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Technical Expert Panel Summary Report: Development and Maintenance of Quality Measures for Inpatient Rehabilitation Facilities Quality Reporting Program (IRF QRP)

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RTI INTERNATIONAL

TECHNICAL EXPERT PANEL SUMMARY REPORT: DEVELOPMENT AND MAINTENANCE OF QUALITY MEASURES FOR INPATIENT REHABILITATION FACILITIES QUALITY REPORTING PROGRAM (IRF QRP)

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SECTION 1
INTRODUCTION AND OVERVIEW

1.1 Introduction

RTI International, on behalf of the Centers for Medicare & Medicaid Services (CMS), convened a Technical Expert Panel (TEP) to seek expert input on the Development and Maintenance of Performance Measures for the Inpatient Rehabilitation Facilities Quality Reporting Program (IRF QRP). An all-day, in-person TEP meeting was held on March 27, 2017 in Baltimore, MD.

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

1.2 Background

CMS has contracted with RTI to develop and maintain performance measures for the IRF QRP. The contract name is Development and Maintenance of Symptom Management Measures (contract number HHSM-500-2013-13015I). As part of its measure development process, CMS asks measure developers to convene groups of stakeholders and experts who contribute direction and thoughtful input to the measure contractor during performance measure development and maintenance.

The purpose of the contract, Development and Maintenance of Symptom Management Measures, is to develop performance measures reflective of quality of care, including resource use, for post-acute care (PAC) settings, which could be used to support CMS quality missions. Care settings included in this measure development project are skilled nursing facilities (SNFs), IRFs, and long-term care hospitals (LTCHs). Measures developed are consistent with the three broad aims and six priorities of the National Quality Strategy, available at http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.pdf, and the CMS Quality Strategy, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf.

The objectives of the TEP meeting were to obtain input on IRF QRP performance measures adopted into the program and obtain guidance and recommendations for future measures.

1.3 Process of TEP Meeting

1.3.1 TEP Nomination Process

On January 26, 2017, a “Call for TEP” and a “TEP Nomination Form” were posted on the CMS Measures Management System website (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/TechnicalExpertPanels.html) to recruit TEP members. The TEP nomination opportunity period was 29 days (January 26, 2017 to February 23, 2017). Information about the opportunity to participate as a TEP member was also

disseminated to national provider and professional associations, measure development experts, patient advocacy groups, potential consumer/patient representatives, and other stakeholder organizations.

After the nomination period, RTI finalized the TEP composition by selecting ten nominees who offered a combination of clinical, research, and administrative expertise in the IRF setting and who demonstrated knowledge of IRF QRP performance measures. The selected TEP members offered a variety of perspectives related to quality improvement, patient outcomes, research methodology, data collection and implementation, and health care disparities. One TEP member provided a consumer perspective. **Table 1** lists the selected TEP members.

Table 1.
Members of the TEP on the Development and Maintenance of Quality Measures for the Inpatient Rehabilitation Facilities Quality Reporting Program (IRF QRP)

Name	Professional Role	Location
Mary Ellen DeBardeleben, MBA, MPH, CJCP	Director of Quality HealthSouth	Birmingham, AL
Karen Green, PT, DPT	Director of Rehabilitation Cleveland Clinic	Cleveland, OH
Brigid Greenberg, PT, MHS	Business Development Advisor, Manager of Post Discharge Services and Appeals Uniform Data System for Medical Rehabilitation	Amherst, NY
Kurtis Hoppe, MD	IRF Medical Director Mayo Clinic	Rochester, MN
Cristina Huerta, CRRN, MBA-HCM	Vice President-Rehab Operations, HCA, Inc. Association of Rehabilitation Nurses	El Paso, TX
Steven Lichtman, EdD, MAACVPR	Patient representative Director, Cardiopulmonary Outpatient Services, Rehabilitation Research; Research Scientist Helen Hayes Hospital	Monroe, NY
Stephanie Nadolny, TRS, MHA	Vice President of Hospital Operations Spaulding Rehabilitation Hospital Cape Cod	East Sandwich, MA

(continued)

Table 1. (continued)
Members of the TEP on the Development and Maintenance of Quality Measures for the Inpatient Rehabilitation Facilities Quality Reporting Program (IRF QRP)

Name	Professional Role	Location
Pam Roberts, PhD, MSHA, OTR/l, SCFES, FAOTA, CPHQ, FNAP, FACRM	Director and Professor Physical Medicine and Rehabilitation and Academic and Physician Informatics Cedars-Sinai Health System	Los Angeles, CA
Mary Van de Kamp, MS/CCC-SLP	Senior Vice President of Quality Kindred Healthcare	Louisville, KY
Alan Zaph, PT	Coordinator Carolinas Rehabilitation – Patient Safety Organization	Charlotte, NC

1.3.2 Pre-TEP Call

Prior to the TEP, RTI held a 30-minute call with TEP members. The purpose of the call was to review the TEP Charter and TEP agenda (see ***Appendix A*** for meeting agenda) and to clarify TEP members' roles and responsibilities.

In addition, RTI provided an opportunity for TEP members to review the IRF QRP performance measures derived from the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) and Medicare claims data prior to the meeting. The Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) measures were not discussed during this TEP. To support this activity, RTI developed and provided to TEP members a table summarizing the selected IRF QRP quality measures (see ***Appendix B*** for IRF QRP Performance Measures Summary Table).

1.3.3 TEP Meeting

The all-day, in-person TEP meeting took place in Baltimore, Maryland, on March 27, 2017. The ten selected TEP members attended the meeting in addition to CMS staff and RTI staff. Discussions were facilitated by RTI's IRF and function measures lead, Anne Deutsch and RTI's measure leads: Amy Helburn, Jill McArdle, Erin White, Julie Seibert, Laurie Coots, Poonam Pardasaney, and Melissa Morley. Throughout the meeting, there were active discussions related to implementation, data collection, and specifications of the IRF QRP quality and resource use measures. The meeting was audio recorded for the purpose of summarizing TEP proceedings and TEP member input on the IRF QRP performance measures.

1.4 Organization of the Report

The following sections of the report discuss the overview and specifications of the IRF QRP measures and summarize the input obtained from TEP members during the meeting:

Section 2: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680); ***Section 3:*** Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674); ***Section 4:*** Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC IRF QRP; ***Section 5:*** Function Process and Outcome Quality Measures; ***Section 6:*** Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678); ***Section 7:*** Readmission Quality Measures; ***Section 8:*** Discharge to Community–PAC IRF QRP; ***Section 9:*** Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP; and ***Section 10:*** Future Measures.

SECTION 2
PERCENT OF RESIDENTS OR PATIENTS WHO WERE ASSESSED AND APPROPRIATELY GIVEN THE SEASONAL INFLUENZA VACCINE (SHORT STAY) (NQF #0680)

2.1 Measure Overview

2.1.1 Overview of Measure

The Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) is a National Quality Forum-endorsed process measure that reports the percentage of stay-level records in which the patients were assessed and appropriately given the influenza vaccine during the most recent influenza vaccination season (IVS).

This measure is intended to encourage IRF staff to assess patients' seasonal influenza immunization status and to administer the immunization as deemed clinically appropriate.

This measure was first endorsed by the NQF as a short-stay nursing home (NH) measure in 2012. In June 2012, the resident influenza vaccination measure was expanded to include patients treated in IRFs and LTCHs. The measure is now endorsed by the NQF for all three settings. Data collection for this measure began October 1, 2014 using version 1.2 of the IRF–PAI.

2.1.2 Overview of Measure Specifications

This stay-based influenza vaccine quality measure is based on data collected from the IRF-PAI for IRF Medicare patients. Data are collected separately in each of the three settings using standardized items that have been harmonized across the MDS, LTCH CARE Data Set, and IRF-PAI.

The measure is based on the completion of two influenza vaccine assessment items:

Item O0250A: "Did the patient receive the influenza vaccine in this facility for this year's influenza vaccination season" with two responses "Yes" and "No."

Item O0250C: "If influenza vaccine not received, state reason:" and the response options include:

(1) Patient/Resident not in this facility during this year's IVS

(2) Received outside of this facility

(3) Not eligible – medical contraindication

(4) Offered and declined

(5) Not offered

(6) Inability to obtain influenza vaccine due to a declared shortage

(7) None of the above

The measure numerator is an aggregate of three separately calculated submeasures to reflect the process by which a patient is appropriately assessed or given the influenza vaccination during the stay. The numerator is the number of patients who were in the facility for one or more days during the influenza vaccination season (IVS) and meet any one of the following criteria:

(1) Received the seasonal influenza vaccine during the most recently completed influenza season, either in the facility/hospital or outside the facility/hospital (NQF #0680a);

(2) Were offered and declined the seasonal influenza vaccine (NQF #0680b); or

(3) Were ineligible due to contraindication(s) (NQF #0680c).

