data Elements to Assess Hearing and Vision Impairments

CMS has identified two data elements for cross-setting standardized assessment of hearing and vision impairment. The proposed data elements are:

1. Hearing
2. Vision

Hearing

Hearing impairment is one of the most common complaints in adults over the age of 60 and is a major contributor to difficulties in speech comprehension.³⁰⁷ Causes of hearing loss can include noise, earwax or fluid buildup, a punctured ear drum, viruses and bacteria, certain health conditions (e.g., stroke, cardiac conditions, and brain injury), medications, heredity, and aging.³⁰⁸ Age-related hearing loss is caused by presbycusis and occurs gradually over time as an individual ages. It is typically hereditary and usually affects both ears. Hearing impairment in older adults has been associated with a myriad of outcomes,³⁰⁹ including falls,³¹⁰ dementia,³¹¹ ³¹² ³¹³ cognitive impairment,³¹⁴ anxiety,³¹⁵ emotional vitality,³¹⁶ and various medical conditions (e.g., arthritis, cancer, cardiovascular disease, diabetes, emphysema, high blood pressure, and stroke).³¹⁷

³⁰⁷ Peelle, J. E., Troiani, V., Grossman, M., & Wingfield, A. (2011). "Hearing loss in older adults affects neural systems supporting speech comprehension." *Journal of Neuroscience* 31(35): 12638-12643.

³⁰⁸ National Institute on Aging. (2018). *Hearing Loss: A Common Problem for Older Adults*. Retrieved from <https://www.nia.nih.gov/health/hearing-loss-common-problem-older-adults>

³⁰⁹ Contrera, K. J., Wallhagen, M. I., Mamo, S. K., Oh, E. S., & Lin, F. R. (2016). Hearing loss health care for older adults. *The Journal of the American Board of Family Medicine*, 29(3), 394-403.

³¹⁰ Jiam, N. T. L., Li, C., & Agrawal, Y. (2016). Hearing loss and falls: A systematic review and meta-analysis. *The Laryngoscope*, 126(11), 2587-2596.

³¹¹ Thomson, R. S., Auduong, P., Miller, A. T., & Gurgel, R. K. (2017). Hearing loss as a risk factor for dementia: a systematic review. *Laryngoscope Investigative Otolaryngology*, 2(2), 69-79.

³¹² Deal, J. A., Betz, J., Yaffe, K., Harris, T., Purchase-Helzner, E., Satterfield, S., ... & Health ABC Study Group. (2016). Hearing impairment and incident dementia and cognitive decline in older adults: the health ABC study. *Journals of Gerontology Series A: Biomedical Sciences and Medical Sciences*, 72(5), 703-709.

³¹³ Wei, J., Hu, Y., Zhang, L., Hao, Q., Yang, R., Lu, H., ... & Chandrasekar, E. K. (2017). Hearing Impairment, Mild Cognitive Impairment, and Dementia: A Meta-Analysis of Cohort Studies. *Dementia and Geriatric Cognitive Disorders Extra*, 7(3), 440-452.

³¹⁴ Wei, J., Hu, Y., Zhang, L., Hao, Q., Yang, R., Lu, H., ... & Chandrasekar, E. K. (2017). Hearing Impairment, Mild Cognitive Impairment, and Dementia: A Meta-Analysis of Cohort Studies. *Dementia and Geriatric Cognitive Disorders Extra*, 7(3), 440-452.

³¹⁵ Contrera, K. J., Betz, J., Deal, J., Choi, J. S., Ayonayon, H. N., Harris, T., ... & Rubin, S. M. (2017). Association of hearing impairment and anxiety in older adults. *Journal of Aging and Health*, 29(1), 172-184.

³¹⁶ Contrera, K. J., Betz, J., Deal, J. A., Choi, J. S., Ayonayon, H. N., Harris, T., ... & Rubin, S. M. (2016). Association of hearing impairment and emotional vitality in older adults. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 71(3), 400-404.

³¹⁷ McKee, M. M., Stransky, M. L., & Reichard, A. (2018). Hearing loss and associated medical conditions among individuals 65 years and older. *Disability and Health Journal*, 11(1), 122-125.

A high proportion of older adults receiving services in a PAC setting experience hearing impairment. About 51 percent of nursing facility patients and residents are estimated to have moderate to severe hearing impairment.³¹⁸ Data from the PAC PRD suggest that severe hearing impairment affects 1 to 2 percent of Medicare FFS beneficiaries in the four types of PAC.³¹⁹ ³²⁰ Among older adults more generally, reports on the prevalence of hearing loss vary. The National Institute on Deafness and Other Communication Disorders (NIDCD) has stated that one third of people between ages 65 and 74 have hearing loss and roughly half of those older than 75 are hearing-impaired.³²¹ Additionally, a study found that two thirds of individuals aged 70 years or older have bilateral hearing loss and approximately three quarters have hearing loss in at least one ear.³²²

Assessing hearing impairment is critical to improving patient outcomes, safety, and quality of life. In addition, assessment can inform future care planning and care transitions.

Relevance to IRFs

The IRF-PAI does not currently include Hearing or any comparable hearing impairment assessment items. In PAC PRD testing, 1.1 percent of IRF patients demonstrated severely impaired hearing.³²³ Hearing impairments can impact the effectiveness of patient communication with providers, which has implications for patient understanding of and adherence to treatment plans and rehabilitation goals. Hearing impairments are also correlated with lower functional status and lower performance on measures of cognitive functioning in older adults,³²⁴ ³²⁵ which has implications for monitoring patient progress toward goals for some IRF patients and may also affect participation in some intensive rehabilitation therapies (e.g., speech and language therapies, cognitive rehabilitation). Assessing Hearing would provide important information for communication, ensuring safety, care planning, care transitions, and resource use in IRFs.

³¹⁸ Garahan, M. B., Waller, J. A., Houghton, M., Tisdale, W. A., & Runge, C. F. (1992). "Hearing loss prevalence and management in nursing home residents." *Journal of the American Geriatrics Society* 40(2): 130-134.

³¹⁹ Hearing impairments were classified into categories from mildly impaired to severely impaired. The percentages reported here refer to severe impairment of hearing, defined as "Absence of useful hearing" (Gage et al., 2012).

³²⁰ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. 2012. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

³²¹ National Institute on Deafness and Other Communication Disorders. (2018). *Hearing Loss and Older Adults*. Retrieved from <https://www.nidcd.nih.gov/health/hearing-loss-older-adults>

³²² Goman, A. M., & Lin, F. R. (2016). Prevalence of hearing loss by severity in the United States. *American Journal of Public Health*, 106(10), 1820-1822.

³²³ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. (2012). Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

³²⁴ Lin FR, Ferrucci L, Metter EJ, An Y, Zonderman AB, Resnick SM. (2011). Hearing loss and cognition in the Baltimore Longitudinal Study of Aging. *Neuropsychology* 25(6):763.

³²⁵ Keller BK, Morton JL, Thomas VS, Potter JF. (1999). The effect of visual and hearing impairments on functional status. *Journal of the American Geriatrics Society* 1;47(11):1319-25.

Proposed Data Element for the Assessment of Impairments: Hearing

B0200. Hearing	
Enter Code <input type="checkbox"/>	<p>Ability to hear (with hearing aid or hearing appliances if normally used)</p> <p>0. Adequate – no difficulty in normal conversation, social interaction, listening to TV</p> <p>1. Minimal difficulty – difficulty in some environments (e.g., when person speaks softly or setting is noisy)</p> <p>2. Moderate difficulty – speaker has to increase volume and speak distinctly</p> <p>3. Highly impaired – absence of useful hearing</p>

Current use

The Hearing data element is currently collected in the MDS, and is assessed with the use of a hearing aid, if applicable.

Prior evidence supporting use of Hearing

The Hearing data element tested in the PAC PRD includes one question regarding hearing ability, which showed high reliability across PAC settings (unweighted kappa = 0.78). The MDS 3.0 version of the Hearing data element also had almost perfect agreement in the MDS 3.0 national test in nursing homes (weighted kappas = 0.94 and 0.89).³²⁶

Evidence supporting use of Hearing from the National Beta Test

Assessing Hearing: In the Beta testing, a Hearing assessment item (with hearing aids, when applicable) was administered to 643 patients/residents in HHA, 783 in IRF, 498 in LTCH, and 1141 in SNF (n = 3,065 overall). Overall, 74 percent of patients/residents had adequate hearing, 17 percent had minimal difficulty hearing, 8 percent had moderate difficulty hearing, and 1 percent were highly impaired. In the IRF setting, 75 percent of patients had adequate hearing, 18 percent had minimal difficulty hearing, 6 percent had moderate difficulty hearing, and 1 percent were highly impaired. See Appendix C, Table 8.1.1 for setting-specific response frequencies for the Hearing data element.

Missing data: There were very low rates of missing responses for the Hearing data element both overall (0.3 percent) and in the IRF setting (0.4 percent), indicating feasibility of administration.

Time to complete: Time to complete was assessed among 396 patients/residents in HHA, 499 in IRF, 301 in LTCH, and 456 in SNF (n = 1,652 overall). Across all settings, the mean time to complete the Hearing item was 0.3 minutes (SD=0.2 minutes). Likewise, in the IRF setting, mean time to complete the Hearing item was 0.3 minutes (SD=0.2 minutes).

Interrater reliability: Interrater reliability (IRR) was assessed for the Hearing item for 197 patients/residents in HHA, 258 in IRF, 237 in LTCH, and 268 in SNF (n = 960 overall). Across all settings, kappa for the Hearing item was substantial/good (0.65). In the IRF setting, kappa for the Hearing item was substantial/good (0.67). Percent agreement was high for the Hearing item both across settings (84 percent) and in the IRF setting (87 percent). More detailed IRR statistics are shown in Appendix C, Table 8.1.2.

³²⁶ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>

Vision

Visual impairment can be caused not only by age-related diseases (e.g., age-related macular degeneration [AMD], cataract, glaucoma, and diabetic retinopathy) but also due to nearsightedness, farsightedness, loss of near vision with age, and/or untreated disease.³²⁷ In addition to conditions affecting the eye itself, visual deficits can also be caused by other conditions such as stroke and traumatic brain injury. Visual impairment in older adults has been associated with depression and anxiety,³²⁸ lower cognitive function,³²⁹ and poorer quality of life.³³⁰

The PAC PRD study found that between 1 and 3 percent of Medicare FFS beneficiaries among the four types of PAC providers had the most extreme category of visual impairment assessed, having “No vision or object identification questionable.”³³¹ While the majority of patients and residents in the PAC settings do not exhibit severely impaired vision, visual impairment affects a substantial proportion of older adults and is predicted to increase substantially over time. A study examining visual impairment among adults in the United States found that in 2015, among the 3.22 million persons in the US who were visually impaired, the largest proportions comprised those in older age categories: aged 80 years and older (50 percent), 70–79 years (24 percent), and 60–69 years (16 percent).³³² By 2050, the proportion of adults with visual impairment will increase to 64 percent among individuals aged 80 years and older.³³³

Assessing visual impairment is critical to improving patient outcomes, safety, and quality of life. Additionally, assessment can inform future care planning and care transitions.

Relevance to IRFs

The IRF-PAI does not currently assess vision impairment. In PAC PRD testing, 1.7 percent of IRF patients demonstrated severely impaired vision,³³⁴ and this was associated with poorer outcomes with respect to change in self-care and mobility.³³⁵ Additionally, assessment of this information is useful for ensuring safety in the IRF setting, as impaired vision increases the risk of falls.^{336 337} Visual

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- ³²⁷ Cimarolli, V. R., Boerner, K., Brennan-Ing, M., Reinhardt, J. P., & Horowitz, A. (2012). “Challenges faced by older adults with vision loss: a qualitative study with implications for rehabilitation.” *Clinical Rehabilitation* 26(8): 748-757.
- ³²⁸ Heesterbeek, T. J., van der Aa, H. P., van Rens, G. H., Twisk, J. W., & van Nispen, R. M. (2017). The incidence and predictors of depressive and anxiety symptoms in older adults with vision impairment: a longitudinal prospective cohort study. *Ophthalmic and Physiological Optics*, 37(4), 385-398.
- ³²⁹ Chen, S. P., Bhattacharya, J., & Pershing, S. (2017). Association of vision loss with cognition in older adults. *JAMA Ophthalmology*, 135(9), 963-970.
- ³³⁰ Tseng, Y. C., Liu, S. H. Y., Lou, M. F., & Huang, G. S. (2018). Quality of life in older adults with sensory impairments: a systematic review. *Quality of Life Research*, 1-15.
- ³³¹ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. 2012. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.
- ³³² Varma, R., Vajaranant, T. S., Burkemper, B., Wu, S., Torres, M., Hsu, C., ... & McKean-Cowdin, R. (2016). Visual impairment and blindness in adults in the United States: demographic and geographic variations from 2015 to 2050. *JAMA Ophthalmology*, 134(7), 802-809.
- ³³³ Varma, R., Vajaranant, T. S., Burkemper, B., Wu, S., Torres, M., Hsu, C., ... & McKean-Cowdin, R. (2016). Visual impairment and blindness in adults in the United States: demographic and geographic variations from 2015 to 2050. *JAMA Ophthalmology*, 134(7), 802-809.
- ³³⁴ *Ibid*
- ³³⁵ *Ibid*
- ³³⁶ Ivers, R. Q., Norton, R., Cumming, R. G., Butler, M., & Campbell, A. J. (2000). Visual impairment and risk of hip fracture. *American Journal of Epidemiology* 152(7): 633-639.
- ³³⁷ Freeman, E. E., Munoz, B., Rubin, G., West, S. K. (2007). Visual field loss increases the risk of falls in older adults: the Salisbury eye evaluation. *Investigative Ophthalmology & Visual Science* 48(10): 4445-4450.

impairments are also associated with poorer rehabilitation outcomes among older IRF patients.³³⁸ Visual impairments may also affect patients’ participation in some rehabilitation therapies and/or ability to complete cognitive assessment tools (e.g., performance on visual-motor tasks). Assessing Vision would provide important information for patient safety, communication, care planning, care transitions, and resource use in IRFs.