The numerator coincides with the most recently-completed IVS which begins on October 1 and ends on March 31st of the following year.

The denominator consists of all IRF Medicare patients 180 days of age or older on the target date of the assessment who had a discharge date within the current influenza season (July 1 to June 30) and were in the facility for at least one day during the most recently-completed IVS.

2.2 TEP Discussion and Recommendations

2.2.1 IRF Patient Refusal Rate

RTI shared that during the 2014-2015 IVS, IRFs reported that about one-quarter of patients (24%) were offered and declined the vaccine, which is higher than the percentage of short-stay NH residents (22%) and LTCH patients (15%) who declined. One expert noted that persons from certain age groups are more likely to decline the vaccination than others, and that education about the risk associated with influenza can address this issue. Several TEP members stated that a lack of knowledge about influenza and vaccinations may also lead to patient refusals. One expert noted that IRF patients decline the vaccine because they are asked often, or they cannot remember if they already received the vaccine, and providers cannot check in other medical record systems. Some patients feel overwhelmed, and they tend to decline optional vaccinations. Patients declining the vaccination may also be associated with issues of the patient wanting to control one aspect of care.

2.2.2 Rehabilitation Context and Priorities

Some TEP members believed the measure may not be a good indicator of quality in post-acute care settings, because patients are often offered this vaccination in the acute care setting. There was discussion as to whether the influenza vaccination is a quality measure well suited to the IRF setting and whether it is aligned with the goals of IRF care. Some TEP members expressed that this measure is simply tracking compliance. One TEP member disagreed, stating

that the measure is important in IRFs and that this is an important intervention IRFs can provide to patients. Another TEP member noted that influenza is considered potentially preventable and that IRF staff have the ability to address this issue, thus the outcome (potentially preventing influenza) should be related to other measures such as potentially preventable readmissions. A third TEP member believed that influenza vaccination was related to the transfer of health information across settings. Several TEP members noted the potential of a patient being vaccinated more than once, because patients are being offered the vaccination in multiple settings.

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SECTION 3
APPLICATION OF PERCENT OF RESIDENTS EXPERIENCING ONE OR MORE FALLS WITH MAJOR INJURY (LONG STAY) (NQF #0674)

3.1 Measure Overview

3.1.1 Overview of Measure

The cross-setting quality measure, Application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) addresses the IMPACT Act domain of incidence of major falls. This quality measure reports the percentage of patients/residents who experience one or more falls with major injury (defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) during the SNF, LTCH, or IRF stay. The measure was endorsed by the NQF in March 2011 for the long-stay nursing home population.

The measure was finalized for use in the IRF QRP in the FY 2016 IRF Prospective Payment System (PPS) Final Rule. Data collection for the measure began using the 2016 release (Version 1.4) of the IRF–PAI which became effective October 1, 2016 for all Medicare patients discharged from IRFs on or after October 1, 2016.

3.1.2 Overview of Measure Specifications

This quality measure is calculated using data reported for two items on the IRF-PAI:

Item J1800: "Has the patient had any falls since admission" with two responses: "Yes" and "No."

Item J1900C: "Number of falls since admission: Major injury" which allows providers to respond "None", "One" or "Two or more" to indicate the number of falls since admission that resulted in a major injury to the patient.

For measure calculation, the numerator is the number of Medicare (Part A or Medicare Advantage) patient stays that occurred during the selected time window and during which one or more falls resulted in a major injury (J1900C = [1] or [2]). The denominator is the total number of Medicare patient stays (Part A or Medicare Advantage) that occurred during the selected time window and did not meet any of the exclusion criteria. Patient stays are excluded from the denominator if the fall with major injury data is missing on the IRF-PAI (J1900C = [-]) during the selected time window. This measure is not risk-adjusted or stratified.

3.2 TEP Discussion and Recommendations

3.2.1 General Support

Among the TEP members there was general support regarding the scientific soundness and usability of this measure.

3.2.2 Measuring All Falls

TEP members voiced concern that the measure captures a rare event, a fall that results in a major injury, and that there is little or no room for improvement. It was suggested that it may be better to measure all falls that occur, regardless of injury. Due to their greater frequency of occurrence, falls without major injury may have a greater cost impact on the Medicare program and measuring and monitoring all falls may lead to greater improvements in quality of care and patient safety.

3.2.3 Falls Definition

Multiple TEP members stated that there are questions in the industry regarding the definition of a fall, which includes intercepted falls. According to the IRF-PAI Training Manual, "An intercepted fall occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person—this is still considered a fall." Several TEP members suggested that "intercepted falls" be removed from the definition of falls because there are situations in which a clinician may be working on ambulation training with a patient, and the patient may need support to prevent a fall. The RTI staff clarified that challenging a patient's balance is an intentional therapeutic intervention and an anticipated loss of balance that occurs during a supervised therapeutic intervention is not considered an intercepted fall.

3.2.4 Risk Adjustment

One TEP member stated that it would be beneficial to risk adjust this measure and suggested risk adjustment for comorbidities and level of care. Another TEP member expressed concern about the complexity of risk adjustment for falls and to account for the interaction of numerous factors that are related to patient safety, including cognitive status, function, medications, and comorbidities.

SECTION 4
DRUG REGIMEN REVIEW CONDUCTED WITH FOLLOW-UP FOR IDENTIFIED ISSUES – PAC IRF QRP

4.1 Measure Overview

4.1.1 Overview of Measure

Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC IRF QRP is a process quality measure that reports whether IRF providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified at the time of admission and throughout the patient stay. Specifically, this measure reports the percentage of patient stays in which a drug regimen review was conducted at the time of admission and timely follow-up with a physician (or physician-designee) occurred each time a clinically significant medication issue was identified throughout that stay.

CMS finalized this measure in the IRF PPS FY 2017 Final Rule to address the IMPACT Act quality measure domain, medication reconciliation. Data collection for the measure will begin October 1, 2018, using data elements that are included on IRF-PAI Version 2.0

4.1.2 Overview of Measure Specifications

This assessment-based quality measure will be calculated using data collected from the IRF-PAI for IRF patients. In IRFs, this measure includes Medicare Part A and Medicare Advantage patients.

This quality measure will be calculated from data reported for three items on the IRF-PAI Version 2.0:

Item N2001: "Did a complete drug regimen review identify potential clinically significant medication issues" with three responses "Yes", "No", and "N/A – Patient is not taking any medications."

Item N2003: "Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues" with two responses "Yes" and "No."

Item N2005: "Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the Admission" with three responses "Yes", "No", and "N/A – There were no potential clinically significant medication issues identified since Admission or patient is not taking any medications."

For this measure, the numerator is the number of stays for which all of the following are each true:

(1) The facility conducted a drug regimen review at the admission (N2001= [0,1]) or patient is not taking any medications (N2001= [9]); and

(2) If potential clinically significant medication issues were identified at admission (N2001 = [1]), then the facility contacted a physician (or physician-designee) and completed prescribed/recommended actions in response to the identified issues (N2003= [1]) by midnight of the next calendar day; and

(3) The facility contacted a physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission (N2005 = [1]) or no potential clinically significant medications issues were identified since the admission (N2005 = [9]).

If data are missing on any of the three items used to calculate the numerator of the measure (specifically, (N2001= [-] or N2003= [-] or N2005= [-])), the patient's stay will not be included in the numerator count, but the patient's stay will still be included in the denominator count.

The denominator is the number of Medicare patient stays (Part A or Medicare Advantage) during the IRF reporting period. The measure has no denominator exclusions for IRFs.

4.2 TEP Discussion and Recommendations

4.2.1 Measure Importance

The TEP members agreed that medication reconciliation is a necessary and important component of communication and patient safety in IRFs, especially during periods of transition.

4.2.2 Definitions

The TEP members suggested that several item definitions should be refined for enhanced clarity and understanding. Members requested that additional details be included in revised definitions. The most discussed term among TEP members was "clinically significant medication issue." One TEP member noted several public comment letters, including letters submitted by the American Hospital Association and the Association of Rehabilitation Nurses, requested clarification of the term. The following additional terms were also mentioned by TEP members: "potential clinically significant medication issue", "clinically significant", "medication issue", and "clinician's professional judgment." One TEP member noted that without clear item definitions, data may be unreliable, because clinicians with insufficient understanding of item definitions will be unable to code the items correctly. RTI staff noted that training materials for providers are currently being developed to provide definitions and coding guidance.

4.2.3 Burden

Several TEP members brought up the issue of burden, specifically burden related to data collection. One TEP member noted that data collection-related burden will be greater for the many IRFs that are not on an electronic medical records system. One member noted that unlike the home health sector, where a clinician cares for a patient for a brief period of time, the IRF setting requires 24-hour patient care for an extended period of time; therefore, it is more

challenging and time-consuming for IRFs to track every medication issue that occurs throughout the patient stay. One TEP member noted the burden related to the process of medication reconciliation specific to the time of admission because the medication reconciliation conducted at admission requires data collection from multiple sources.

4.2.4 Duplicative of Current Regulatory Requirements

Multiple TEP members noted that the measure is duplicative, given current regulatory requirements established by The Joint Commission and the CMS Conditions of Participation, and that IRFs already have longstanding processes in place for completing and documenting these requirements. For example, IRFs are currently required to document each instance in which the pharmacist contacts a physician to clarify or revise a medication order, such as changing the medication dose. Further, during regular internal reviews, IRFs verify that physicians are responsive to clinician and pharmacist questions. One TEP member conveyed concern that the measure would require IRF clinicians to document the same information a second time, with no added benefit for the IRF.

4.2.5 Overly Broad

Several TEP members conveyed that the measure attempts to address too many issues with one metric. For example, one member noted that the measure monitors everything related to medication, whether at admission or throughout the stay, using one measure. Another TEP member suggested that the scope of the measure, which assesses safety and transition and communication, is too broad. The member asked whether pilot testing had identified key elements of patient risk, such as highest-risk medication issues, which could be used to narrow the scope of the measure. Another TEP member suggested isolating one issue for measurement (e.g., timeliness of response to a medication issue, timeliness of the medication reconciliation at admission) and revising the measure to address this single variable. One TEP member noted that, because the measure will be reported as several different processes rolled into a single measure, the measure would not be as valuable to IRFs for internal quality improvement purposes.

4.2.6 Insufficiently Addresses Transition Points of Care

Some TEP members indicated that medication reconciliation typically focuses on transition points of care, and that emphasis on transition points of care is missing from the measure. One TEP member suggested that a measure focused on transition points of care would be a better use of the IMPACT Act mandate to fulfill the domain, medication reconciliation. Members noted that IRFs focus on medication issues at discharge in order to reduce readmissions, and this is not included in the current measure. TEP members conveyed preference for a medication reconciliation measure that focuses more on transition points of care.

4.2.7 Examples of Current Approaches to Medication Review

One TEP member's facility has implemented a medication simplification program designed to help meet patients' economic and medication literacy needs and capture changes in medication dosage, and possibly prevent a patient readmission. Another TEP member's IRF involves occupational therapists in the medication administration process, in order to determine

the patients' cognitive ability to understand how and when to take their medications and what to do if they run low on a medication.

SECTION 5
FUNCTION PROCESS AND OUTCOME QUALITY MEASURES

5.1 Function Process Measure: Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)

5.1.1 Measure Overview

5.1.1.1 Overview of Measure—The Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure is an NQF-endorsed (NQF #2631) process quality measure that reports the percent of patients with an admission and a discharge functional assessment and a treatment goal that addresses function. The treatment goal provides evidence that a care plan with a goal has been established for the patient. Given that the primary goal of rehabilitation is improvement in function, assessment and documentation of a patient's functional status and the development of individualized care plans and treatment goals is imperative for patients to achieve maximal therapeutic benefit.

An application of this measure was finalized for use in the IRF QRP in the FY 2016 IRF PPS Final Rule (80 FR 47111). Data collection for this measure began using the 2016 version (Version 1.4) of the IRF-PAI which became effective October 1, 2016 for all Medicare patients discharged from IRFs on or after October 1, 2016.

This measure is a cross-setting function measure in the IRF, LTCH, SNF QRPs and was implemented to meet the IMPACT Act domain addressing function. This measure meets the patient and family engagement priorities of the Department of Health and Human Services, the Centers for Medicare and Medicaid, and the NQF.

5.1.1.2 Overview of Measure Specifications—RTI reviewed the measure specifications with the TEP members. The functional assessment data elements included in the functional process quality measure were originally developed and tested as part of the Continuity Assessment Record and Evaluation (CARE) Item Set, which was designed to standardize assessment of patients' status across acute and post-acute providers, including IRFs, skilled nursing facilities (SNFs), home health agencies (HHAs), and long-term care hospitals (LTCHs).

This quality measure is based on data reported for three self-care items and eleven mobility items on the IRF-PAI. These items are collected on admission for admission functional performance and discharge goals, and on discharge for discharge function performance.

- Self-Care Items
  - Item GG0130A: Eating
  - Item GG0130B: Oral hygiene
  - Item GG0130C: Toileting hygiene

- Mobility Items
  - **Item GG0170B:** Sit to lying
  - **Item GG0170C:** Lying to sitting on side of bed
  - **Item GG0170D:** Sit to stand
  - **Item GG0170E:** Chair/bed-to-chair transfer
  - **Item GG0170F:** Toilet transfer
  - **Item GG0170J:** Walk 50 feet with two turns
  - **Item GG0170K:** Walk 150 feet
  - **Item GG0170R:** Wheel 50 feet with two turns
  - **Item GG0170RR:** Indicate the type of wheelchair/scooter used
  - **Item GG0170S:** Wheel 150 feet
  - **Item GG0170SS:** Indicate the type of wheelchair/scooter used

The valid numeric codes and code labels for the admission and discharge Self-Care and Mobility functional assessment items are:

- 06 – Independent
- 05 – Setup or clean-up assistance
- 04 – Supervision or touching assistance
- 03 – Partial/moderate assistance
- 02 – Substantial/maximal assistance
- 01 – Dependent
- 07 – Patient Refused
- 09 – Not applicable
- 88 – Not attempted due to medical condition or safety concerns

Only codes 01 – 06 are valid for the Self-Care and Mobility Discharge Goal items.

The numerator for this quality measure is the number of IRF patients who had functional admission and discharge assessment data reported for each self-care and mobility activity and at least one self-care or mobility discharge goal. For patients with a complete stay, all three of the following are required for the patient's stay to be counted in the numerator:

(1) A valid numeric score indicating the patient's status, or a valid code indicating the activity was not attempted, for each of the functional assessment items on the admission assessment;

(2) A valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment; and

(3) A valid numeric score indicating the patient's status, or a valid code indicating the activity was not attempted, for each of the functional assessment items on the discharge assessment.

For patients who had an incomplete stay, discharge data are not required. For patients with an incomplete stay, the following are required to be counted in the numerator:

(1) A valid numeric score indicating the patient's status, or a valid code indicating the activity was not attempted, for each of the functional assessment items on the admission assessment; and

(2) A valid numeric score, which is a discharge goal indicating the patient's expected level of independence, for at least one self-care or mobility item on the admission assessment.

The denominator for this measure is the number of Medicare (Part A and Medicare Advantage) patient stays. This measure is not risk adjusted, and there are no exclusion criteria. Data for this measure is gathered via the IRF-PAI.

5.1.2 TEP Discussion and Recommendations

5.1.2.1 Relation of Process Measure and Outcome Measures in IRF Setting—Several TEP members noted that this process measure was created as a foundation for the functional outcome measures. The implementation of standardized items that were developed and tested across all PAC settings was an important step towards outcome measure development. Now that outcome measures have been developed and implemented in the IRF setting, some TEP members suggested retiring or suspending the process measure. Furthermore, several panel members believe that this measure is not necessary in the IRF setting, because IRFs are already assessing function and developing care plans with goals throughout a patient's IRF stay.

One TEP member reminded the group that, while IRFs do well on this measure, it is important to show the benefit of IRF rehabilitation care relative to other types of providers. RTI staff asked whether the measure should be modified to require more discharge goals, but the TEP members indicated this would not likely change the measure scores much for the IRF setting.

5.2 Function Outcome Quality Measures: IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633); IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634); IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635); and IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)

5.2.1 Measures Overview

5.2.1.1 Overview of Measures—The four IRF functional outcome measures reviewed by the TEP included two change measures and two discharge score measures. The two change measures reviewed were the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) and IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634). These are quality measures that estimate the risk-adjusted mean change in self-care and mobility score between admission and discharge among IRF patients, respectively. The two discharge score measures reviewed were the IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635) and IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636). These two quality measures estimate the percentage of IRF patients who meet or exceed an expected discharge self-care or mobility score, respectively.

All four quality measures were finalized for use in the IRF QRP in the FY 2016 IRF PPS Final Rule (80 FR 47117 through 47120). The function discharge score measures, NQF #2635 and #2636, received NQF endorsement in July 2015 and the function change measures, NQF #2633 and #2634, received NQF endorsement in November 2015. Data collection for these measures began with the 2016 release (Version 1.4) of the IRF-PAI which became effective October 1, 2016 for all Medicare patients discharged from IRFs on or after October 1, 2016. All four measures meet the effective prevention and treatment priorities of the Department of Health and Human Services, the Centers for Medicare and Medicaid, and the NQF.