Proposed Data Element for the Assessment of Impairments: Vision

B1000. Vision	
Enter Code <input type="checkbox"/>	Ability to see in adequate light (with glasses or other visual appliances) 0. Adequate – sees fine detail, such as regular print in newspapers/books 1. Impaired – sees large print, but not regular print in newspapers/books 2. Moderately impaired – limited vision; not able to see newspaper headlines but can identify objects 3. Highly impaired – object identification in question, but eyes appear to follow objects 4. Severely impaired – no vision or sees only light, colors or shapes; eyes do not appear to follow objects

Current use

Vision is currently assessed in the OASIS and MDS, with corrective lenses when applicable. Vision is assessed in OASIS with three response options ranging from 0 (normal vision) to 2 (severely impaired). The Vision data element (Ability to See in Adequate Light) in the MDS contains five response options ranging from 0 (adequate) to 4 (severely impaired).

Prior evidence supporting use of Vision

The MDS 3.0 Vision data element has been shown to perform reliably in screening for vision impairment (weighted kappa = 0.917) in the national MDS 3.0 test in nursing homes.³³⁹ The Vision data element is also linked to performance with readily available materials (i.e., newspaper). Finally, the Vision data element was tested in the PAC PRD assessment. The PAC PRD found substantial agreement for interrater reliability across settings for this data element (kappa of 0.74).³⁴⁰

Evidence supporting use of Vision from the National Beta Test

Assessing Vision: In the Beta testing, the Vision assessment item (with corrective lenses when applicable) was administered to 643 patients/residents in HHA, 783 in IRF, 498 in LTCH, and 1141 in SNF (n = 3,065 overall).

Overall, 78 percent of patients/residents had adequate vision, 16 percent had impaired vision, and 6 percent had moderately to severely impaired vision. In the IRF setting, 85 percent of patients/residents had adequate vision, 12 percent had impaired vision, and 3 percent had moderately to severely impaired vision. Setting-specific frequencies are shown in Appendix C, Table 9.2.1.

³³⁸ Lieberman, D., Friger, M., Lieberman, D. (2004). Visual and hearing impairment in elderly patients hospitalized for rehabilitation following hip fracture. *Journal of Rehabilitation Research and Development* 41:669–674.

³³⁹ Saliba, D., & Buchanan, J. Development and validation of a revised nursing home assessment tool: MDS 3.0. Appendices. Santa Monica, CA: RAND Corporation. 2008. Available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReportAppendix.pdf>

³⁴⁰ Gage, B., Morley, M., Smith, L., Ingber, M. J., Deutsch, A., Kline, T., ... & Kelleher, C. Post-acute care payment reform demonstration: Final report. Research Triangle Park, NC: RTI International. 2012. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html.

Missing data: There were very low rates of missing responses for the Vision item both overall (0.6 percent) and the IRF setting (0.6 percent), indicating feasibility of administration.

Time to complete: Time to complete was assessed among 396 patients/residents in HHA, 499 in IRF, 301 in LTCH, and 456 in SNF (n = 1,652 overall). Across all settings, the mean time to complete the Vision item was 0.3 minutes (SD = 0.2 minutes). Likewise, in the IRF setting, mean time to complete the Vision item was 0.3 minutes (SD = 0.2 minutes).

Interrater reliability: Interrater reliability (IRR) was assessed for the Vision item for 197 patients/residents in HHA, 258 in IRF, 237 in LTCH, and 268 in SNF (n = 960). Across all settings, kappa for the Vision item was moderate (0.56). In the IRF setting, kappa for the Vision item was also moderate (0.50). Percent agreement was high for the Vision item across settings (83 percent). Agreement for the Vision items in the IRF setting was slightly higher (90 percent). More detailed IRR statistics are shown in Appendix C, Table 9.2.2.

Section 6: Proposed New Category: Social Determinants of Health

Standardized Data Elements to Assess for Social Determinants of Health

CMS has identified data elements for cross-setting standardization of assessment for seven social determinants of health (SDOH). The proposed data elements are:

1. Race;
2. Ethnicity;
3. Preferred Language;
4. Interpreter Services;
5. Health Literacy;
6. Transportation; and
7. Social Isolation.

Race and Ethnicity

Relevance to IRFs

The persistence of racial and ethnic disparities in health and health care is widely documented, including but not limited to PAC settings.^{341,342,343,344,345} Although racial and ethnic disparities decrease when social factors are controlled for, they often remain. The root cause of these disparities is not always clear because data on many SDOH are not collected. Measuring SDOH in IRF settings is an important step to addressing these avoidable differences in health outcomes. Collecting data on race and ethnicity supports patient-centered care, and informs understanding of patient complexity and risk factors that may affect payment, quality measurement, and care outcomes for IRFs. Improving how race and ethnicity data are collected is an important component of improving quality by identifying and addressing health disparities that impact Medicare beneficiaries.

³⁴¹ 2017 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; September 2018. AHRQ Pub. No. 18-0033-EF.

³⁴² Fiscella, K. and Sanders, M.R. Racial and Ethnic Disparities in the Quality of Health Care. (2016). Annual Review of Public Health. 37:375-394.

³⁴³ 2018 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Reports. Baltimore, MD: US Department of Health and Human Services, Centers for Medicare and Medicaid Services; February 28, 2018.

³⁴⁴ Smedley, B.D., Stith, A.Y., & Nelson, A.R. (2003). Unequal treatment: confronting racial and ethnic disparities in health care. Washington, D.C., National Academy Press.

³⁴⁵ Chase, J., Huang, L. and Russell, D. (2017). Racial/ethnic disparities in disability outcomes among post-acute home care patients. J of Aging and Health. 30(9):1406-1426.

Proposed Data Elements for the Assessment of Social Determinants of Health: Race and Ethnicity

Ethnicity

A1005. Ethnicity	
Are you Hispanic, Latino/a, or Spanish origin?	
↓	Check all that apply
<input type="checkbox"/>	A. No, not of Hispanic, Latino/a, or Spanish origin
<input type="checkbox"/>	B. Yes, Mexican, Mexican American, Chicano/a
<input type="checkbox"/>	C. Yes, Puerto Rican
<input type="checkbox"/>	D. Yes, Cuban
<input type="checkbox"/>	E. Yes, Another Hispanic, Latino, or Spanish origin
<input type="checkbox"/>	X. Patient unable to respond

Race

A1010. Race	
What is your race?	
↓	Check all that apply
<input type="checkbox"/>	A. White
<input type="checkbox"/>	B. Black or African American
<input type="checkbox"/>	C. American Indian or Alaska Native
<input type="checkbox"/>	D. Asian Indian
<input type="checkbox"/>	E. Chinese
<input type="checkbox"/>	F. Filipino
<input type="checkbox"/>	G. Japanese
<input type="checkbox"/>	H. Korean
<input type="checkbox"/>	I. Vietnamese
<input type="checkbox"/>	J. Other Asian
<input type="checkbox"/>	K. Native Hawaiian
<input type="checkbox"/>	L. Guamanian or Chamorro
<input type="checkbox"/>	M. Samoan
<input type="checkbox"/>	N. Other Pacific Islander
<input type="checkbox"/>	X. Patient unable to respond

Current use

There is currently a Race and Ethnicity data element, collected in the MDS, LCDS, IRF-PAI, and OASIS that consists of a single question, which aligns with the 1997 Office of Management and Budget (OMB) minimum data standards for federal data collection efforts.³⁴⁶ The 1997 OMB Standard lists five minimum categories of race: (1) American Indian or Alaska Native; (2) Asian; (3) Black or African

³⁴⁶ “Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity (Notice of Decision)”. Federal Register 62:210 (October 30, 1997) pp. 58782-58790. Available from: <https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf>.

American; (4) Native Hawaiian or Other Pacific Islander; and, (5) White. The 1997 OMB Standard also lists two minimum categories of ethnicity: (1) Hispanic or Latino, and (2) Not Hispanic or Latino.³⁴⁷ The current version uses a “Mark all that apply” response option.

Evidence supporting use of Race and Ethnicity

The proposed modification would result in two separate data elements, one for Race and one for Ethnicity that would conform with the 2011 HHS Data Standards for person-level data collection and the 1997 OMB Standards. The 2011 HHS Data Standards permit the collection of more detailed information on population groups provided additional categories can be aggregated into the OMB minimum standard set of categories. The 2011 HHS Data Standards require a two-question format when self-identification is used to collect data on race and ethnicity, as would be required by these two data elements. Large federal surveys, such as the National Health Interview Survey, Behavioral Risk Factor Surveillance System, and the National Survey on Drug Use and Health have implemented the 2011 HHS Data Standards. CMS has similarly updated the Medicare Current Beneficiary Survey, the Medicare Health Outcomes Survey, and the Health Insurance Marketplace Application for Health Coverage with the 2011 HHS data standards.

Preferred Language and Interpreter Services

Relevance to IRFs

More than 64 million people in the United States speak a language other than English at home, and nearly 40 million of those individuals have limited English proficiency (LEP).³⁴⁸ Individuals with LEP have been shown to receive worse care and have poorer health outcomes, including higher readmission rates.^{349,350,351} Communication with individuals with LEP is an important component of quality health care, which starts by understanding the population in need of language services. Unaddressed language barriers between a patient and provider care team negatively affects the ability to identify and address individual medical and non-medical care needs, to convey and understand clinical information, as well as discharge and follow up instructions, all of which are necessary for providing high quality care. Understanding the communication assistance needs of residents and patients with LEP, including individuals who are Deaf or hard of hearing, is critical for ensuring good outcomes.

³⁴⁷ Office of Management and Budget. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Washington, DC. Federal Register Notice, October 30, 1997.

³⁴⁸ U.S. Census Bureau, 2009-2013 American Community Survey.

³⁴⁹ Karliner LS, Kim SE, Meltzer DO, Auerbach AD. Influence of language barriers on outcomes of hospital care for general medicine inpatients. *J Hosp Med.* 2010 May-Jun;5(5):276-82. doi: 10.1002/jhm.658.

³⁵⁰ Kim EJ, Kim T, Paasche-Orlow MK, et al. Disparities in Hypertension Associated with Limited English Proficiency. *J Gen Intern Med.* 2017 Jun;32(6):632-639. doi: 10.1007/s11606-017-3999-9.

³⁵¹ National Academies of Sciences, Engineering, and Medicine. 2016. Accounting for social risk factors in Medicare payment: Identifying social risk factors. Washington, DC: The National Academies Press.

Proposed Data Elements for the Assessment of Social Determinants of Health: Preferred Language and Interpreter Services

A1110. Language	
Enter Code <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/>	<p>A. What is your preferred language?</p> <div style="border: 1px solid black; width: 300px; height: 15px; margin: 5px 0;"></div> <p>B. Do you need or want an interpreter to communicate with a doctor or health care staff?</p> <p>0. No</p> <p>1. Yes</p> <p>9. Unable to determine</p>

Current use

The preferred language of residents and patients and need for interpreter services are assessed in two PAC assessment tools. The LCDS and the MDS use the same two data elements to assess preferred language and whether a patient or resident needs or wants an interpreter to communicate with health care staff. The current preferred language data element in LCDS and MDS is open-ended, allowing the patient or resident to identify their preferred language, including American Sign Language (ASL). The MDS initially implemented preferred language and interpreter services data elements to assess the needs of SNF residents and patients and inform care planning. For alignment purposes, the LCDS later adopted the same data elements for LTCHs.

Evidence supporting use of Preferred Language and Interpreter Services

The 2009 National Academies of Sciences, Engineering, and Medicine (NASEM) report on standardizing data for health care quality improvement emphasizes that language and communication needs should be assessed as a standard part of health care delivery and quality improvement strategies.³⁵² While the 2011 HHS Primary Language Data Standard recommends a two-part question to assess spoken language, the need to improve the assessment of language preferences and communication needs across PAC settings should be balanced with the provider and patient assessment burden. In addition, preferred spoken language would not allow information to be collected on American Sign Language, as is accounted for by the preferred language and interpreter services data elements currently in the MDS and LCDS.

Health Literacy

Relevance to IRFs

Similar to language barriers, low health literacy can interfere with communication between the provider and resident or patient and the ability for residents and patients or their caregivers to understand and follow treatment plans, including medication management. Poor health literacy is linked to lower levels of knowledge about health, worse health outcomes, and the receipt of fewer preventive services but higher medical costs and rates of emergency department use.³⁵³

³⁵² IOM (Institute of Medicine). 2009. *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC: The National Academies Press.

³⁵³ National Academies of Sciences, Engineering, and Medicine. 2016. *Accounting for social risk factors in Medicare payment: Identifying social risk factors*. Washington, DC: The National Academies Press.

Proposed Data Element for the Assessment of Social Determinants of Health: Health Literacy

B1300. Health Literacy	
How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	
Enter Code <input type="checkbox"/>	<p>0. Never</p> <p>1. Rarely</p> <p>2. Sometimes</p> <p>3. Often</p> <p>4. Always</p> <p>9. Patient unable to respond</p>

Current use

A health literacy data element is not currently used in any of the PAC assessment tools.

Evidence supporting use of Health Literacy

Health literacy is prioritized by Healthy People 2020 as an SDOH.³⁵⁴ Health literacy is also considered an individual risk factor impacted by other social risk factors in NASEM’s 2016 report on accounting for social risk factors in Medicare payment.³⁵⁵ The Single Item Literacy Screener (SILS) question, which assesses reading ability (a primary component of health literacy), tested reasonably well against the 36 item Short Test of Functional Health Literacy in Adults (S-TOFHLA), a thoroughly vetted and widely adopted health literacy test, in assessing the likelihood of low health literacy in an adult sample from primary care practices participating in the Vermont Diabetes Information System.^{356,357} SILS is publicly available, and shorter and easier to administer than the S-TOFHLA, and research found that a positive result on the SILS demonstrates an increased likelihood that an individual has low health literacy.

Transportation

Relevance to IRFs

Transportation barriers can affect access to needed health care, causing missed appointments, delayed care, unfilled prescriptions, all of which can have a negative impact on health outcomes.³⁵⁸ Access to transportation for ongoing health care and medication access needs, particularly for those with chronic diseases, is essential to successful chronic disease management. Adopting a data element to collect and analyze information regarding transportation needs across PAC settings would facilitate the connection to programs that can address identified needs.