5.2.1.2 Overview of Measure Specifications—RTI provided an overview of the measure specifications with the TEP members. RTI described details about the specifications for one measure, the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) and then briefly summarizing the other three measures and their similarities and differences. A summary of the four measure specifications are provided in **Table 2**.

Table 2.
Measure Specifications Summary for the IRF Functional Outcome Measures

IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)	
Items	GG0130A. Eating GG0130B. Oral hygiene GG0130C. Toileting hygiene GG0130E. Shower/bathe self GG0130F. Upper body dressing GG0130G. Lower body dressing GG0130H. Putting on/taking off footwear
Description	This measure estimates the risk-adjusted change in self-care score between admission and discharge among IRF Medicare patients age 21 or older. The change in self-care score is calculated as the difference between the discharge self-care score and the admission self-care score.
Denominator	The denominator is the number of IRF Medicare patient stays, except those that meet the exclusion criteria.
Exclusion Criteria	1) Patients with incomplete stays. 2) Patients who are independent with all self-care activities at the time of admission. 3) Patients with the following medical conditions: coma; persistent vegetative state; complete tetraplegia; locked-in syndrome; or severe anoxic brain damage, cerebral edema or compression of brain. 4) Patients younger than age 21. 5) Patients discharged to hospice. 6) Patients who are not Medicare beneficiaries.
Risk Adjusters	Age group; admission self-care score – continuous; admission self-care score – squared; primary diagnosis group; interaction between admission self-care and primary diagnosis group; prior surgery; prior functioning – self-care; prior functioning – indoor ambulation; prior mobility/device aids; stage 2 pressure ulcer; stage 3, 4, or unstageable pressure ulcer; cognitive function; communication impairment; bladder incontinence; bowel incontinence; swallowing ability; and comorbidities based on Hierarchical Condition Categories (HCCs).

(continued)

Table 2. (continued)
Measure Specifications Summary for the IRF Functional Outcome Measures

IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)	
Items	GG0170A. Roll left and right GG0170B. Sit to lying GG0170C. Lying to sitting on side of bed GG0170D. Sit to stand GG0170E. Chair/bed-to-chair transfer GG0170F. Toilet transfer GG0170G. Car transfer GG0170I. Walk 10 feet GG0170J. Walk 50 feet with two turns GG0170K. Walk 150 feet GG0170L. Walking 10 feet on uneven surfaces GG0170M. 1 step (curb) GG0170N. 4 steps GG0170O. 12 steps. GG0170P. Picking up object
Description	This measure estimates the risk-adjusted change in mobility score between admission and discharge among IRF Medicare patients age 21 or older. The change in mobility score is calculated as the difference between the discharge mobility score and the admission mobility score.
Denominator	The denominator is the number of IRF Medicare patient stays, except those that meet the exclusion criteria.
Exclusion Criteria	1) Patients with incomplete stays. 2) Patients who are independent with all mobility activities at the time of admission. 3) Patients with the following medical conditions: coma; persistent vegetative state; complete tetraplegia; locked-in syndrome; or severe anoxic brain damage, cerebral edema or compression of brain. 4) Patients younger than age 21. 5) Patients discharged to hospice. 6) Patients who are not Medicare beneficiaries.

(continued)

Table 2. (continued)
Measure Specifications Summary for the IRF Functional Outcome Measures

IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)	
Risk Adjusters	Age group; admission mobility score – continuous; admission mobility score – squared; primary diagnosis group; interaction between admission mobility and primary diagnosis group; prior surgery; prior functioning – indoor ambulation; prior functioning – stair negotiation; prior functioning – cognition; prior mobility/device aids; stage 2 pressure ulcer; stage 3, 4, or unstageable pressure ulcer; cognitive function; communication impairment; bladder incontinence; bowel incontinence; swallowing ability; total parenteral nutrition; history of falls; and comorbidities based on Hierarchical Condition Categories (HCCs).

(continued)

Table 2. (continued)
Measure Specifications Summary for the IRF Functional Outcome Measures

IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)	
Items	GG0130A. Eating GG0130B. Oral hygiene GG0130C. Toileting hygiene GG0130E. Shower/bathe self GG0130F. Upper body dressing GG0130G. Lower body dressing GG0130H. Putting on/taking off footwear
Numerator	The numerator is the number of patients in an IRF with a discharge self-care score that is equal to or higher than the calculated expected discharge self-care score.
Denominator	The denominator is the number of IRF Medicare patient stays, except those that meet the exclusion criteria.
Exclusion Criteria	1) Patients with incomplete stays. 2) Patients with the following medical conditions: coma; persistent vegetative state; complete tetraplegia; locked-in syndrome; or severe anoxic brain damage, cerebral edema or compression of brain. 3) Patients younger than age 21. 4) Patients discharged to hospice. 5) Patients who are not Medicare beneficiaries.
Risk Adjusters	Age group; admission self-care score – continuous; admission self-care score – squared; primary diagnosis group; interaction between admission self-care and primary diagnosis group; prior surgery; prior functioning – self-care; prior functioning – indoor ambulation; prior mobility/device aids; stage 2 pressure ulcer; stage 3, 4, or unstageable pressure ulcer; cognitive function; communication impairment; bladder incontinence; bowel incontinence; swallowing ability; and comorbidities based on Hierarchical Condition Categories (HCCs).

(continued)

Table 2. (continued)
Measure Specifications Summary for the IRF Functional Outcome Measures

IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)	
Items	GG0170A. Roll left and right GG0170B. Sit to lying GG0170C. Lying to sitting on side of bed GG0170D. Sit to stand GG0170E. Chair/bed-to-chair transfer GG0170F. Toilet transfer GG0170G. Car transfer GG0170I. Walk 10 feet GG0170J. Walk 50 feet with two turns GG0170K. Walk 150 feet GG0170L. Walking 10 feet on uneven surfaces GG0170M. 1 step (curb) GG0170N. 4 steps GG0170O. 12 steps. GG0170P. Picking up object
Numerator	The numerator is the number of patients in an IRF with a discharge mobility score that is equal to or higher than a calculated expected discharge mobility score.
Denominator	The denominator is the number of IRF Medicare patient stays, except those that meet the exclusion criteria.
Exclusion Criteria	1) Patients with incomplete stays. 2) Patients with the following medical conditions: coma; persistent vegetative state; complete tetraplegia; locked-in syndrome; or severe anoxic brain damage, cerebral edema or compression of brain. 3) Patients younger than age 21. 4) Patients discharged to hospice. 5) Patients who are not Medicare beneficiaries.
Risk Adjusters	Age group; admission mobility score – continuous; admission mobility score – squared; primary diagnosis group; interaction between admission mobility and primary diagnosis group; prior surgery; prior functioning – indoor ambulation; prior functioning – stair negotiation; prior functioning – cognition; prior mobility/device aids; stage 2 pressure ulcer; stage 3, 4, or unstageable pressure ulcer; cognitive function; communication impairment; bladder incontinence; bowel incontinence; swallowing ability; total parenteral nutrition; history of falls; and comorbidities based on Hierarchical Condition Categories (HCCs).

5.2.2 TEP Discussion and Recommendations

5.2.2.1 Risk Adjustment—The IRF TEP members discussed the measure specifications and risk factors included in the regression model. When asked about suggestions for new risk adjustors, several TEP members mentioned the importance of measuring severe cognitive impairment as a risk adjuster. Several TEP members noted that the function measures have limited ability to capture mobility improvement for patients using a wheelchair. RTI staff noted that the process measure includes 4 items related to wheelchair, including the type of wheelchair used to mobilize.

5.2.2.2 FIM™ Instrument and Section GG Items—Some TEP members were concerned that the FIM and IRF-PAI Section GG function items overlapped and that the different rating scales (1-7 for FIM and 01-06 for Section GG items) caused potential coding confusion among providers. They also noted added burden. One member of the panel expressed concern about comparisons of FIM and Section GG coding at her facility. RTI staff noted that a simple one-to-one comparison of FIM and GG item coding may not account for differences in the rating scales, item definitions, and coding instructions.

5.2.2.3 Consumer Usability and Interpretation—Several TEP members voiced their support for the functional outcome measures, in particular the discharge self-care and discharge mobility measures, stating that these are patient-focused measures tailored to what individual patients can achieve by discharge. Some TEP members supported all the Section GG function items being implemented across PAC settings and public reporting of the measures in the future, and the potential of comparing data across PACs. Several panel members voiced concern about a consumer's ability to interpret the function change scores and discharge scores. Some TEP members believed consumers may not understand the differences between the two types of measures; that is, the change scores and discharge scores. RTI agreed that plain language descriptions of the measures would be important and noted that the change measures are familiar to IRFs and quality measures reporting percent values, such as the discharge measures, can be easier for consumers to interpret.