³⁵⁴ Social Determinants of Health. Healthy People 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>. (February 2019).

³⁵⁵ U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Programs. Available at: <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>. Washington, DC: 2016.

³⁵⁶ Morris, N. S., MacLean, C. D., Chew, L. D., & Littenberg, B. (2006). The Single Item Literacy Screener: evaluation of a brief instrument to identify limited reading ability. *BMC family practice*, 7, 21. doi:10.1186/1471-2296-7-21.

³⁵⁷ Brice, J.H., Foster, M.B., Principe, S., Moss, C., Shofer, F.S., Falk, R.J., Ferris, M.E., DeWalt, D.A. (2013). Single-item or two-item literacy screener to predict the S-TOFHLA among adult hemodialysis patients. *Patient Educ Couns*. 94(1):71-5.

³⁵⁸ Syed, S.T., Gerber, B.S., and Sharp, L.K. (2013). Traveling Towards Disease: Transportation Barriers to Health Care Access. *J Community Health*. 38(5): 976–993.

Proposed Data Element for the Assessment of Social Determinants of Health: Transportation

A1250. Transportation	
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	
↓ Check all that apply	
<input type="checkbox"/>	A. Yes, it has kept me from medical appointments or from getting my medications
<input type="checkbox"/>	B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
<input type="checkbox"/>	C. No
<input type="checkbox"/>	D. Patient unable to respond

Current use

A transportation data element is not currently used in any of the PAC assessment tools.

Evidence supporting use of Transportation

The proposed data element uses the Transportation item from the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) tool and is responsive to research on the importance of addressing transportation as a critical SDOH. The national PRAPARE social determinants of health assessment protocol is developed and owned by the National Association of Community Health Centers (NACHC), in partnership with the Association of Asian Pacific Community Health Organization, the Oregon Primary Care Association, and the Institute for Alternative Futures. More information about development of the PRAPARE tool can be found at: <https://protect2.fireeye.com/url?k=7cb6eb44-20e2f238-7cb6da7b-0cc47adc5fa2-1751cb986c8c2f8c&u=http://www.nachc.org/prapare>.³⁵⁹ Items in the assessment tool are consistent with Healthy People 2020 priorities and ICD-10 coding.

Social Isolation

Relevance to IRFs

Distinct from loneliness, social isolation refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area.^{360,361} Social isolation tends to increase with age, is a risk factor for physical and mental illness, and a predictor of mortality.^{362,363,364} Post-acute care providers are well-suited to design and implement programs to increase social engagement of patients, while also taking into account individual needs and preferences. Adopting a data element to collect and analyze information about social isolation in IRFs and across PAC settings would facilitate the identification of patients who are socially isolated and who may benefit from engagement efforts.

³⁵⁹ PRAPARE. National Association of Community Health Centers. <http://www.nachc.org/research-and-data/prapare/>. (December 2018).

³⁶⁰ Tomaka, J., Thompson, S., and Palacios, R. (2006). The Relation of Social Isolation, Loneliness, and Social Support to Disease Outcomes Among the Elderly. *J of Aging and Health*. 18(3): 359-384.

³⁶¹ Social Connectedness and Engagement Technology for Long-Term and Post-Acute Care: A Primer and Provider Selection Guide. (2019). *Leading Age*. Available at <https://www.leadingage.org/white-papers/social-connectedness-and-engagement-technology-long-term-and-post-acute-care-primer-and#1.1>

³⁶² Landeiro, F., Barrows, P., Nuttall Musson, E., Gray, A.M., and Leal, J. (2017). Reducing Social Loneliness in Older People: A Systematic Review Protocol. *BMJ Open*. 7(5): e013778.

³⁶³ Ong, A.D., Uchino, B.N., and Wethington, E. (2016). Loneliness and Health in Older Adults: A Mini-Review and Synthesis. *Gerontology*. 62:443-449.

³⁶⁴ Leigh-Hunt, N., Bagguley, D., Bash, K., Turner, V., Turnbull, S., Valtorta, N., and Caan, W. (2017). An overview of systematic reviews on the public health consequences of social isolation and loneliness. *Public Health*. 152:157-171.

Proposed Data Element for the Assessment of Social Determinants of Health: Social Isolation

D0700. Social Isolation	
How often do you feel lonely or isolated from those around you?	
Enter Code <input type="checkbox"/>	<ul style="list-style-type: none">0. Never1. Rarely2. Sometimes3. Often4. Always9. Patient unable to respond

Current use

A social isolation data element is not currently used in any of the PAC assessment tools.

Evidence supporting use of Social Isolation

The proposed data element uses the social isolation item from the Accountable Health Communities (AHC) Screening Tool, which was selected from the PROMIS Item Bank on Emotional Distress. The AHC Screening Tool was developed by a panel of interdisciplinary experts that looked at evidence-based ways to measure social determinants of health, including social isolation. More information about the AHC Screening Tool can be found at:

<https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf>.

APPENDIX A: Transfer of Health Information – Setting-Specific Language

Tables A-1 and A-2 below summarize the setting specific language used to describe the resident or patient within each PAC setting. There are no other differences in the content or language within each Transfer of Health Information to the Provider-Post-Acute Care quality measure data element and within each Transfer of Health Information to the Patient-Post-Acute Care quality measure data element.

**Table A-1
Transfer of Health Information to the Provider-Post-Acute Care - Setting-Specific Language**

IRF	LTCH	SNF
Discharge	Discharge	Discharge
<p>A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge At the time of discharge to another provider, did your facility provide the patient’s current reconciled medication list to the subsequent provider? Enter Code: <input type="checkbox"/></p> <p>0. No - Current reconciled medication list not provided to the subsequent provider 1. Yes - Current reconciled medication list provided to the subsequent provider</p>	<p>A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge At the time of discharge to another provider, did your facility provide the patient’s current reconciled medication list to the subsequent provider? Enter Code: <input type="checkbox"/></p> <p>0. No - Current reconciled medication list not provided to the subsequent provider 1. Yes - Current reconciled medication list provided to the subsequent provider</p>	<p>A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge At the time of discharge to another provider, did your facility provide the resident’s current reconciled medication list to the subsequent provider? Enter Code: <input type="checkbox"/></p> <p>0. No - Current reconciled medication list not provided to the subsequent provider 1. Yes - Current reconciled medication list provided to the subsequent provider</p>
<p>A2123. Route of Current Reconciled Medication List Transmission (column 1) Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider and/or patient/family/caregiver. A. Electronic Health Record B. Health Information Exchange Organization C. Verbal (e.g., in-person, telephone, video conferencing) D. Paper-based (e.g., fax, copies, printouts) E. Other Methods (e.g., texting, email, CDs)</p>	<p>A2123. Route of Current Reconciled Medication List Transmission (column 1) Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider and/or patient/family/caregiver. A. Electronic Health Record B. Health Information Exchange Organization C. Verbal (e.g., in-person, telephone, video conferencing) D. Paper-based (e.g., fax, copies, printouts) E. Other Methods (e.g., texting, email, CDs)</p>	<p>A2123. Route of Current Reconciled Medication List Transmission (column 1) Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider and/or patient/family/caregiver. A. Electronic Health Record B. Health Information Exchange Organization C. Verbal (e.g., in-person, telephone, video conferencing) D. Paper-based (e.g., fax, copies, printouts) E. Other Methods (e.g., texting, email, CDs)</p>

Table 2
Transfer of Health Information to the Patient–Post-Acute Care - Setting-Specific Language

IRF	LTCH	SNF
Discharge	Discharge	Discharge
<p>A2122. Provision of Current Reconciled Medication List to Patient at Discharge At the time of discharge, did your facility provide the patient’s current reconciled medication list to the patient, family and/or caregiver? Enter Code: <input type="checkbox"/></p> <p>0. No - Current reconciled medication list not provided to the patient, family and/or caregiver 1. Yes - Current reconciled medication list provided to the patient, family and/or caregiver</p> <p>A2123. Route of Current Reconciled Medication List Transmission (column 2) Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider and/or patient/family/caregiver. A. Electronic Health Record B. Health Information Exchange Organization C. Verbal (e.g., in-person, telephone, video conferencing) D. Paper-based (e.g., fax, copies, printouts) E. Other Methods (e.g., texting, email, CDs)</p>	<p>A2122. Provision of Current Reconciled Medication List to Patient at Discharge At the time of discharge, did your facility provide the patient’s current reconciled medication list to the patient, family and/or caregiver? Enter Code: <input type="checkbox"/></p> <p>0. No - Current reconciled medication list not provided to the patient, family and/or caregiver 1. Yes - Current reconciled medication list provided to the patient, family and/or caregiver</p> <p>A2123. Route of Current Reconciled Medication List Transmission (column 2) Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider and/or patient/family/caregiver. A. Electronic Health Record B. Health Information Exchange Organization C. Verbal (e.g., in-person, telephone, video conferencing) D. Paper-based (e.g., fax, copies, printouts) E. Other Methods (e.g., texting, email, CDs)</p>	<p>A2122. Provision of Current Reconciled Medication List to Resident at Discharge At the time of discharge, did your facility provide the resident’s current reconciled medication list to the resident, family and/or caregiver? Enter Code: <input type="checkbox"/></p> <p>0. No - Current reconciled medication list not provided to the resident, family and/or caregiver 1. Yes - Current reconciled medication list provided to the resident, family and/or caregiver?</p> <p>A2123. Route of Current Reconciled Medication List Transmission (column 2) Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider and/or patient/family/caregiver. A. Electronic Health Record B. Health Information Exchange Organization C. Verbal (e.g., in-person, telephone, video conferencing) D. Paper-based (e.g., fax, copies, printouts) E. Other Methods (e.g., texting, email, CDs)</p>

APPENDIX B: Discharge to Community–PAC IRF QRP Analyses

**Table B-1.
Logistic Regression Model Results for Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Calendar Year 2015–2016**

Number of beneficiaries included in the model = 594,733

Observed number (percent) of beneficiaries in the sample who were discharged to community = 383,703 (64.52%).

Model c-statistic = 0.708

Based on Medicare fee-for-service claims data from CY 2015–2016. These model estimates only apply to CY 2015–2016 IRF data. We will re-estimate the regression model for each measurement period to allow the estimated effects of patient characteristics to vary over time.

Risk Adjuster	N	%	Estimate	SE ¹	p-value	Odds Ratio (OR)	OR 95% Lower CL ²	OR 95% Upper CL
Intercept	.		3.060	0.038	<.0001	.	.	.
Age and Sex Groupings (Reference: Female, age 18–64 years)								
Male, age 18–64 years	36,396	6.1	–0.034	0.017	0.0486	0.967	0.935	1.000
Male, age 65–74 years	91,141	15.3	–0.050	0.015	0.0009	0.951	0.923	0.980
Male, age 75–79 years	49,544	8.3	–0.163	0.017	<.0001	0.849	0.822	0.877
Male, age 80–84 years	43,991	7.4	–0.280	0.017	<.0001	0.756	0.731	0.781
Male, age 85–89 years	31,807	5.4	–0.468	0.018	<.0001	0.626	0.604	0.649
Male, age 90–94 years	12,492	2.1	–0.623	0.024	<.0001	0.536	0.512	0.562
Male, age ≥ 95 years	2,360	0.4	–0.660	0.045	<.0001	0.517	0.473	0.565
Female, age 65–74 years	98,577	16.6	–0.010	0.015	0.4982	0.990	0.961	1.019
Female, age 75–79 years	58,311	9.8	–0.149	0.016	<.0001	0.862	0.835	0.890
Female, age 80–84 years	57,036	9.6	–0.299	0.016	<.0001	0.742	0.718	0.766
Female, age 85–89 years	49,097	8.3	–0.504	0.017	<.0001	0.604	0.584	0.624
Female, age 90–94 years	23,430	3.9	–0.616	0.020	<.0001	0.540	0.520	0.562
Female, age ≥ 95 years	5,493	0.9	–0.714	0.032	<.0001	0.490	0.460	0.521
Original Reason for Entitlement								
Age ≥ 65 at IRF admission and original reason for entitlement was disability or ESRD	76,090	12.8	–0.108	0.009	<.0001	0.898	0.882	0.914

(continued)

Table B-1.
Logistic Regression Model Results for Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Calendar Year 2015–2016 (continued)

Risk Adjuster	N	%	Estimate	SE ¹	p-value	Odds Ratio (OR)	OR 95% Lower CL ²	OR 95% Upper CL
Principal Diagnosis Clinical Classifications Software (CCS) Groupings Based on Prior Acute Stay (Reference: includes all CCS numbers not listed as risk adjusters)								
Other Infectious and Parasitic Diseases (1, 3-10)	1,367	0.2	-0.323	0.063	<.0001	0.724	0.640	0.818
Infectious & Parasitic Disease: Septicemia (2)	31,937	5.4	-0.263	0.026	<.0001	0.769	0.731	0.809
Neoplasms - Liver, Pancreas, Bronchus, Lung, Ovary, Brain & Nervous System (16, 17, 19, 27, 35)	2,958	0.5	-0.593	0.048	<.0001	0.553	0.503	0.607
Secondary Malignant Neoplasm (42)	2,181	0.4	-0.638	0.053	<.0001	0.528	0.476	0.586
Neoplasms-Benign (44-47); Neoplasms-Low (22-26, 28-31, 36); Neoplasms-Medium (11-15, 18, 20-21, 32-34, 37-41, 43)	7,911	1.3	-0.418	0.035	<.0001	0.658	0.615	0.705
Endocrine Disorders (48, 51, 53, 54)	1,745	0.3	-0.166	0.058	0.0041	0.847	0.756	0.949
Diabetes with and without Complications (49, 50)	8,230	1.4	-0.401	0.034	<.0001	0.670	0.626	0.716
Nutritional Defic and Other Nutritional Disorders (52, 58)	1,021	0.2	-0.503	0.071	<.0001	0.605	0.527	0.695
Fluid/Electrolyte Disorders (55)	4,236	0.7	-0.411	0.040	<.0001	0.663	0.613	0.717
Diseases of Blood and Blood-Forming Organs (56-57, 59-64)	2,298	0.4	-0.457	0.050	<.0001	0.633	0.575	0.698
Dis Nerv Syst: Meningitis, Encephalitis, Other CNS infection (76-78)	1,577	0.3	-0.531	0.059	<.0001	0.588	0.524	0.660
Dis Nerv Syst: Parkinson's, MS, Other Hered CNS Disease, Paralysis (79-82)	5,732	1.0	-0.498	0.037	<.0001	0.608	0.565	0.654
Dis Nerv Syst: Epilepsy; Convulsions (83)	3,790	0.6	-0.221	0.043	<.0001	0.802	0.737	0.872
Dis Nerv Syst: Other Nervous System Disorders (95)	10,013	1.7	-0.364	0.032	<.0001	0.695	0.653	0.740
Circ Syst: Heart Valve Disorders (96)	7,951	1.3	-0.300	0.039	<.0001	0.741	0.687	0.799
Circ Syst: Carditis & Other Heart Disease (97, 104)	1,088	0.2	-0.420	0.070	<.0001	0.657	0.573	0.753
Circ Syst: HTN & HTN Complication (98, 99)	5,209	0.9	-0.322	0.038	<.0001	0.725	0.673	0.780
Circ Syst: Acute MI & Cardiac Arrest (100, 107)	11,904	2.0	-0.395	0.032	<.0001	0.674	0.633	0.717

(continued)

Table B-1.
Logistic Regression Model Results for Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Calendar Year 2015–2016 (continued)

Risk Adjuster	N	%	Estimate	SE ¹	p-value	Odds Ratio (OR)	OR 95% Lower CL ²	OR 95% Upper CL
Circ Syst: Coron Athero & Chest Pain (101, 102)	10,491	1.8	-0.331	0.035	<.0001	0.718	0.670	0.769
Circ Syst: Pulmonary Heart Disease (103)	2,767	0.5	-0.214	0.047	<.0001	0.807	0.736	0.886
Circ Syst: Conduction Disorders & Cardiac Dysrhythmia (105, 106)	9,441	1.6	-0.300	0.032	<.0001	0.741	0.696	0.789
Circ Syst: CHF (108)	13,531	2.3	-0.388	0.030	<.0001	0.679	0.640	0.720
Circ Syst: CVD (109-111, 113)	105,186	17.7	-0.582	0.027	<.0001	0.559	0.530	0.589
Circ Syst: TIA (112)	2,964	0.5	-0.082	0.049	0.0954	0.921	0.837	1.014
Circ Syst: Peripheral and Visceral Atherosclerosis (114)	3,891	0.7	-0.532	0.042	<.0001	0.588	0.541	0.638
Circ Syst: Aneurysm (115)	2,407	0.4	-0.366	0.051	<.0001	0.693	0.627	0.766
Circ Syst: Arterial Embolism & Other Circul Disease (116, 117)	3,418	0.6	-0.424	0.043	<.0001	0.654	0.601	0.712
Circ Syst: Phlebitis, Varicose Veins, Hemorrhoids, Other Vein Disease (118-121)	2,182	0.4	-0.343	0.051	<.0001	0.709	0.642	0.784
Resp Syst: Pneumonia, Influenza, Acute Bronchitis, Other Upper Resp (122,123, 125-126)	11,289	1.9	-0.212	0.031	<.0001	0.809	0.762	0.859
Resp Syst: Tonsillitis, Pleurisy, Lung Disease, Other Lower or Upper Resp (124, 130, 132-134)	2,509	0.4	-0.343	0.049	<.0001	0.709	0.645	0.780
Resp Syst: COPD & Asthma (127, 128)	6,501	1.1	-0.410	0.037	<.0001	0.664	0.617	0.713
Resp Syst: Aspiration Pneumonia (129)	2,988	0.5	-0.374	0.045	<.0001	0.688	0.630	0.752
Resp Syst: Adult Respiratory Failure (131)	7,560	1.3	-0.299	0.034	<.0001	0.741	0.693	0.793
Diseases of Digestive System (135-144, 146-148, 154,155)	11,510	1.9	-0.332	0.031	<.0001	0.717	0.676	0.762
Digestive System - Intestinal Obstruction without Hernia (145)	2,948	0.5	-0.188	0.046	<.0001	0.829	0.757	0.907
Biliary Disease, Liver Disease, Pancreatic disorders (149-152)	4,161	0.7	-0.335	0.041	<.0001	0.716	0.661	0.775
GI Hemorrhage (153)	3,846	0.6	-0.301	0.041	<.0001	0.740	0.683	0.803
Genitourinary: Other (156, 160-166, 168-175)	1,721	0.3	-0.274	0.059	<.0001	0.760	0.678	0.853
Genitourinary: Acute or Chronic Renal Failure (157,158)	9,630	1.6	-0.417	0.032	<.0001	0.659	0.620	0.702
Genitourinary: UTI (159)	8,102	1.4	-0.356	0.033	<.0001	0.700	0.656	0.747

(continued)

Table B-1.
Logistic Regression Model Results for Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Calendar Year 2015–2016 (continued)

Risk Adjuster	N	%	Estimate	SE ¹	p-value	Odds Ratio (OR)	OR 95% Lower CL ²	OR 95% Upper CL
Diseases of the Skin and Subcutaneous Tissue (167, 197-200)	4,479	0.8	-0.288	0.040	<.0001	0.749	0.694	0.810
Infective Arthritis and Osteomyelitis (201)	2,046	0.3	-0.448	0.052	<.0001	0.639	0.577	0.708
Rheumatoid Arthritis, Lupus, Other Connective Tissue Disease (202, 210)	4,150	0.7	-0.368	0.041	<.0001	0.692	0.640	0.750
Other Joint Disorders & Osteoporosis (204, 206)	1,104	0.2	-0.253	0.073	0.0006	0.777	0.673	0.897
Back Problem (205)	30,099	5.1	-0.171	0.026	<.0001	0.843	0.802	0.886
Pathological Fracture (207)	5,536	0.9	-0.426	0.037	<.0001	0.653	0.608	0.702
Other Bone Disease (212)	1,957	0.3	-0.193	0.058	0.0008	0.824	0.737	0.923
Congenital Anomalies (213-217)	914	0.2	-0.226	0.082	0.0056	0.798	0.680	0.936
Joint Injury (225)	616	0.1	-0.427	0.092	<.0001	0.652	0.544	0.782
Fracture of Hip (226)	57,263	9.6	-0.466	0.028	<.0001	0.627	0.594	0.662
Spinal Cord Injury (227)	1,527	0.3	-0.760	0.063	<.0001	0.468	0.414	0.529
Skull and Face Fractures & Other Fractures (228, 231)	21,298	3.6	-0.324	0.028	<.0001	0.723	0.684	0.764
Fracture of Upper Limb (229)	5,236	0.9	-0.468	0.038	<.0001	0.626	0.581	0.674
Fracture of Lower Limb (230)	12,229	2.1	-0.622	0.030	<.0001	0.537	0.506	0.569
Sprains and Strains & Superficial Injury/Contusion (232, 239)	1,963	0.3	-0.174	0.056	0.0018	0.841	0.754	0.938
Intracranial Injury (233)	16,147	2.7	-0.538	0.034	<.0001	0.584	0.546	0.625
Crush Injury (234)	1,746	0.3	-0.069	0.060	0.244	0.933	0.830	1.048
Open Wound Head & Extremities, Burns, Other Injuries due to External Causes (235, 236, 240, 244)	2,256	0.4	-0.311	0.052	<.0001	0.733	0.661	0.811
Complications of Device, Procedures, or Medical Care (237-238)	27,998	4.7	-0.386	0.023	<.0001	0.680	0.649	0.711
Poison Psychotropic Agents, Poison Other Med, Poison Nonmed (241-243)	1,093	0.2	-0.175	0.071	0.014	0.840	0.730	0.965
Symptoms, Signs & Ill-Defined Conditions & Factors influencing health status (245-247, 249-259)	5,237	0.9	-0.277	0.038	<.0001	0.758	0.704	0.816

(continued)

Table B-1.
Logistic Regression Model Results for Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Calendar Year 2015–2016 (continued)

Risk Adjuster	N	%	Estimate	SE ¹	p-value	Odds Ratio (OR)	OR 95% Lower CL ²	OR 95% Upper CL
Gangrene (248)	2,824	0.5	-0.674	0.049	<.0001	0.510	0.464	0.561
Mental Illness (650-670)	3,272	0.6	-0.289	0.049	<.0001	0.749	0.681	0.824
IRF Case-Mix Groups (CMGs) (Reference: Stroke: Motor Score > 44.45 (CMGs: 0101-0103); Expired (CMGs: 5101-5104))								
Stroke: Motor Score 26.15-44.45 (CMGs: 0104-0107)	51,933	8.7	-0.574	0.027	<.0001	0.563	0.535	0.593
Stroke: (Motor <26.15 Age >84.5), (Motor > 22.35 Motor <26.15 Age <84.5) (CMGs: 0108-0109)	22,064	3.7	-1.481	0.028	<.0001	0.227	0.215	0.240
Stroke: Motor Score <22.35 and Age <84.5 (CMG: 0110)	37,142	6.3	-1.982	0.027	<.0001	0.138	0.131	0.145
Traumatic Brain Injury: Motor Score >28.75 (CMGs: 0201-0205)	10,363	1.7	-0.543	0.039	<.0001	0.581	0.538	0.627
Traumatic Brain Injury: Motor Score <28.75 (CMGs: 0206-0207)	9,844	1.7	-1.405	0.038	<.0001	0.245	0.228	0.264
Non-traumatic Brain Injury: Motor Score >35.05 (CMGs: 0301-0302)	11,886	2.0	-0.473	0.036	<.0001	0.623	0.581	0.668
Non-traumatic Brain Injury: Motor Score <35.05 (CMGs: 0303-0304)	24,887	4.2	-1.190	0.031	<.0001	0.304	0.286	0.323
Traumatic Spinal Cord Injury: All (CMGs: 0401-0405)	4,262	0.7	-1.299	0.047	<.0001	0.273	0.249	0.299
Non-traumatic Spinal Cord Injury: Motor Score >31.25 (CMGs: 0501-0503)	9,265	1.6	-0.527	0.042	<.0001	0.591	0.544	0.641
Non-traumatic Spinal Cord Injury: Motor Score <31.25 (CMGs: 0504-0506)	15,463	2.6	-1.494	0.035	<.0001	0.224	0.209	0.241
Neurological: Motor Score >37.35 (CMGs: 0601-0602)	14,291	2.4	-0.495	0.035	<.0001	0.610	0.570	0.653
Neurological: Motor Score <37.35 (CMGs: 0603-0604)	54,240	9.1	-1.112	0.030	<.0001	0.329	0.310	0.349
Fracture of Lower Extremity: Motor Score >28.15 (CMGs: 0701-0703)	24,735	4.2	-0.386	0.036	<.0001	0.680	0.633	0.730
Fracture of Lower Extremity: Motor Score <28.15 (CMG: 0704)	47,974	8.1	-1.360	0.034	<.0001	0.257	0.240	0.274
Replacement of Lower Extremity Joint: Motor Score >28.65 (CMGs: 0801-0804)	25,157	4.2	-0.382	0.039	<.0001	0.682	0.632	0.737
Replacement of Lower Extremity Joint: Motor Score <28.65 (CMGs: 0805-0806)	16,215	2.7	-1.191	0.038	<.0001	0.304	0.282	0.327
Other Orthopedic: Motor Score >24.15 (CMGs: 0901-0903)	11,492	1.9	-0.453	0.039	<.0001	0.636	0.589	0.686
Other Orthopedic: Motor Score <24.15 (CMG: 0904)	29,110	4.9	-1.239	0.032	<.0001	0.290	0.272	0.309
Amputation, Lower Extremity: Motor Score >36.25 (CMGs:1001-1002)	3,408	0.6	-0.481	0.052	<.0001	0.618	0.559	0.684
Amputation, Lower Extremity: Motor Score <36.25 (CMG:1003) & Amputation, Non-Lower Extremity (CMGs: 1101-1102)	12,303	2.1	-1.146	0.039	<.0001	0.318	0.295	0.343
Osteoarthritis: All (CMGs: 1201-1203)	866	0.2	-1.077	0.081	<.0001	0.341	0.291	0.399
Rheumatoid, Other Arthritis: All (CMGs: 1301-1303)	1,573	0.3	-1.003	0.063	<.0001	0.367	0.324	0.415
Cardiac: Motor Score >38.55 (CMGs: 1401-1402)	10,982	1.9	-0.473	0.038	<.0001	0.623	0.579	0.671

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Table B-1.
Logistic Regression Model Results for Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Calendar Year 2015–2016 (continued)