SECTION 6
PERCENT OF RESIDENTS OR PATIENTS WITH PRESSURE ULCERS THAT ARE NEW OR WORSENED (SHORT STAY) (NQF #0678)

6.1 Measure Overview

6.1.1 Overview of Measure

The Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678) is an outcome measure that reports the percent of patients with Stage 2-4 pressure ulcers that are new or worsened since admission. This measure is a cross-setting IMPACT Act measure and addresses the domain of skin integrity or changes in skin integrity. This measure is intended to encourage IRFs to focus on this important clinical and patient safety issue to prevent pressure ulcers and to closely monitor and promote healing of existing pressure ulcers.

This measure was implemented for the short-stay nursing home population in the NH/SNF setting in 2010. This measure was finalized for use in the IRF QRP in the FY 2012 IRF PPS Final Rule (76 FR 47876) for FY 2014 and subsequent years' payment determination. Data collection for this measure began using the 2012 version of the IRF-PAI. This measure is also currently publicly reported on the CMS IRF Compare website.

This measure meets three of the six priorities of the Department of Health and Human Services, the Centers for Medicare and Medicaid, and the NQF including making care safer, promoting effective communication and coordination of care, and promoting wide use of best practices.

6.1.2 Overview of Measure Specifications

This stay-based pressure ulcer quality measure is calculated using data collected on the IRF-PAI for IRF patients. Data are collected separately in each of the three settings using standardized items that have been harmonized across the MDS, LTCH CARE Data Set, and IRF-PAI. For IRFs, this measure reports the percent of patients with reports of Stage 2-4 pressure ulcers that were not present or were at a lesser stage on admission. In IRFs, this measure includes Medicare (Part A and Medicare Advantage) patients.

This quality measure is calculated using data reported for three pressure ulcer items on the IRF-PAI. These items have been used since October 1, 2016 (prior to this date M0300 items were used in the measure calculation):

Item M0800A: "Worsening in pressure ulcer status since admission: Stage 2" and providers respond with the number of current pressure ulcers that were not present or were at a lesser stage on admission.

Item M0800B: "Worsening in pressure ulcer status since admission: Stage 3" and providers respond with the number of current pressure ulcers that were not present or were at a lesser stage on admission.

Item M0800C: "Worsening in pressure ulcer status since admission: Stage 4" and providers respond with the number of current pressure ulcers that were not present or were at a lesser stage on admission.

The numerator is the number of stays for which the IRF-PAI indicates one or more Stage 2-4 pressure ulcer(s) that are new or worsened at discharge compared to admission.

The denominator is the number of Medicare patient stays (Part A and Medicare Advantage) with an IRF-PAI, except those that meet the following exclusion criteria:

(1) Patient stay is excluded if data on new or worsened Stage 2, 3, and 4 pressure ulcers are missing at discharge.

(2) Patient stay is excluded if the patient died during the IRF stay.

The measure is risk adjusted for bed mobility limitations, bowel incontinence, diabetes or peripheral vascular disease, and low body mass index.

6.2 TEP Discussion and Recommendations

6.2.1 Incidence of New or Worsened Pressure Ulcers in the IRF Setting

Some TEP members commented on the utility of the pressure ulcer quality measure in the IRF setting as currently specified. Several TEP members noted the incidence of pressure ulcers in IRFs is relatively low when compared to other post-acute care settings, with one member noting this was likely due to characteristics of patients in an IRF setting. Some TEP members commented on the burden of collecting data for this measure which currently seems to be low in the IRF setting. One TEP member encouraged CMS to add a component that would capture improved or healed pressure ulcer status, as this was deemed more relevant to the IRF setting.

6.2.2 Need for Additional Training Materials

RTI sought TEP feedback on the need for additional training materials and guidance regarding the pressure ulcer quality measure for the IRF QRP. Several TEP members commented on training needs, with the major themes including the need for comprehensive coding guidance, clarification on "present on admission" and resolution of all training materials with National Pressure Ulcer Advisory Panel's (NPUAP) guidance.

One TEP member commented on some instances of lack of congruence between IRF-PAI instructions, NPUAP guidance and current clinical practices. Specifically, the TEP member noted that NPUAP definitions and the definitions that are currently in the IRF PAI manual are not always aligned. Two TEP members stressed the importance of aligning IRF-PAI training materials with NPUAP guidance and providing clarification in the IRF-PAI manual as to which current guidelines providers should follow when completing the wound assessments.

One TEP member commented on the need for additional training and guidance on identifying and coding worsened pressure ulcer status for the new or worsened pressure ulcer items. The TEP member also indicated a need for significant training on coding "present on

admission." The TEP member recommended that additional guidance be added to the M0300 items on the IRF-PAI manual and specific guidance and clarification regarding identifying and coding present on admission status for new or worsened pressure ulcers.

One TEP member requested comprehensive, cohesive coding guidance. The TEP member stated that current training resources tended to focus on exceptional coding cases and that providers would benefit from guidance on all potential coding scenarios. Finally, one TEP member agreed on the need for additional training and suggested utilizing other formats, such as pictures, videos, and interactive web-based training materials to supplement the existing training materials.

6.2.3 Risk Adjustment

The cross-setting pressure ulcer measure is currently risk adjusted for four factors: functional limitation (bed mobility), bowel incontinence, diabetes or peripheral vascular disease/peripheral arterial disease, and low body mass index. One TEP member recommended other comorbidities be added in addition to the existing vascular disease and peripheral arterial disease risk adjustors to account for patients with wounds that are considered non-healable. One TEP member recommended that urinary incontinence, in addition to bowel incontinence, be added as an additional risk adjustor. The same TEP member also recommended that prior surgeries, specifically prolonged surgery or surgery limiting patient mobility, such as transplant surgery, be considered for additional risk adjustment.

6.2.4 Additional Pressure Ulcer Item

One TEP member commented that while new or worsened unstageable pressure ulcers are reported on the IRF-PAI, providers have no way to document healed unstageable pressure ulcers on the IRF-PAI. The TEP member recommended an additional item to capture healed pressure ulcers be added to the IRF-PAI, and other TEP members concurred. One TEP member added that the size of pressure ulcers should be captured on the IRF-PAI assessment.

6.2.5 "Pressure Ulcer" versus "Pressure Injury" Terminology

Some TEP members sought clarification on CMS' intention to adopt the NPUAP's terminology and use the term "pressure injury" in place of "pressure ulcer" in the IRF-PAI, the quality measure, and training materials. A few TEP members agreed on the need to align terminology with stakeholders and across IRF QRP training materials. Some TEP members noted discussions amongst other stakeholders regarding the possible interpretation of the term "injury" and potential legal implications. One TEP member stressed the importance of giving thoughtful and careful consideration to adopting terminology that would not lead to increasing patient anxiety.

6.2.6 Considerations for public reporting

One TEP member also requested that the number of pressure ulcers be available to providers, either in provider reports, or as part of public reporting to validate provider data and account for risk adjustment. Several TEP members commented on how patients might interpret this quality measure. One TEP member suggested that reporting on low incidence occurrences would not be meaningful to patients or families. However, another TEP member perceived that

comparing scores across facilities would be valuable to patients and family members. One TEP member commented that including a range score and the percent of facilities with perfect scores would be valuable to patients and/or caregivers when selecting a facility. Another TEP member commented on the value of this quality measure being compared across PAC settings. There was general agreement that comparing the scores across the PAC settings would be helpful for patients and families in deciding which type of facility to select for care.

SECTION 7
READMISSION QUALITY MEASURES

7.1 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502)

7.1.1 Measure Overview

This quality measure calculates the facility-level all-cause unplanned risk-standardized readmission rate for 30-days post-discharge from IRFs. The goal of this measure is to improve patient care and transitions of care by monitoring hospital readmissions of patients using post-acute care. The measure is calculated using 2 calendar years of claims data.

This measure was first adopted into the IRF QRP in the FY 2014 IRF PPS Final Rule (78 FR 47906 through 47910). The measure was proposed and adopted again for the IRF QRP in the FY 2016 IRF PPS Final Rule (80 FR 47087 through 47089), to reflect NQF-endorsement. This measure is currently being publicly reported on the IRF Compare website.

7.1.2 Overview of Measure Specifications

Data used to calculate this outcome quality measure is collected through Medicare Fee-For-Service (FFS) claims. The measure does not have a simple form for the numerator and denominator. Instead, the numerator is the risk-adjusted estimate of the number of unplanned readmissions that occurred within 30 days from discharge. This estimate includes risk adjustment for patient characteristics and a statistical estimate of the facility effect beyond patient mix. The denominator is computed the same way as the numerator, but the facility effect is set at the average. It is the risk-adjusted expected number of readmissions. The “expected” number of readmissions is the predicted number of risk-adjusted readmissions if the same patients were treated at the average IRF. This measure includes all the IRF stays in the reporting period that are not excluded.

7.2 TEP Discussion and Recommendations

7.2.1 Need for More Detailed Information

CMS has received feedback that more detailed information (patient- or stay-level) is needed to use these readmission measures for quality improvement. TEP members reiterated this feedback during the meeting, noting that they can see their readmission rate and their performance category, but they need to understand the reason their patients are readmitted.

CMS and RTI clarified that CMS supports the intent to seek information that will drive improved quality but explained that they are not currently able to provide this level of information for the program due to Health Insurance Portability and Accountability Act (HIPAA) concerns. CMS and RTI clarified that they are actively investigating avenues by which greater detail may be made available in the future.

7.2.2 Feedback on Use and Usability

RTI requested input on ways that the measures could be more valuable to patients and families. It was mentioned that the risk adjustment data are helpful for a facility to understand what is impacting the readmission rate. From a patient and provider perspective, it was suggested that having multiple readmission quality measures is confusing and that the unplanned readmission measure may not be useful for quality improvement initiatives. The potentially preventable measure was preferred by some TEP members.

It was suggested that the comparative facility results are more easily understood by the public than the actual readmission rate. However, some TEP questioned whether it is misleading to categorize performance when most facilities are within 1 to 2 percentage points of the national average.

One TEP member noted a lag in the timeframe in which facilities are receiving data pertaining to the measures. RTI noted that CMS specified dates in the FY17 final rule for the confidential feedback report and public reporting, and the gap was shortened by about a year.

7.2.3 Other Feedback on Measure Specifications

RTI sought TEP input on any additional topics pertaining to the unplanned readmission measure. One suggestion was to exclude short IRF stays because these cases are paid differently based on payment system rules.

One TEP member asked whether there is risk adjustment for socio-economic status (SES). RTI explained that the all-cause unplanned readmission measure entered a 2-year trial period after initial NQF-endorsement in which SES risk adjustment testing was conducted using several patient-level and county-level indicators. The testing showed mixed results; there was not consistent evidence indicating that the measure specifications should be revised. CMS will continue to monitor this issue and continues to welcome input from the provider community.

TEP members discussed the Potentially Preventable Readmission (PPR) definition, which is based on the diagnosis coded by the hospital upon readmission and may differ from the IRF discharge diagnosis. RTI noted that the claims data are reliable, and testing was conducted to ensure that the data are accurate. Additionally, CMS is examining providing more detailed patient-level information as a mechanism for providers to see patients' diagnoses coded upon readmission.

7.3 Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP and Potentially Preventable Within Stay Readmission Measure for IRFs

7.3.1 Measure Overview

The Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRFs was developed to meet the requirements of the IMPACT Act of 2014. It calculates the facility-level unplanned and potentially preventable risk-standardized readmission rate for 30-days post-discharge from IRFs. The Potentially Preventable Within Stay Readmission Measure for IRFs was developed for use in the IRF QRP. It calculates the facility-level unplanned and potentially

preventable risk-standardized readmission rate for readmissions occurring within the IRF stay. Both measures are calculated on 2 calendar years of claims data.

PPRs are defined based on the principal diagnosis on the readmission claim. For post-IRF discharge, PPRs are unplanned readmissions that should be avoidable with adequately planned, explained, and implemented post discharge instructions, including the establishment of appropriate follow-up ambulatory care. For within-stay, PPRs are unplanned readmissions that should be avoidable with sufficient medical monitoring and appropriate patient treatment. The categories of potentially preventable readmissions include inadequate management of chronic conditions (e.g. CHF, hypertension), inadequate management of infections (e.g. septicemia, bacterial pneumonia), and inadequate management of other unplanned events (e.g. acute renal failure). For the within-stay measure, a fourth category is inadequate injury prevention during (e.g. lower extremity fracture).

These measures were adopted into the IRF QRP in the FY 2017 IRF PPS Final Rule (81 FR 52103 through 52111).

7.3.2 Overview of Measure Specifications

The post-PAC discharge PPR measures are based on Medicare FFS claims data and include PAC discharges to non-hospital post-acute levels of care or to the community. For measure calculation, the numerator is mathematically related to the number of patients in the target population who have a potentially preventable, unplanned readmission (PPR definitions and planned readmissions are further described in the measure specifications) during the 30 days following IRF discharge. 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 readmissions the numerator, and a predicted number the denominator. Instead, the numerator is the risk-adjusted estimate of the number of potentially preventable, unplanned readmissions that occurred within 30 days of IRF discharge. This estimate starts with the observed readmissions and is then risk-adjusted for patient characteristics and a statistical estimate of the facility effect, beyond patient case mix. The denominator is computed the same way as the numerator, but the facility effect is set at the average. It is the risk-adjusted expected number of readmissions. The "expected" number of readmissions is the predicted number of risk-adjusted readmissions if the same patients were treated at the average IRF.

This measure includes all the IRF stays in the measurement period that do not fall into an excluded category. Denominator exclusion criteria includes:

(1) Patients who died during the IRF stay.

(2) Patients less than 18 years old.

(3) Patients who were transferred at the end of a stay to another IRF or short-term acute care hospital.

(4) Patients who were not continuously enrolled in Part A FFS Medicare for the 12 months prior to the IRF admission date, and at least 30 days after IRF discharge date.

(5) Patients who did not have a short-term acute-care stay within 30 days prior to a IRF admission date.

(6) Patients discharged against medical advice (AMA).

(7) Patients for whom the prior short-term acute-care stay was for nonsurgical treatment of cancer.

(8) Patients who were transferred to a federal hospital from the PAC facility.

(9) Patients who received care from a provider located outside of the United States, Puerto Rico, or a U.S. territory.

(10) IRF stays with data that are problematic (e.g., anomalous records for hospital stays that overlap wholly or in part, or are otherwise erroneous or contradictory).

SECTION 8
DISCHARGE TO COMMUNITY–PAC IRF QRP

8.1 Measure Overview

8.1.1 Overview of Measure

The Discharge to Community – PAC IRF QRP measure reports an IRF's risk standardized rate of Medicare fee-for-service patients who are discharged to the community following an IRF stay, and do not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to community, and remain alive in the 31 days following discharge to community. RTI provided an overview of the measure, including the measure description, data sources, exclusion criteria, risk adjusters, and measure calculation. We noted that the IRFs are not expected to achieve a 100 percent discharge to community rate, as CMS recognizes that discharge to a community setting may not be appropriate for some PAC patients.

8.1.2 Overview of Measure Specifications

Data required for the calculation of this measure is collected via Medicare FFS claims. Discharge to community is determined based on the "Patient Discharge Status Code" from the PAC claim. Discharge to community is defined as discharge to home or self-care with or without home health services. The applicable Discharge Status Codes indicating discharge to community include 01, 06, 81, and 86. For measure calculation, the denominator 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.

The measure does not have a simple formula 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 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 post-acute 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.

8.2 TEP Discussion and Recommendations

8.2.1 Measure importance

One TEP member strongly emphasized the importance of the discharge to community measure, stating it was among the most important measures from a patient perspective. This TEP member stated that patients are focused on returning home and staying home.

8.2.2 Baseline nursing facility residents

One TEP member shared concerns regarding the proposed exclusion of post-acute stays that end in discharge to the same level of care. The concern was that the measure exclusion criteria fail to consider when a patient's home is a custodial nursing facility and the patient's post-acute episode involves a discharge back to their home. RTI noted similar feedback in previous public comment periods; however, RTI was not easily able to identify baseline nursing facility residents using claims data alone. RTI stated that use of assessment data to identify these residents is under consideration for future refinements of the measure.

8.2.3 Post-discharge readmissions

Two TEP members noted that there is overlap between the discharge to community and readmission measures as both capture post-discharge readmissions. One TEP member stated that this results in facilities being penalized twice for a single readmission. These TEP members supported removing the post-discharge readmissions component from the measure and only examining discharge destination as the outcome. One member noted that capturing readmissions only in the readmissions measure, and not in the discharge to community measure, would still drive quality improvement.

One TEP member stated that, rather than examining all-cause unplanned readmissions, the measure should examine potentially preventable readmissions in the post-discharge window stating that this would drive quality to a greater extent.