Risk Adjuster	N	%	Estimate	SE ¹	p-value	Odds Ratio (OR)	OR 95% Lower CL ²	OR 95% Upper CL
Cardiac: Motor Score <38.55 (CMGs: 1403-1404)	29,247	4.9	-1.002	0.032	<.0001	0.367	0.345	0.391
Pulmonary: Motor Score >39.05 (CMGs: 1501-1502)	4,083	0.7	-0.544	0.047	<.0001	0.581	0.530	0.637
Pulmonary: Motor Score <39.05 (CMGs: 1503-1504)	8,948	1.5	-1.057	0.037	<.0001	0.348	0.323	0.374
Pain Syndrome: All (CMGs: 1601-1603)	2,207	0.4	-1.025	0.057	<.0001	0.359	0.321	0.401
Major Multiple Trauma Without Brain or Spinal Cord Injury (CMGs: 1701-1704)	10,641	1.8	-1.114	0.038	<.0001	0.328	0.305	0.354
Major Multiple Trauma With Brain or Spinal Cord Injury (CMGs: 1801-1803)	3,141	0.5	-1.036	0.050	<.0001	0.355	0.322	0.392
Guillain Barre (CMGs: 1901-1903)	1,231	0.2	-1.180	0.070	<.0001	0.307	0.268	0.352
Miscellaneous (CMGs: 2001-2004), Burns (CMG 2101), Short-stay cases (CMG: 5001)	72,447	12.2	-0.907	0.030	<.0001	0.404	0.381	0.428
Surgical Categories Based on Prior Acute Stay								
Cardiothoracic surgery	31,341	5.3	0.211	0.020	<.0001	1.235	1.189	1.283
Otolaryngology	1,652	0.3	0.043	0.055	0.4294	1.044	0.938	1.162
Neurosurgery	27,063	4.6	0.016	0.017	0.3397	1.016	0.984	1.049
General surgery	44,588	7.5	0.105	0.015	<.0001	1.110	1.078	1.143
Obstetrics/Gynecology	930	0.2	-0.085	0.072	0.24	0.919	0.797	1.058
Orthopedic surgery	170,827	28.7	0.066	0.013	<.0001	1.068	1.041	1.097
Plastic surgery	12,880	2.2	-0.083	0.021	<.0001	0.920	0.884	0.958
Urologic surgery	4,018	0.7	0.066	0.036	0.069	1.068	0.995	1.147
Vascular surgery	14,347	2.4	0.100	0.020	<.0001	1.106	1.063	1.150
Dialysis in Prior Acute Stay where End-Stage Renal Disease not Indicated								
Dialysis Where HCC133 (End-Stage Renal Disease) Not Indicated	6,099	1.0	-0.086	0.029	0.0033	0.918	0.867	0.972
Prior Acute Length of Stay in Non-Psychiatric Hospital or Prior Stay in Psychiatric Hospital (Reference: 1-3 days in Non-Psychiatric Hospital)								
Prior acute stay in psychiatric hospital	683	0.1	-0.538	0.091	<.0001	0.584	0.489	0.698
4-5 days in non-psychiatric hospital	150,262	25.3	-0.089	0.008	<.0001	0.915	0.900	0.930
6-8 days in non-psychiatric hospital	123,559	20.8	-0.224	0.009	<.0001	0.799	0.785	0.814

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Table B-1.
Logistic Regression Model Results for Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Calendar Year 2015–2016 (continued)

Risk Adjuster	N	%	Estimate	SE ¹	p-value	Odds Ratio (OR)	OR 95% Lower CL ²	OR 95% Upper CL
9-10 days in non-psychiatric hospital	41,459	7.0	-0.310	0.013	<.0001	0.734	0.715	0.753
11-14 days in non-psychiatric hospital	45,891	7.7	-0.369	0.013	<.0001	0.692	0.674	0.710
15-20 days in non-psychiatric hospital	28,005	4.7	-0.470	0.016	<.0001	0.625	0.606	0.645
21-30 days in non-psychiatric hospital	14,369	2.4	-0.520	0.021	<.0001	0.595	0.570	0.620
30+ days in non-psychiatric hospital	6,038	1.0	-0.691	0.031	<.0001	0.501	0.471	0.532
Comorbidities - Hierarchical Condition Categories (HCCs) (* indicates that the HCC is based on the most recent acute care claim only. HCCs not preceded by * are based on acute care claims from the past 365 days (including the most recent acute care claim)).								
HCC3: Bacterial, Fungal, and Parasitic Central Nervous System Infections*	2,497	0.4	-0.111	0.044	0.0109	0.895	0.822	0.975
HCC6: Opportunistic Infections	2,395	0.4	-0.093	0.044	0.032	0.911	0.836	0.992
HCC7: Other Infectious Diseases*	64,584	10.9	-0.026	0.010	0.0117	0.975	0.956	0.994
HCC8: Metastatic Cancer and Acute Leukemia*	8,774	1.5	-0.288	0.024	<.0001	0.750	0.716	0.785
HCC9: Lung and Other Severe Cancers*	7,099	1.2	-0.182	0.026	<.0001	0.834	0.793	0.877
HCC10: Lymphoma and Other Cancers*	6,990	1.2	-0.101	0.026	0.0001	0.904	0.859	0.952
HCC11: Colorectal, Bladder, and Other Cancers*	3,107	0.5	-0.022	0.039	0.5774	0.979	0.907	1.056
HCC12: Breast, Prostate, and Other Cancers and Tumors*	8,071	1.4	-0.042	0.025	0.0895	0.959	0.913	1.007
HCC13; HCC14: Other Respiratory and Heart Neoplasms; Other Digestive and Urinary Neoplasms*	3,190	0.5	-0.021	0.039	0.5843	0.979	0.908	1.056
HCC17: Diabetes with Acute Complications	1,887	0.3	-0.143	0.050	0.0045	0.867	0.785	0.957
HCC18; HCC19: Diabetes with Chronic Complications; Diabetes without Complication	214,610	36.1	-0.047	0.006	<.0001	0.954	0.942	0.966
HCC20: Type I Diabetes Mellitus*	4,232	0.7	-0.063	0.034	0.067	0.939	0.878	1.004

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Table B-1.
Logistic Regression Model Results for Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Calendar Year 2015–2016 (continued)

Risk Adjuster	N	%	Estimate	SE ¹	p-value	Odds Ratio (OR)	OR 95% Lower CL ²	OR 95% Upper CL
HCC21: Protein-Calorie Malnutrition	40,992	6.9	-0.170	0.012	<.0001	0.844	0.825	0.863
HCC22: Morbid Obesity	45,288	7.6	-0.067	0.012	<.0001	0.935	0.914	0.956
HCC23: Other Significant Endocrine and Metabolic Disorders*	24,160	4.1	-0.044	0.015	0.0027	0.957	0.930	0.985
HCC24: Disorders of Fluid/Electrolyte/Acid-Base Balance*	208,632	35.1	-0.071	0.007	<.0001	0.931	0.919	0.943
HCC27: End-Stage Liver Disease	3,796	0.6	-0.368	0.035	<.0001	0.692	0.646	0.742
HCC28: Cirrhosis of Liver	5,487	0.9	-0.268	0.029	<.0001	0.765	0.722	0.810
HCC29: Chronic Hepatitis	1,930	0.3	-0.030	0.051	0.5499	0.970	0.879	1.071
HCC36: Peptic Ulcer, Hemorrhage, Other Specified Gastrointestinal Disorders*	31,245	5.3	-0.046	0.013	0.0005	0.956	0.931	0.980
HCC39: Bone/Joint/Muscle Infections/Necrosis*	12,511	2.1	-0.083	0.022	0.0002	0.921	0.882	0.961
HCC40: Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	31,201	5.3	-0.013	0.013	0.3136	0.987	0.962	1.013
HCC46: Severe Hematological Disorders*	3,468	0.6	-0.148	0.037	<.0001	0.862	0.803	0.927
HCC48: Coagulation Defects and Other Specified Hematological Disorders*	50,705	8.5	-0.039	0.011	0.0004	0.962	0.942	0.983
HCC49: Iron Deficiency and Other/Unspecified Anemias and Blood Disease*	207,568	34.9	-0.030	0.007	<.0001	0.970	0.957	0.983
HCC50: Delirium and Encephalopathy*	65,056	10.9	-0.047	0.010	<.0001	0.954	0.936	0.972
HCC51; HCC52: Dementia With Complications; Dementia Without Complication	62,160	10.5	-0.159	0.009	<.0001	0.853	0.837	0.869
HCC53: Nonpsychotic Organic Brain Syndromes/Conditions	9,747	1.6	-0.089	0.023	<.0001	0.915	0.875	0.957
HCC54; HCC55: Drug/Alcohol Psychosis; Drug/Alcohol Dependence*	16,762	2.8	-0.040	0.018	0.0263	0.961	0.928	0.995
HCC56: Drug/Alcohol Abuse, Without Dependence*	57,695	9.7	-0.046	0.010	<.0001	0.956	0.936	0.975
HCC57: Schizophrenia	3,293	0.6	-0.223	0.039	<.0001	0.800	0.742	0.863
HCC58: Major Depressive, Bipolar, and Paranoid Disorders	13,759	2.3	-0.109	0.019	<.0001	0.896	0.863	0.931

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Table B-1.
Logistic Regression Model Results for Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Calendar Year 2015–2016 (continued)

Risk Adjuster	N	%	Estimate	SE ¹	p-value	Odds Ratio (OR)	OR 95% Lower CL ²	OR 95% Upper CL
HCC59: Reactive and Unspecified Psychosis	2,825	0.5	-0.124	0.041	0.0024	0.883	0.815	0.957
HCC60: Personality Disorders	309	0.1	-0.249	0.124	0.0435	0.779	0.612	0.993
HCC61: Depression	79,813	13.4	-0.057	0.009	<.0001	0.944	0.929	0.961
HCC64 - HCC67: Profound Mental Retardation/Developmental Disability; Severe Mental Retardation/Developmental Disability; Moderate Mental Retardation/Developmental Disability; Mild Mental Retardation, Autism, Down Syndrome	2,088	0.4	-0.141	0.049	0.004	0.869	0.790	0.956
HCC68; HCC69: Other Developmental Disability; Attention Deficit Disorder	1,497	0.3	-0.144	0.058	0.0136	0.866	0.772	0.971
HCC70: Quadriplegia	3,073	0.5	-0.294	0.040	<.0001	0.745	0.690	0.806
HCC71: Paraplegia	4,102	0.7	-0.213	0.035	<.0001	0.808	0.755	0.866
HCC72: Spinal Cord Disorders/Injuries	7,962	1.3	-0.112	0.027	<.0001	0.894	0.849	0.942
HCC73: Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease*	316	0.1	-0.130	0.122	0.2874	0.878	0.691	1.116
HCC74: Cerebral Palsy	1,148	0.2	-0.224	0.066	0.0006	0.799	0.703	0.909
HCC78: Parkinson's and Huntington's Diseases	19,341	3.3	-0.058	0.016	0.0004	0.943	0.913	0.974
HCC80: Coma, Brain Compression/Anoxic Damage	19,430	3.3	-0.144	0.018	<.0001	0.866	0.836	0.897
HCC82: Respirator Dependence/Tracheostomy Status	3,322	0.6	-0.052	0.038	0.1666	0.949	0.882	1.022
HCC85: Congestive Heart Failure	147,151	24.7	-0.085	0.008	<.0001	0.918	0.905	0.932
HCC86: Acute Myocardial Infarction*	12,259	2.1	-0.100	0.020	<.0001	0.905	0.871	0.941
HCC87: Unstable Angina and Other Acute Ischemic Heart Disease*	9,721	1.6	-0.046	0.023	0.0413	0.955	0.914	0.998
HCC90: Heart Infection/Inflammation, Except Rheumatic*	5,209	0.9	-0.088	0.031	0.0039	0.916	0.862	0.972
HCC91: Valvular and Rheumatic Heart Disease*	53,766	9.0	-0.026	0.010	0.0103	0.974	0.955	0.994
HCC96: Specified Heart Arrhythmias	177,247	29.8	-0.088	0.007	<.0001	0.916	0.904	0.928
HCC99: Cerebral Hemorrhage*	9,314	1.6	-0.151	0.024	<.0001	0.860	0.821	0.901

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Table B-1.
Logistic Regression Model Results for Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Calendar Year 2015–2016 (continued)

Risk Adjuster	N	%	Estimate	SE ¹	p-value	Odds Ratio (OR)	OR 95% Lower CL ²	OR 95% Upper CL
HCC100: Ischemic or Unspecified Stroke*	16,066	2.7	-0.193	0.020	<.0001	0.824	0.793	0.857
HCC103: Hemiplegia/Hemiparesis	82,270	13.8	-0.146	0.011	<.0001	0.864	0.846	0.883
HCC104: Monoplegia, Other Paralytic Syndromes	2,549	0.4	-0.030	0.045	0.5036	0.971	0.889	1.059
HCC105: Late Effects of Cerebrovascular Disease, Except Paralysis	25,984	4.4	-0.073	0.015	<.0001	0.929	0.902	0.957
HCC106: Atherosclerosis of the Extremities with Ulceration or Gangrene*	8,107	1.4	-0.233	0.029	<.0001	0.792	0.748	0.838
HCC107: Vascular Disease with Complications*	10,636	1.8	-0.065	0.022	0.0025	0.937	0.898	0.977
HCC108: Vascular Disease*	70,461	11.9	-0.042	0.009	<.0001	0.959	0.941	0.976
HCC109: Other Circulatory Disease*	52,711	8.9	-0.004	0.010	0.6912	0.996	0.976	1.016
HCC110 - HCC112: Cystic Fibrosis; Chronic Obstructive Pulmonary Disease; Fibrosis of Lung and Other Chronic Lung Disorders	119,087	20.0	-0.086	0.008	<.0001	0.918	0.904	0.932
HCC114: Aspiration and Specified Bacterial Pneumonias*	20,928	3.5	-0.062	0.016	0.0001	0.940	0.911	0.970
HCC116: Viral and Unspecified Pneumonia, Pleurisy*	35,314	5.9	-0.007	0.013	0.5576	0.993	0.968	1.017
HCC117: Pleural Effusion/Pneumothorax*	23,621	4.0	-0.041	0.015	0.0073	0.960	0.932	0.989
HCC120: Major Eye Infections/Inflammations*	151	0.03	-0.149	0.174	0.3918	0.862	0.613	1.211
HCC132: Kidney Transplant Status	4,575	0.8	-0.300	0.034	<.0001	0.741	0.694	0.791
HCC133: End-Stage Renal Disease	27,548	4.6	-0.364	0.015	<.0001	0.695	0.675	0.716
HCC134: Dialysis Status	445	0.1	-0.202	0.102	0.0472	0.817	0.670	0.998
HCC135; HCC140: Acute Renal Failure; Unspecified Renal Failure	101,623	17.1	-0.134	0.009	<.0001	0.875	0.860	0.890
HCC136: Chronic Kidney Disease (Stage 5)	638	0.1	-0.353	0.084	<.0001	0.703	0.596	0.828
HCC137: Chronic Kidney Disease, Severe (Stage 4)	6,523	1.1	-0.202	0.027	<.0001	0.817	0.775	0.862
HCC138: Chronic Kidney Disease, Moderate (Stage 3)	31,128	5.2	-0.026	0.013	0.0525	0.975	0.950	1.000
HCC139: Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)	24,845	4.2	-0.067	0.015	<.0001	0.935	0.909	0.962
HCC142: Urinary Obstruction and Retention*	53,230	9.0	-0.051	0.010	<.0001	0.951	0.932	0.970