8.2.4 Risk adjustment for geography, socioeconomic factors, caregiver support

A few TEP members emphasized the importance of risk adjustment for geography, socioeconomic support, and caregiver support. Several TEP members noted that geography can be a proxy for caregiver support, and in areas that are primarily retirement communities, discharge to community can be limited due to the lack of caregiver support at home. One TEP member noted that caregiver support is a key factor that impacts both post-acute length of stay and the ability to discharge to the community. A TEP member stated that in retirement communities where patients live without caregiver support, IRFs often discharge patients to a SNF to regain a higher level of functional independence than would be required if they had support at home. One TEP member noted that perhaps socioeconomic factors did not have a significant impact on outcomes in other (readmissions) measures because of data limitations, and this lack of significance should not be interpreted to mean that socioeconomic factors do not

have an impact on outcomes. This TEP member noted that empirically, one would expect socioeconomic factors to impact discharge to community rates.

8.2.5 Actionability

One TEP member questioned the actionability of this measure for quality improvement by IRF providers stating that it would be difficult to invoke a relatively simple process improvement for physicians, nurses, and therapists.

8.2.6 Usability

One TEP member shared concerns about the usability of claims-based measures, and the lag between claims data submission and availability of quality data to providers.

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SECTION 9
MEDICARE SPENDING PER BENEFICIARY (MSPB)–PAC IRF QRP

9.1 Measure Overview

9.1.1 Overview of Measure

The MSPB-PAC IRF QRP measure evaluates IRF providers' resource use relative to the resource use of the national median IRF provider. Specifically, the measure reports the cost to Medicare for services performed by the IRF provider during an MSPB-PAC IRF episode.

9.1.2 Overview of Measure Specifications

Data required for the calculation of this measure is collected via Medicare FFS claims. The measure is calculated as the ratio of the price-standardized, risk-adjusted MSPB-PAC amount for each IRF divided by the episode-weighted median MSPB-PAC amount across all IRF providers.

The numerator for a PAC provider's MSPB-PAC measure is the MSPB-PAC Amount. The MSPB-PAC Amount is the average risk-adjusted episode spending across all episodes for the attributed provider, multiplied by the national average episode spending level for all PAC providers in the same setting.

The denominator for a PAC provider's MSPB-PAC measure is the episode-weighted national median of the MSPB-PAC Amounts across all PAC providers in the same setting.

9.2 TEP Discussion and Recommendations

9.2.1 Purpose of the measure

Several TEP member raised the question of the purpose of the MSPB-PAC measure. While understanding that the goal is to get a sense of spending across multiple sites of care, panel members requested clarity on how this measure ties back to quality and whether costs and quality would be measured over the same time periods. Panel member agreed that this measure cannot stand alone and needs to be tied to other quality measures. Panel members also noted that the time-period of the measure is important to consider.

9.2.2 Exclusions

TEP panel members raised the topic of clinically-related and clinically-unrelated services. They asked that the team consider service exclusions on the first day of the stay. They also asked that the team consider excluding patients discharged against medical advice and address short stays in the methodology.

9.2.3 Risk Adjustment

Panel members raised questions regarding the risk adjustment for the measure. Specifically, panel members asked that RTI consider whether the hierarchical condition categories (HCCs) are appropriate in this context. Panel members also raised the importance of

SES characteristics in predicting overall expenditures. Panel members requested that the RTI staff consider using the IRF Case-Mix Groups rather than rehabilitation impairment categories in the risk adjustment methodology to increase precision.

9.2.4 Beneficiary Impact

TEP panel members noted that this measure may have negative consequences for beneficiaries because of the incentives to reduce expenditures overall. Patients may not want to go to providers that perform well on this measure. It will be important to educate patients on how to make appropriate provider choices based on this measure to ensure that beneficiaries have access to high-quality providers.

SECTION 10
FUTURE MEASURES

10.1 TEP Discussion and Recommendations

The IRF TEP members were asked to provide general input about any future quality measures they would like to see implemented as part of the IRF QRP.

10.1.1 Experience of Care

One TEP member suggested creating a measure that captures patient experiences of care given that patient experience is measurable, actionable, and now has a strong scientific-basis in the clinical setting. RTI noted that an IRF-specific patient survey is currently under development. Another TEP member provided additional details about the survey and mentioned that it was developed by a separate TEP and the survey addresses various components of a patient's stay and rehabilitative care including physical therapy, occupational therapy, speech therapy, physician care, goal setting, and preparing for discharge. The survey was developed for the IRF setting and can be completed by the patient or the patient's caregiver. The TEP member added that the survey utilizes a frequency-based scale and is currently 10 pages long.

Several TEP members expressed concern over the survey's length; one TEP member who administers a patient survey in her IRF mentioned that one challenge in collecting this data is capturing patient experiences with the IRF stay and not the entire period of care including any acute-care hospital stays.

10.1.2 Measures that Address Sexual Function, Mental Health, Swallowing, Pain, and Fatigue

The TEP members also suggested developing quality measures that address cognitive function, sexual function, mental health (for the patient and the patient's family members), swallowing, pain, and fatigue or a patient's preparedness to handle increased fatigue. Several TEP members encouraged that future measures be outcome measures and not process measures, although they recognized that process measures are often a stepping stone to outcome measures.

10.1.3 Provider Burden and Retiring Measures

Several TEP members expressed concern that adding any additional measures to the program might be duplicative and would add unnecessary burden. One TEP member expressed concern about the burden with the current IRF-PAI. Several TEP members emphasized the need to measure the aspects of care that accurately capture and reflect quality of care. One TEP member suggested retiring measures that are less applicable to the IRF setting or that are very similar across IRFs. Other TEP members emphasized that future metrics should be calculated using data that is already collected.

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APPENDIX A
TEP IN-PERSON MEETING AGENDA

Development and Maintenance of Quality Measures for Inpatient Rehabilitation Facilities Quality Reporting Program (IRF QRP)

Technical Expert Panel Meeting Agenda

Monday, March 27, 2017
8:15 AM – 5:00 PM EST
BWI Marriot 1743 W Nursery Rd, Linthicum Heights, MD 21090

Time	Agenda Item	Lead(s)
8:15 – 8:30	**Welcome and Introductions** **Review of Agenda**	Laura Smith Anne Deutsch
8:30 – 9:30	• **Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)** • **Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)** • **Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC IRF QRP**	Amy Helburn Jill McArdle Erin White
9:30 – 11:15 (BREAK 10:15 – 10:30)	• **Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)** • **IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)** • **IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)** • **IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)** • **IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)**	Anne Deutsch
11:15 – 12:15	• **Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)**	Julie Seibert
12:15 – 1:15	**LUNCH BREAK (lunch not provided)**	
1:15 – 2:15	• **All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502)** • **Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP** • **Potentially Preventable Within Stay Readmission Measure for IRFs**	Laurie Coots
2:15 – 3:00	• **Discharge to Community–PAC IRF QRP** • **Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP**	Poonam Pardasaney Melissa Morley
3:00 – 3:15	**BREAK**	
3:15 - 4:45	**Future Measures**	Anne Deutsch
4:45 – 5:00	**Concluding Remarks & Meeting Summary**	Anne Deutsch

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APPENDIX B
DEVELOPMENT AND MAINTENANCE OF QUALITY MEASURES FOR INPATIENT REHABILITATION FACILITIES QUALITY REPORTING PROGRAM (IRF QRP) TECHNICAL EXPERT PANEL
March 27, 2017

IRF QRP Quality Measures*

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
1.	**Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)** This measure reports the percentage of stay-level records in which the patients were assessed and appropriately given the influenza vaccine during the most recent influenza vaccination season.	Effective prevention and treatment	Process	The numerator is the number of residents or patients in the denominator sample who, during the numerator time window, meet any one of the following criteria: (1) those who received the seasonal influenza vaccine during the most recently-completed influenza season, either in the facility/hospital or outside the facility/ hospital (NQF #0681a); (2) those who were offered and declined the seasonal influenza vaccine (NQF #0681b); or (3) those who were ineligible due to contraindication(s) (NQF #0681c). The numerator time window coincides with the most recently-completed seasonal IVS which begins on October 1 and ends on March 31 of the following year.	The denominator consists of patients or short-stay residents 180 days of age and older on the target date of the assessment who were in the facility/hospital for at least one day during the denominator time window.	N	Y	IRF-PAI	http://www.qualityforum.org/QPS/0680

(continued)

* CDC NHSN measures not listed

IRF QRP Quality Measures (continued)

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
2.	**Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)** This quality measure reports the percentage of patients/ residents who experience one or more falls with major injury during the SNF, LTCH, or IRF stay.	Making care safer	Outcome	The numerator is the number of Medicare (Part A or Medicare Advantage) patient stays during the selected time window who experienced one or more falls that resulted in major injury.	The denominator is the number of Medicare patient stays (Part A and Medicare Advantage) during the selected time window, except those who meet the exclusion criteria.	Y	Y	IRF-PAI	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF_Final_Rule_Quality_Measure_Specifications_7-29-2015.pdf (pp. 16-20)