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Table B-1.
Logistic Regression Model Results for Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Calendar Year 2015–2016 (continued)

Risk Adjuster	N	%	Estimate	SE ¹	p-value	Odds Ratio (OR)	OR 95% Lower CL ²	OR 95% Upper CL
HCC143: Urinary Incontinence*	22,227	3.7	-0.020	0.015	0.1931	0.980	0.951	1.010
HCC144: Urinary Tract Infection*	82,781	13.9	-0.058	0.009	<.0001	0.944	0.927	0.961
HCC157; HCC158: Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone; Pressure Ulcer of Skin with Full Thickness Skin Loss*	3,998	0.7	-0.269	0.034	<.0001	0.764	0.715	0.817
HCC159: Pressure Ulcer of Skin with Partial Thickness Skin Loss*	5,120	0.9	-0.283	0.030	<.0001	0.753	0.711	0.798
HCC160: Pressure Pre-Ulcer Skin Changes or Unspecified Stage*	4,739	0.8	-0.225	0.031	<.0001	0.799	0.752	0.849
HCC161: Chronic Ulcer of Skin, Except Pressure	11,066	1.9	-0.124	0.022	<.0001	0.883	0.845	0.922
HCC162: Severe Skin Burn or Condition	196	0.03	-0.071	0.153	0.6453	0.932	0.690	1.258
HCC164: Cellulitis, Local Skin Infection*	21,169	3.6	-0.070	0.016	<.0001	0.933	0.904	0.963
HCC166; HCC167: Severe or Major Head Injury*	8,872	1.5	-0.104	0.026	<.0001	0.901	0.856	0.948
HCC169: Vertebral Fractures without Spinal Cord Injury*	13,949	2.3	-0.056	0.020	0.005	0.945	0.909	0.983
HCC170: Hip Fracture/Dislocation*	11,610	2.0	-0.169	0.022	<.0001	0.844	0.809	0.882
HCC171: Major Fracture, Except of Skull, Vertebrae, or Hip*	8,797	1.5	-0.201	0.025	<.0001	0.818	0.779	0.859
HCC174: Other Injuries*	165,242	27.8	-0.093	0.010	<.0001	0.912	0.895	0.929
HCC176: Complications of Specified Implanted Device or Graft*	11,794	2.0	-0.087	0.021	<.0001	0.917	0.880	0.954
HCC178: Major Symptoms, Abnormalities*	264,309	44.4	-0.052	0.007	<.0001	0.950	0.937	0.962
HCC179: Minor Symptoms, Signs, Findings*	101,062	17.0	-0.048	0.009	<.0001	0.953	0.938	0.970
HCC188: Artificial Openings for Feeding or Elimination*	7,624	1.3	-0.148	0.025	<.0001	0.862	0.821	0.905
HCC189; HCC190: Amputation Status, Lower Limb/Amputation Complications; Amputation Status, Upper Limb	10,966	1.8	-0.028	0.022	0.2082	0.972	0.931	1.016
HCC197: Supplemental Oxygen	19,741	3.3	-0.089	0.017	<.0001	0.915	0.886	0.945
HCC199: Patient Lifts, Power Operated Vehicles, Beds*	1,344	0.2	-0.061	0.058	0.2928	0.941	0.840	1.054
HCC200: Wheelchairs, Commodes*	3,362	0.6	-0.087	0.038	0.02	0.917	0.852	0.986

(continued)

Table B-1.
Logistic Regression Model Results for Discharge to Community–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Calendar Year 2015–2016 (continued)

Risk Adjuster	N	%	Estimate	SE ¹	p-value	Odds Ratio (OR)	OR 95% Lower CL ²	OR 95% Upper CL
Acute History: Number of Hospital Stays in Past Year, Excluding Most Recent Stay (Reference: No stays)								
1 Stay - Acute history	138,336	23.3	-0.423	0.007	<.0001	0.655	0.646	0.664
2 Stays - Acute history	42,380	7.1	-0.426	0.011	<.0001	0.653	0.639	0.668
3 Stays - Acute history	34,795	5.9	-0.849	0.012	<.0001	0.428	0.418	0.438
4 Stays - Acute history	11,464	1.9	-0.694	0.020	<.0001	0.499	0.480	0.520
5 Stays - Acute history	11,014	1.9	-1.042	0.021	<.0001	0.353	0.339	0.367
6 Stays - Acute history	6,150	1.0	-1.096	0.027	<.0001	0.334	0.317	0.352
7 Stays - Acute history	4,818	0.8	-1.223	0.031	<.0001	0.294	0.277	0.313
8 Stays - Acute history	2,268	0.4	-1.027	0.044	<.0001	0.358	0.328	0.390
9 Stays - Acute history	2,874	0.5	-1.370	0.041	<.0001	0.254	0.235	0.275
10+ Stays - Acute history	7,413	1.2	-1.476	0.026	<.0001	0.229	0.217	0.241

¹ SE = Standard Error; ² CL = Confidence Limit.

Source: RTI International analysis of Medicare claims data (program reference: MM130 Model 3)

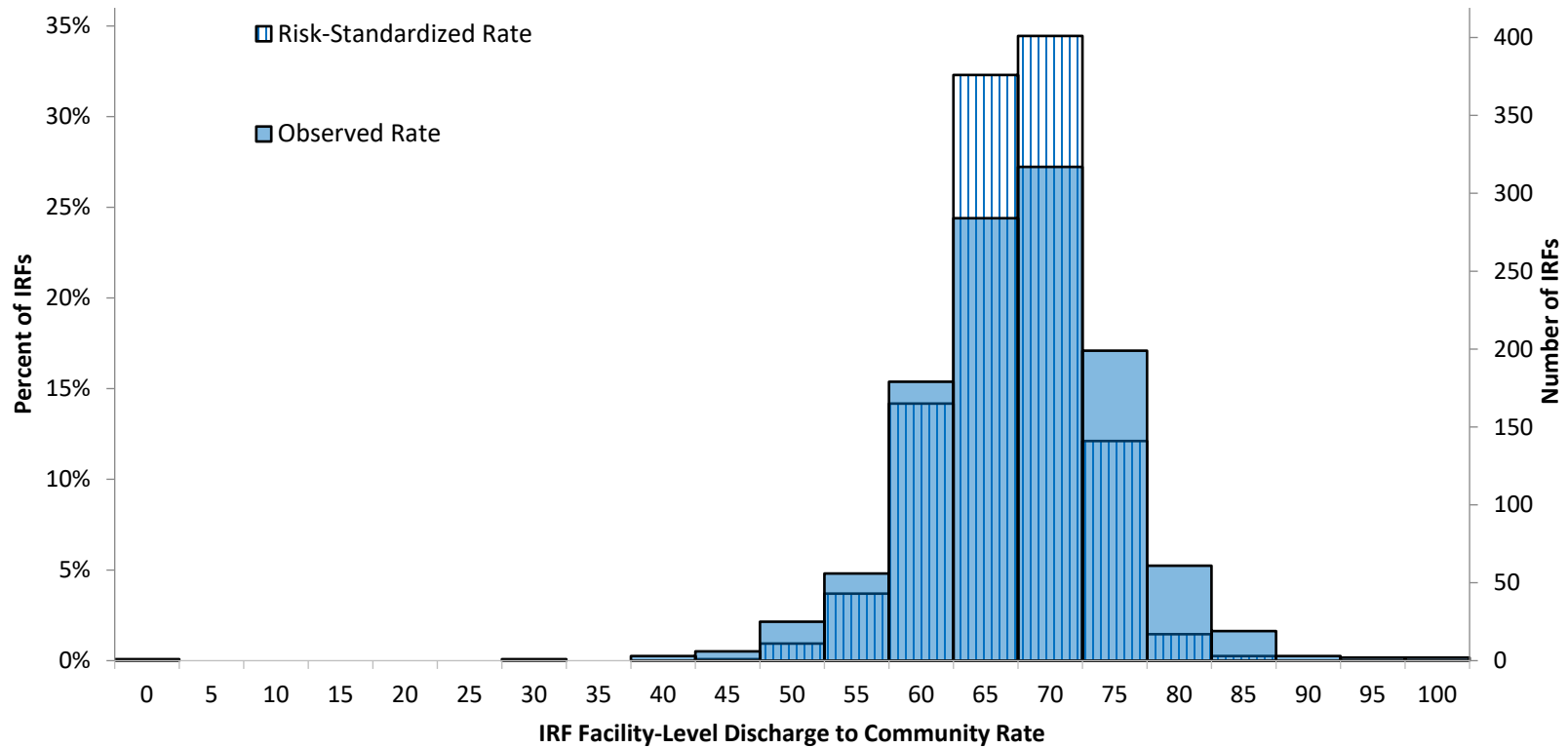
Table B-2.**Inpatient Rehabilitation Facility: Facility-Level Observed and Risk-Standardized Discharge to Community Rates, 2015-2016**

Discharge to Community Rate	Mean	SD	Min	1st pctl	5th pctl	10th pctl	25th pctl	50th pctl (Median)	75th pctl	90th pctl	95th pctl	99th pctl	Max
Observed	65.10	7.83	0	45.51	52.44	55.97	60.52	65.35	69.95	73.82	77.20	82.23	100.00
Risk-Standardized	64.46	5.35	42.44	50.19	55.39	57.79	60.97	64.74	67.94	70.99	72.79	76.50	84.26

NOTE: Based on CY 2015-2016 Medicare fee-for-service claims data from 1,158 IRFs. Facility-level number of IRFs stays ranged from 1 to 6,469 with a mean of 514.6 and median of 341.0. SD = standard deviation, pctl = percentile. Source: RTI International analysis (program reference: MM130).

Figure B-1.

Inpatient Rehabilitation Facility: Facility-Level Observed and Risk-Standardized Discharge to Community Rates, 2015-2016



NOTE: Based on CY 2015-2016 Medicare fee-for-service claims data from 1,158 IRFs. Facility-level number of IRFs stays ranged from 1 to 6,469 with a mean of 514.6 and median of 341.0. Solid bars represent the observed rate distribution; striped bars represent the risk-standardized rate distribution; the overlap between solid and striped bars represents the overlap between observed and risk-standardized rate distributions. Source: RTI International analysis (program reference: MM130).

APPENDIX C: National Beta Test Supplementary Tables

The reference tables in this appendix refer to the SPADEs tested in the National Field Test. Alphanumeric item numbers (Example: b1a, b1b, b1c) refer to the items as labeled in the assessment protocols, which are available for download here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/-IMPACT-Act-Standardized-Assessment-National-Testing-.html>

Table 1.1: Assessment counts for National Beta Test results

	HHA N=35	IRF N=22	LTCH N=26	SNF N=60	Overall N=143
Admission	653	794	507	1167	3121
Time to Complete (Facility/Agency Staff only)	469	549	386	565	1969
IRR	198	261	242	274	976

Table 1.2: Frequency and percent of assessments completed of each module

Module	Domains	Frequency	Percent
<i>Communicative, N=3121</i>			
A1-A2	Hearing and Vision	3065	98.2
B1	Brief Interview for Mental Status (BIMS)	3062	98.1
D	Pain Interview	3031	97.1
E1	PHQ-2 to 9	3010	96.4
B2	Confusion Assessment Method (CAM)	2973	95.3
I	Medication Reconciliation Protocol	2951	94.6
J	Special Services, Treatments, and Interventions (SSTI)	2926	93.8
All modules	At least one response in each module	2795	89.2

NOTE: Percentage of assessments are based on assessments used in the frequency tables where “completed” means responded to at least one data element.

COGNITIVE STATUS: Brief Interview for Mental Status (BIMS)

Table 2.1.1: Admission response distributions (in percent) for BIMS items

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	646	786	496	1134	3062
# of words repeated after 1st attempt (b1a)					
Three	94	96	91	94	94
Two	4	3	4	4	4
One	1	1	2	1	1
None or no answer	0	1	3	1	1
Recalls current year (b1b)					
Correct	89	94	88	87	89
Missed by 1 year	2	1	4	2	2
Missed by 2-5 years	1	1	1	2	1
Missed by >5 years or no answer	7	4	8	9	7
Recalls current month (b1c)					
Accurate within 5 days	94	93	90	90	91
Missed by 6 days - 1 mo	3	3	2	4	3
Missed by >1 mo or no answer	4	4	8	6	5
Recalls current day of week (b1d)					
Accurate	88	84	77	76	81
Incorrect or no answer	12	16	23	24	19
Recalls 'sock' (b1e)					
Yes, no cue required	80	84	78	76	79
Yes, after cue	9	5	9	9	8
No recall or answer	11	11	13	15	13
Recalls 'blue' (b1f)					
Yes, no cue required	84	85	78	79	81
Yes after cue	11	11	12	13	12
No recall or answer	6	5	10	8	7
Recalls 'bed' (b1g)					
Yes, no cue required	73	75	64	66	70
Yes, after cue	12	10	12	14	12
No recall or answer	14	14	24	19	18

Items	HHA	IRF	LTCH	SNF	Overall
BIMS Impairment Category					
Intact	80	82	73	72	76
Moderately impaired	17	15	19	22	18
Severely impaired	4	3	7	7	5

Table 2.1.2: IRR Kappa/Weighted Kappa and Percent Agreement for BIMS Items

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	199	259	238	270	966
Kappa/weighted kappa					
# of words repeated after 1st attempt (b1a)	-	-	-	-	-
Recalls current year (b1b)	0.88	-	0.90	0.93	0.90
Recalls current month (b1c)	-	-	0.89	0.86	-
Recalls current day of week (b1d)	0.92	0.81	0.91	0.86	0.88
Recalls 'sock' (b1e)	0.87	0.91	0.91	0.91	0.91
Recalls 'blue' (b1f)	0.84	0.82	0.87	0.78	0.83
Recalls 'bed' (b1g)	0.93	0.90	0.93	0.93	0.93
BIMS Impairment Category	0.94	0.85	0.91	0.91	0.91
Percent agreement					
# of words repeated after 1st attempt (b1a)	96	97	96	96	96
Recalls current year (b1b)	97	98	97	97	98
Recalls current month (b1c)	98	99	97	96	98
Recalls current day of week (b1d)	98	94	97	95	96
Recalls 'sock' (b1e)	94	97	95	96	95
Recalls 'blue' (b1f)	95	95	93	91	94
Recalls 'bed' (b1g)	96	95	95	96	96
BIMS Impairment Category	97	95	95	95	96

NOTE: Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

COGNITIVE STATUS: Confusion Assessment Method (CAM)

Table 2.2.1: Admission response distributions (in percent) for CAM items

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	630	771	471	1101	2973
Evidence of change in mental status from baseline (b2a)					
Yes	5	6	5	4	5
Did patient have difficulty focusing attn (b2b)					
Behavior not present	89	85	89	90	88
Behavior continuously present	2	3	3	3	3
Behavior present, fluctuates	9	11	8	8	9
Was patient thinking disorganized (b2c)					
Behavior not present	95	94	93	94	94
Behavior continuously present	1	2	2	1	1
Behavior present, fluctuates	4	5	4	6	5
Did patient have altered consciousness (b2d)					
Behavior not present	98	95	94	96	96
Behavior continuously present	1	1	2	1	1
Behavior present, fluctuates	2	3	3	3	3

Table 2.2.2: IRR Kappa/Weighted Kappa and Percent Agreement for CAM items

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	189	245	223	257	914
Kappa/weighted kappa					
Evidence of change in mental status from baseline (b2a)	-	0.60	-	-	-
Did patient have difficulty focusing attn (b2b)	0.66	0.55	0.75	0.70	0.66
Was patient thinking disorganized (b2c)	-	-	-	0.68	-
Did patient have altered consciousness (b2d)	-	-	-	-	-
Percent agreement					
Evidence of change in mental status from baseline (b2a)	97	93	98	97	96
Did patient have difficulty focusing attn (b2b)	91	89	93	93	91
Was patient thinking disorganized (b2c)	94	93	96	94	94
Did patient have altered consciousness (b2d)	98	97	95	96	96

NOTE: Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Mental Status: PHQ-2 to 9

Table 3.1.1: Admission response distribution (in percent) for PHQ-2 to 9 items

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	639	776	479	1116	3010
Symptom presence & frequency: little interest or pleasure (e1a)					
No	65	61	56	65	62
0-1 day	4	4	5	3	4
2-6 days	15	16	13	13	14
7-11 days (half or more)	9	10	11	9	10
12-14 days (nearly all)	8	10	16	10	11
Symptom presence & frequency: feeling down, depressed, hopeless (e1b)					
No	62	57	49	58	57
0-1 day	3	6	4	5	4
2-6 days	20	19	19	19	19
7-11 days (half or more)	7	9	13	8	9
12-14 days (nearly all)	8	8	16	11	10
PHQ-2					
Mean (SD)	2.2 (1.6)	2.3 (1.7)	2.7 (1.8)	2.4 (1.7)	2.4 (1.7)
Eligible for PHQ-9 per PHQ-2					
Yes	24	27	38	27	28
# of assessments eligible for PHQ-9 per PHQ-2	153	209	182	306	850
Symptom presence & frequency: too little/too much sleep (e1c)					
No	30	34	34	33	33
0-1 day	2	3	1	2	2
2-6 days	15	15	13	16	15
7-11 days (half or more)	19	16	20	16	17
12-14 days (nearly all)	34	31	32	34	33
Symptom presence & frequency: tired / no energy (e1d)					
No	10	11	13	10	11
0-1 day	1	0	1	1	1
2-6 days	9	17	13	17	15
7-11 days (half or more)	27	26	23	28	26
12-14 days (nearly all)	52	46	50	44	48
Symptom presence & frequency: poor appetite or overeating (e1e)					
No	50	43	34	46	44
0-1 day	1	2	2	1	1

Items	HHA	IRF	LTCH	SNF	Overall
2-6 days	9	11	10	9	10
7-11 days (half or more)	17	13	16	15	15
12-14 days (nearly all)	22	31	39	29	30
Symptom presence & frequency: feel bad about self (e1f)					
No	55	52	51	58	55
0-1 day	1	2	1	1	1
2-6 days	12	12	12	10	12
7-11 days (half or more)	15	16	10	12	13
12-14 days (nearly all)	17	17	26	18	19
Symptom presence & frequency: trouble concentrating (e1g)					
No	54	47	44	48	48
0-1 day	1	1	1	1	1
2-6 days	15	16	9	16	14
7-11 days (half or more)	11	11	12	13	12
12-14 days (nearly all)	19	25	34	22	25
Symptom presence & frequency: moving or speaking slowly (e1h)					
No	64	62	50	68	62
0-1 day	1	0	2	1	1
2-6 days	9	9	10	7	9
7-11 days (half or more)	8	13	13	10	11
12-14 days (nearly all)	18	16	25	14	18
Symptom presence & frequency: suicidal thoughts (e1i)					
No	82	78	77	80	79
0-1 day	2	4	3	2	3
2-6 days	9	7	7	9	8
7-11 days (half or more)	5	3	5	5	4
12-14 days (nearly all)	3	7	7	4	5
PHQ-9					
Mean (SD)	11.4 (5.0)	11.8 (5.3)	13.0 (5.8)	11.5 (5.1)	11.9 (5.3)
Depression categorization (PHQ-9)					
None (0 – 4)	10	4	6	7	6
Mild (5 – 9)	27	36	27	33	31
Moderate (10 – 14)	37	32	25	34	32
Moderately severe (15 – 19)	20	19	28	18	21
Severe (20 – 27)	6	9	14	8	9

Table 3.1.2: IRR Kappa/Weighted Kappa and Percent Agreement for PHQ-2 to 9 items

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	196	254	231	267	948
Kappa/weighted kappa					
Symptom present: little interest or pleasure (e1a1)	0.95	0.99	0.99	0.98	0.98
Symptom frequency: little interest or pleasure (e1a2)	0.98	1.00	0.98	0.98	0.99
Symptom present: feeling down, depressed, hopeless (e1b1)	0.99	0.98	1.00	0.99	0.99
Symptom frequency: feeling down, depressed, hopeless (e1b2)	0.93	0.98	0.98	0.99	0.98
Eligible for PHQ-9 per PHQ-2	0.96	0.98	0.98	0.98	0.98
Symptom present: too little/too much sleep (e1c1)	0.90	1.00	1.00	1.00	0.98
Symptom frequency: too little/too much sleep (e1c2)	1.00	0.98	0.90	0.96	0.96
Symptom present: tired / no energy (e1d1)	1.00	0.91	0.95	0.94	0.95
Symptom frequency: tired / no energy (e1d2)	1.00	0.93	0.98	1.00	0.98
Symptom present: poor appetite or overeating (e1e1)	0.96	0.93	0.95	1.00	0.96
Symptom frequency: poor appetite or overeating (e1e2)	1.00	1.00	1.00	1.00	1.00
Symptom present: feel bad about self (e1f1)	1.00	1.00	1.00	1.00	1.00
Symptom frequency: feel bad about self (e1f2)	1.00	1.00	0.95	1.00	0.98
Symptom present: trouble concentrating (e1g1)	1.00	1.00	1.00	0.97	0.99
Symptom frequency: trouble concentrating (e1g2)	0.96	0.97	0.94	1.00	0.97
Symptom present: moving or speaking slowly (e1h1)	1.00	0.94	0.90	1.00	0.95
Symptom frequency: moving or speaking slowly (e1h2)	1.00	0.87	1.00	1.00	0.97
Symptom present: suicidal thoughts (e1i1)	1.00	1.00	0.94	1.00	0.98
Symptom frequency: suicidal thoughts (e1i2)	0.93	1.00	0.95	1.00	0.97
Sum of all symptom frequencies (PHQ-9) *	0.97	0.95	0.95	0.97	0.96
Percent Agreement					
Symptom present: little interest or pleasure (e1a1)	97	100	100	99	99
Symptom frequency: little interest or pleasure (e1a2)	99	100	98	98	99
Symptom present: feeling down, depressed, hopeless (e1b1)	99	99	100	100	100
Symptom frequency: feeling down, depressed, hopeless (e1b2)	95	98	98	99	98
Eligible for PHQ-9 per PHQ-2	98	99	99	99	99
Symptom present: too little/too much sleep (e1c1)	96	100	100	100	99
Symptom frequency: too little/too much sleep (e1c2)	100	98	94	96	97
Symptom present: tired / no energy (e1d1)	100	98	99	99	99
Symptom frequency: tired / no energy (e1d2)	100	96	99	100	99
Symptom present: poor appetite or overeating (e1e1)	98	97	97	100	98
Symptom frequency: poor appetite or overeating (e1e2)	100	100	100	100	100
Symptom present: feel bad about self (e1f1)	100	100	100	100	100
Symptom frequency: feel bad about self (e1f2)	100	100	95	100	98

Items	HHA	IRF	LTCH	SNF	Overall
Symptom present: trouble concentrating (e1g1)	100	100	100	99	100
Symptom frequency: trouble concentrating (e1g2)	96	97	97	100	98
Symptom present: moving or speaking slowly (e1h1)	100	97	95	100	98
Symptom frequency: moving or speaking slowly (e1h2)	100	93	100	100	98
Symptom present: suicidal thoughts (e1i1)	100	100	98	100	99
Symptom frequency: suicidal thoughts (e1i2)	93	100	95	100	97
Sum of all symptom frequencies (PHQ-9)*	96	94	94	96	95

NOTE: As classified into the five categories shown in Table 3.1.1. Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Special Services, Treatment and Interventions (SSTI)

Table 4.1.1: Admission response distributions (in percent) for SSTI - Chemotherapy items

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Treatment performed: Chemotherapy (j2a)	1	3	0	1	1
Chemo treatment performed: IV (j2a2a)	0	1	0	0	0
Chemo treatment performed: oral (j2a3a)	0	2	0	1	1
Chemo treatment performed: other (j2a10a)	0	0	0	0	0

Table 4.1.2: IRR Kappa and Percent Agreement for SSTI – Chemotherapy items

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa/Weighted kappa					
Noted treatment performed: Chemotherapy (j2a)	-	-	-	-	-
Noted chemo treatment performed: IV (j2a2a)	-	-	-	-	-
Noted chemo treatment performed: oral (j2a3a)	-	-	-	-	-
Noted chemo treatment performed: other (j2a10a)	-	-	-	-	-
Percent Agreement					
Noted treatment performed: Chemotherapy (j2a)	99	100	100	99	100
Noted chemo treatment performed: IV (j2a2a)	100	100	100	99	100
Noted chemo treatment performed: oral (j2a3a)	100	100	100	100	100
Noted chemo treatment performed: other (j2a10a)	100	100	100	100	100

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 4.2.1: Admission response distributions (in percent) for SSTI - Radiation

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Treatment performed: Radiation (j2b)	0	0	0	0	0

Table 4.2.2: IRR Kappa and Percent Agreement for SSTI – Radiation item

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa/Weighted kappa					
Noted treatment performed: Radiation (j2b)	-	-	-	-	-
Percent Agreement					
Noted treatment performed: Radiation (j2b)	99	100	100	100	100

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 4.3.1: Admission response distributions (in percent) for SSTI – Oxygen Therapy items

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Treatment performed: Oxygen Therapy (j2c)	13	17	44	16	20
Type of O2 therapy performed: intermittent (j2c2a)	7	11	37	11	14
Type of O2 therapy performed: continuous (j2c3a)	6	8	5	5	6
Type of O2 therapy performed: high-concentration (j2c4a)	0	1	6	0	1

Table 4.3.2: IRR Kappa and Percent Agreement for SSTI – Oxygen Therapy items

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa					
Treatment performed: Oxygen Therapy (j2c)	0.82	0.80	0.86	0.71	0.82
Type of O2 therapy performed: intermittent (j2c2a)	-	0.76	0.82	0.75	0.81
Type of O2 therapy performed: continuous (j2c3a)	-	0.68	0.35	-	0.55
Type of O2 therapy performed: high-concentration (j2c4a)	-	-	-	-	-
Percent Agreement					
Treatment performed: Oxygen Therapy (j2c)	96	94	93	91	93
Type of O2 therapy performed: intermittent (j2c2a)	98	95	92	95	95
Type of O2 therapy performed: continuous (j2c3a)	97	95	92	93	94
Type of O2 therapy performed: high-concentration (j2c4a)	100	100	97	100	99

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 4.4.1: Admission response distributions (in percent) for SSTI – Suctioning items

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Treatment performed: Suctioning (j2d)	0	1	5	1	1
Type of suctioning performed: scheduled (j2d2a)	0	0	1	0	0
Type of suctioning performed: as needed (j2d3a)	0	1	5	1	1

Table 4.4.2: IRR Kappa/Weighted Kappa and Percent Agreement for SSTI – Suctioning items

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa					
Treatment performed: Suctioning (j2d)	-	-	-	-	-
Type of suctioning performed: scheduled (j2d2a)	-	-	-	-	-
Type of suctioning performed: as needed (j2d3a)	-	-	-	-	-
Percent Agreement					
Treatment performed: Suctioning (j2d)	99	99	98	96	98
Type of suctioning performed: scheduled (j2d2a)	100	99	99	99	99
Type of suctioning performed: as needed (j2d3a)	99	100	98	96	98

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 4.5.1: Admission response distributions (in percent) for SSTI – Tracheostomy Care item

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Treatment performed: Tracheostomy Care (j2e)	0	1	5	0	1

Table 4.5.2: IRR Kappa and Percent Agreement for SSTI – Tracheostomy Care item

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa/Weighted kappa					
Treatment performed: Tracheostomy Care (j2e)	-	-	-	-	-
Percent Agreement					
Treatment performed: Tracheostomy Care (j2e)	100	100	99	100	100

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 4.6.1: Admission response distributions (in percent) for SSTI - Non-invasive Mechanical Ventilator (NIMV)

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Treatment performed: Non-invasive Mechanical Ventilator (j2g)	4	6	9	4	5
Type of NIMV performed: BiPAP (j2g2a)	1	1	7	1	2
Type of NIMV performed: CPAP (j2g3a)	2	6	2	3	3

Table 4.6.2: IRR Kappa/Weighted Kappa and Percent Agreement for SSTI – Non-invasive Mechanical Ventilator (NIMV) items

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa					
Treatment performed: Non-invasive Mechanical Ventilator (j2g)	-	-	0.77	-	-
Type of NIMV performed: BiPAP (j2g2a)	-	-	-	-	-
Type of NIMV performed: CPAP (j2g3a)	-	-	-	-	-
Percent Agreement					
Treatment performed: Non-invasive Mechanical Ventilator (j2g)	96	98	96	98	97
Type of NIMV performed: BiPAP (j2g2a)	96	100	97	100	98
Type of NIMV performed: CPAP (j2g3a)	98	98	98	98	98

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 4.7.1: Admission response distributions (in percent) for SSTI - Invasive Mechanical Ventilator item

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Treatment performed: Invasive Mechanical Ventilator (j2f)	0	0	3	0	0

Table 4.7.2: IRR Kappa and Percent Agreement for SSTI – Invasive Mechanical Ventilator

item

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa					
Treatment performed: Invasive Mechanical Ventilator (j2f)	-	-	-	-	-
Percent Agreement					
Treatment performed: Invasive Mechanical Ventilator (j2f)	100	100	100	100	100

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 4.8.1: Admission response distributions (in percent) for SSTI – IV Meds items

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Other treatment performed: IV Meds (j2h)	15	17	77	16	25
Type of IV meds given: antibiotics (j2h3a)	4	8	64	9	16
Type of IV meds given: anticoagulation (j2h4a)	8	6	17	6	8
Type of IV meds given: other (j2h10a)	6	5	20	4	7

Table 4.8.2: IRR Kappa/Weighted Kappa and Percent Agreement for SSTI – IV Meds items

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa					
Other treatment performed: IV Meds (j2h)	0.15	0.61	0.68	0.52	0.70
Type of IV meds given: antibiotics (j2h3a)	-	-	0.84	0.78	0.88
Type of IV meds given: anticoagulation (j2h4a)	-	-	0.13	-	0.13
Type of IV meds given: other (j2h10a)	-	-	0.46	-	0.46
Percent Agreement					
Other treatment performed: IV Meds (j2h)	83	91	89	87	88
Type of IV meds given: antibiotics (j2h3a)	98	97	93	96	96
Type of IV meds given: anticoagulation (j2h4a)	90	94	82	92	90
Type of IV meds given: other (j2h10a)	93	98	79	94	91

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 4.9.1: Admission response distributions (in percent) for SSTI – Transfusions item

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Other treatment performed: Transfusions (j2i)	0	1	2	0	0

Table 4.9.2: IRR Kappa/Weighted Kappa and Percent Agreement for SSTI – Transfusions item

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa					
Other treatment performed: Transfusions (j2i)	-	-	-	-	-
Percent Agreement					
Other treatment performed: Transfusions (j2i)	100	99	99	100	100

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 4.10.1: Admission response distributions (in percent) for SSTI – Dialysis items

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Other treatment performed: Dialysis (j2j)	3	5	15	3	5
Type of dialysis performed: hemodialysis (j2j2a)	3	4	15	3	5
Type of dialysis performed: peritoneal (j2j3a)	0	0	0	0	0

Table 4.10.2: IRR Kappa/Weighted Kappa and Percent Agreement for SSTI – Dialysis items

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa					
Other treatment performed: Dialysis (j2j)	-	-	0.92	-	-
Type of dialysis performed: hemodialysis (j2j2a)	-	-	0.90	-	-
Type of dialysis performed: peritoneal (j2j3a)	-	-	-	-	-
Percent Agreement					
Other treatment performed: Dialysis (j2j)	98	98	98	99	98
Type of dialysis performed: hemodialysis (j2j2a)	98	98	97	99	98
Type of dialysis performed: peritoneal (j2j3a)	100	100	100	100	100

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 4.11.1: Admission response distributions (in percent) for SSTI – IV Access

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Other treatment performed: IV Access (j2k)	4	22	91	10	24
Type of IV access: peripheral IV (j2k2a)	0	14	40	2	11
Type of IV access: midline (j2k3a)	0	1	13	0	2
Type of IV access: central line (j2k4a)	3	6	54	7	13
Type of IV access: other (j2k10a)	0	2	3	1	1

Table 4.11.2: IRR Kappa/Weighted Kappa and Percent Agreement for SSTI – IV Access items

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa					
Other treatment performed: IV Access (j2k)	-	0.81	-	0.74	0.90
Type of IV access: peripheral IV (j2k2a)	-	0.81	0.77	-	0.81
Type of IV access: midline (j2k3a)	-	-	0.75	-	-
Type of IV access: central line (j2k4a)	-	-	0.78	-	0.85
Type of IV access: other (j2k10a)	-	-	-	-	-
Percent Agreement					
Other treatment performed: IV Access (j2k)	97	94	99	95	96
Type of IV access: peripheral IV (j2k2a)	100	96	89	97	96
Type of IV access: midline (j2k3a)	100	99	94	100	98
Type of IV access: central line (j2k4a)	98	98	89	97	96
Type of IV access: other (j2k10a)	97	98	95	99	97

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Nutritional Approaches

Table 5.1.1: Admission response distributions (in percent) for Nutritional Approaches – Parenteral / IV Feeding Tube

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Nutritional approach performed: parenteral/IV (j1a)	0	1	4	0	1

Table 5.1.2: IRR Kappa/Weighted Kappa and Percent Agreement for Nutritional Approaches – Parenteral/IV Feeding Tube

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa					
Nutritional approach performed: parenteral/IV (j1a)	-	-	-	-	-
Percent Agreement					
Nutritional approach performed: parenteral/IV (j1a)	100	100	99	100	100

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 5.2.1: Admission response distributions (in percent) for Nutritional Approaches – Feeding Tube

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Nutritional approach performed: feeding tube (j1b)	0	3	8	2	3

Table 5.2.2: IRR Kappa/Weighted Kappa and Percent Agreement for Nutritional Approaches – Feeding Tube

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa					
Nutritional approach performed: feeding tube (j1b)	-	-	-	-	-
Percent Agreement					
Nutritional approach performed: feeding tube (j1b)	100	100	98	100	100

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 5.3.1: Admission response distributions (in percent) for Nutritional Approaches – Mechanically Altered Diet

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Nutritional approach performed: mechanically altered diet (j1c)	2	15	14	11	10

Table 5.3.2: IRR Kappa/Weighted Kappa and Percent Agreement for Nutritional Approaches – Mechanically Altered Diet

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa					
Nutritional approach performed: mechanically altered diet (j1c)	-	0.53	0.69	0.70	0.65
Percent Agreement					
Nutritional approach performed: mechanically altered diet (j1c)	100	89	92	94	93

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

Table 5.4.1: Admission response distributions (in percent) for Nutritional Approaches – Therapeutic Diet

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	629	762	448	1087	2926
Nutritional approach performed: therapeutic diet (j1d)	54	49	59	49	52

Table 5.4.2: IRR Kappa/Weighted Kappa and Percent Agreement for Nutritional Approaches – Therapeutic Diet

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	236	203	256	882
Kappa					
Nutritional approach performed: therapeutic diet (j1d)	0.43	0.70	0.62	0.61	0.60
Percent Agreement					
Nutritional approach performed: therapeutic diet (j1d)	71	85	82	80	80

NOTE: Based on dichotomized never noted vs. noted any day. Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

High-Risk Drug Classes: Use and Indication items

Table 6.1.1: Admission response distributions (in percent) for Medication Class Taking and Indication Items

Medication Class	HHA (627)		IRF (769)		LTCH (459)		SNF (1096)		Overall (2951)	
	Taking (Percent)	Indication (Percent)	Taking (Percent)	Indication (Percent)	Taking (Percent)	Indication (Percent)	Taking (Percent)	Indication (Percent)	Taking (Percent)	Indication (Percent)
Anticoagulants	29	47	61	29	66	20	42	77	48	45
Antiplatelets	15	52	19	31	16	10	12	77	15	45
Hypoglycemics	29	47	30	49	48	52	26	72	31	56
Opioids	39	87	51	91	64	90	52	96	51	92
Antipsychotics	9	73	9	33	14	30	16	89	12	66
Antimicrobials	13	57	23	60	73	22	27	84	30	53

NOTE: Indication (percent) reflects percent with indication among those taking medications in that class

Table 6.1.2: IRR Kappa and Percent Agreement for Medication Class Taking and Indication items

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	187	240	212	261	900
Kappa					
Is patient taking: anticoagulants (i1a1)	0.78	0.84	0.87	0.85	0.85
Is patient taking: antiplatelets (i1a2)	0.69	0.71	0.83	-	0.72
Is patient taking: hypoglycemics (i1a3)	0.83	0.80	0.97	0.90	0.89
Is patient taking: opioids (i1a4)	0.84	0.86	0.90	0.85	0.86
Is patient taking: antipsychotics (i1a5)	-	-	-	-	-
Is patient taking: antimicrobials (i1a6)	-	0.76	0.93	0.82	0.86
Indication noted for anticoagulants (i1b1)	0.54	0.64	0.80	0.87	0.78
Indication noted for antiplatelets (i1b2)	0.69	0.85	-	0.89	0.87
Indication noted for hypoglycemics (i1b3)	0.39	0.62	0.70	0.75	0.65
Indication noted for opioids (i1b4)	-	-	-	-	-
Indication noted for antipsychotics (i1b5)	0.33	1.00	0.88	0.73	0.81
Indication noted for antimicrobials (i1b6)	0.74	0.63	0.72	-	0.81
Percent Agreement					
Is patient taking: anticoagulants (i1a1)	91	93	94	93	93
Is patient taking: antiplatelets (i1a2)	92	91	95	91	92
Is patient taking: hypoglycemics (i1a3)	92	92	99	96	95
Is patient taking: opioids (i1a4)	92	93	96	92	93
Is patient taking: antipsychotics (i1a5)	96	95	94	93	94
Is patient taking: antimicrobials (i1a6)	94	91	97	93	94
Indication noted for all meds in class (i1b1-6)	79	89	91	96	90
Indication noted for anticoagulants (i1b1)	77	85	94	95	89
Indication noted for antiplatelets (i1b2)	84	93	100	95	94
Indication noted for hypoglycemics (i1b3)	69	82	85	90	82
Indication noted for opioids (i1b4)	87	96	89	100	94
Indication noted for antipsychotics (i1b5)	63	100	95	89	90
Indication noted for antimicrobials (i1b6)	88	81	91	98	91

NOTE: Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

PAIN: Pain Interference

Table 7.1.1: Admission response distributions (in percent) for Pain Interference items among patients/residents reporting any pain in the last 3 days or 5 days

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	489	618	375	872	2354
How often pain made it hard to sleep (d3)					
Rarely or not at all	40	32	29	37	35
Occasionally	29	30	24	28	28
Frequently	19	26	29	23	24
Almost constantly	12	13	17	13	13
Offered rehab therapies (d4a)					
Yes	78	98	81	93	89
Yes N	379	606	302	803	2090
How often limited rehab due to pain (d4b)					
Rarely or not at all	74	76	62	73	73
Occasionall	14	17	17	16	16
Frequently	7	5	14	8	8
Almost constantly	5	2	7	3	4
How often limited daily activities due to pain (d4c)					
Rarely or not at all	40	55	42	41	45
Occasionally	26	18	19	26	23
Frequently	17	16	20	21	19
Almost constantly	16	11	19	12	14

Table 7.1.2: IRR Kappa/Weighted Kappa and Percent Agreement for Pain Interference items

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	197	256	232	268	953
Kappa					
How often pain made it hard to sleep (d3)	0.96	0.98	0.98	0.99	0.98
How often limited rehab due to pain (d4b)	0.95	0.96	0.98	0.97	0.97
How often limited daily activities due to pain (d4c)	0.97	0.98	0.99	0.98	0.98
Percent Agreement					
How often pain made it hard to sleep (d3)	95	98	98	100	98
How often limited rehab due to pain (d4b)	97	98	98	99	98
How often limited daily activities due to pain (d4c)	97	98	99	99	98

NOTE: Interrater reliability not shown for items with proportions out of range for stable kappa estimate (per study power calculations). Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect. *Pearson correlation for rating of worst pain, which is on a 0-10 scale

IMPAIRMENTS: Hearing

Table 8.1.1: Admission response distributions (in percent) for Hearing item

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	643	783	498	1141	3065
Ability to hear (a1)					
Adequate	65	75	81	76	74
Minimal difficulty	24	18	13	15	17
Moderate difficulty	11	6	4	8	8
Highly impaired	0	1	1	1	1

Table 8.1.2: IRR Weighted Kappa and Percent Agreement for Hearing item

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	197	258	237	268	960
Weighted kappa					
Ability to hear (a1)	0.71	0.67	0.58	0.62	0.65
Percent agreement					
Ability to hear (a1)	83	87	84	83	84

NOTE: Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.

IMPAIRMENTS: Vision

Table 9.2.1: Admission response distributions (in percent) for Vision item

Items	HHA	IRF	LTCH	SNF	Overall
# of assessments	643	783	498	1141	3065
Ability to see (a2)					
Adequate	73	85	76	78	78
Impaired	21	12	16	16	16
Moderately impaired	4	2	6	4	4
Highly impaired	1	1	1	1	1
Severely impaired	1	0	1	1	1

Table 9.2.2: IRR Weighted Kappa and Percent Agreement for Vision item

Items	HHA	IRF	LTCH	SNF	Overall
# of patients	197	258	237	268	960
Weighted kappa					
Ability to see (a2)	0.67	0.50	0.47	0.57	0.56
Percent agreement					
Ability to see (a2)	83	90	75	83	83

NOTE: Interpretation of kappa or weighted kappa is as follows: 0.00-0.20: slight/poor; 0.21-0.40: fair; 0.41-0.60: moderate; 0.61-0.80: substantial/good; 0.81-1.00: excellent/almost perfect.