(continued)

IRF QRP Quality Measures (continued)

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
3.	**Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC IRF QRP** This patient assessment - based process quality measure evaluates whether PAC providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified at the admission and throughout the patient stay.	Making care safer; Communication and Care Coordination	Process	The numerator is the number of stays for which the IRF-PAI indicated all the following are each true: 1) The facility conducted a drug regimen review at the admission (N2001= [0,1]) or patient is not taking any medications (N2001= [9]); and 2) If potential clinically significant medication issues were identified at the admission (N2001 = [1]), then the facility contacted a physician (or physician-designee) by midnight of the next calendar day and completed prescribed/ recommended actions in response to the identified issues (N2003= [1]); and 3) The facility contacted a physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission (N2005 = [1]) or no potential clinically significant medication issues were identified since the admission (N2005 = [9]).	The denominator is the number of Medicare patient stays (Part A and Medicare Advantage) during the reporting period.	N	N	IRF-PAI	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-IRF-QRP-Final-Rule.pdf (pp. 35-42; 783-788)

(continued)

IRF QRP Quality Measures (continued)

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
4.	**Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)** This quality measure reports the percent of patients/residents with an admission and a discharge functional assessment and a treatment goal that addresses function. The treatment goal provides evidence that a care plan with a goal has been established for the patient/ resident.	Patient and famil engagement	Process	The numerator is the number of patient/ resident stays with functional assessment data for each self-care and mobility activity and at least one self-care or mobility goal.	The denominator is the number of Medicare (Part A and Medicare Advantage) patient stays.	N	N	IRF-PAI	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF_Final_Rule_Quality_Measure_Specifications_7-29-2015.pdf (pp. 21-28; 63-68; 77-79)
5.	**IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)** This quality measure estimates the risk-adjusted mean change in self-care score between admission and discharge among IRF patients.	Effective prevention and treatment	Outcome	The measure does not have a simple form for the numerator and denominator. This measure estimates the risk-adjusted change in self-care score between admission and discharge among Inpatient Rehabilitation Facility (IRF) Medicare patients age 21 or older. The change in self-care score is calculated as the difference between the discharge self-care score and the admission self-care score.	The denominator is the number of Inpatient Rehabilitation Facility Medicare patient stays, except those that meet the exclusion criteria.	Y	Y	IRF-PAI	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF_Final_Rule_Quality_Measure_Specifications_7-29-2015.pdf (pp. 29-38; 69-79)

(continued)

IRF QRP Quality Measures (continued)

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
6.	**IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)** This quality measure estimates the risk-adjusted mean change in mobility score between admission and discharge among IRF patients.	Effective prevention and treatment	Outcome	The measure does not have a simple form for the numerator and denominator. This measure estimates the risk-adjusted change in mobility score between admission and discharge among Inpatient Rehabilitation Facility (IRF) patients age 21 and older. The change in mobility score is calculated as the difference between the discharge mobility score and the admission mobility score.	The denominator is the number of Inpatient Rehabilitation Facility Medicare patient stays, except those that meet the exclusion criteria.	Y	Y	IRF-PAI	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF_Final_Rule_Quality_Measure_Specifications_7-29-2015.pdf (pp. 39-47; 69-79)
7.	**IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)** This quality measure estimates the percentage of IRF patients who meet or exceed an expected discharge self-care score.	Effective prevention and treatment	Outcome	The numerator is the number of patients in an IRF with a discharge self-care score that is equal to or higher than the calculated expected discharge self-care score.	The denominator is the number of Inpatient Rehabilitation Facility Medicare patient stays, except those that meet the exclusion criteria.	Y	Y	IRF-PAI	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF_Final_Rule_Quality_Measure_Specifications_7-29-2015.pdf (pp. 48-54; 69-79)

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IRF QRP Quality Measures (continued)

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
8.	**IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)** This quality measure estimates the percentage of IRF patients who meet or exceed an expected discharge mobility score.	Effective prevention and treatment	Outcome	The numerator is the number of patients in an IRF with a discharge mobility score that is equal to or higher than a calculated expected discharge mobility score.	The denominator is the number of Inpatient Rehabilitation Facility Medicare patient stays, except those that meet the exclusion criteria.	Y	Y	IRF-PAI	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF_Final_Rule_Quality_Measure_Specifications_7-29-2015.pdf (pp. 55-62; 69-79)
9.	**Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)** This quality measure reports the percent of patients/short-stay residents with Stage 2-4 pressure ulcers that are new or worsened since admission.	Making care safer	Outcome	The numerator is the number of stays for which the IRF-PAI indicates one or more Stage 2-4 pressure ulcer(s) that are new or worsened at discharge compared to admission.	The denominator is the number of Medicare patient stays (Part A and Medicare Advantage) with an IRF-PAI assessment, except those that meet the exclusion criteria.	Y	Y	IRF-PAI	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF_Final_Rule_Quality_Measure_Specifications_7-29-2015.pdf (pp. 4-15)

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IRF QRP Quality Measures (continued)

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
10.	**All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs (NQF #2502)** This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients (Medicare fee-for-service beneficiaries) discharged from an IRF who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital, within 30 days of an IRF discharge.	Communication and care coordination	Outcome	The numerator is mathematically related to the number of patients in the target population who have an unplanned readmission in the 30-day post-discharge window. 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 readmissions the numerator and a predicted number the denominator. Instead, the numerator is the risk-adjusted estimate of the number of unplanned readmissions that occurred within 30 days from discharge. This estimate includes risk adjustment for patient characteristics and a statistical estimate of the facility effect beyond patient mix.	The denominator is computed the same way as the numerator, but the facility effect is set at the average. It is the risk-adjusted expected number of readmissions. The "expected" number of readmissions is the predicted number of risk-adjusted readmissions if the same patients were treated at the average IRF. This measure includes all the IRF stays in the measurement period that do not fall into an excluded category.	Y	Y	Medicare FFS claims	www.qualityforum.org/Qps/2502

(continued)

IRF QRP Quality Measures (continued)

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
11.	**Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP** This measure estimates the risk-standardized rate of unplanned, potentially preventable readmissions for patients (Medicare fee-for-service beneficiaries) discharged from an IRF who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital, in the 30 days post-IRF discharge.	Communication and care coordination	Outcome	The numerator is mathematically related to the number of patients in the target population who have a potentially preventable, unplanned readmission (PPR definitions and planned readmissions are further described in the measure specifications) during the 30 days following IRF discharge. 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 readmissions the numerator, and a predicted number the denominator. Instead, the numerator is the risk-adjusted estimate of the number of potentially preventable, unplanned readmissions that occurred within 30 days of IRF discharge. This estimate starts with the observed readmissions, and is then risk-adjusted for patient characteristics and a statistical estimate of the facility effect, beyond patient case mix.	The denominator is computed the same way as the numerator, but the facility effect is set at the average. It is the risk-adjusted expected number of readmissions. The "expected" number of readmissions is the predicted number of risk-adjusted readmissions if the same patients were treated at the average IRF. This measure includes all the IRF stays in the measurement period that do not fall into an excluded category.	Y	Y	Medicare FFS Claims	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-IRF-QRP-Final-Rule.pdf (pp. 17-31; 59-782)

(continued)

IRF QRP Quality Measures (continued)

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
12.	**Potentially Preventable Within Stay Readmission Measure for IRFs** This measure estimates the risk-standardized rate of unplanned, potentially preventable readmissions for patients (Medicare fee-for-service beneficiaries) who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital, during the IRF stay.	Communication and care coordination	Outcome	The numerator is mathematically related to the number of patients in the target population who have a potentially preventable, unplanned readmission (PPR definitions and planned readmissions are further described in the measure specifications) during the IRF stay. 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 readmissions the numerator, and a predicted number the denominator. Instead, the numerator is the risk-adjusted estimate of the number of potentially preventable, unplanned readmissions that occurred within the IRF stay. This estimate starts with the observed readmissions, and is then risk-adjusted for patient characteristics and a statistical estimate of the facility effect, beyond patient case mix.	The denominator is computed the same way as the numerator, but the facility effect is set at the average. It is the risk-adjusted expected number of readmissions. The "expected" number of readmissions is the predicted number of risk-adjusted readmissions if the same patients were treated at the average IRF. This measure includes all the IRF stays in the measurement period that do not fall into an excluded category.	Y	Y	Medicare FFS Claims	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-IRF-QRP-Final-Rule.pdf (pp. 17-33; 59-782)

(continued)

IRF QRP Quality Measures (continued)

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
13.	**Discharge to Community–PAC IRF QRP** This claims-based measure assesses successful discharge to the community from an IRF setting, with successful discharge to the community including no unplanned rehospitalizations and no death in the 31 days following discharge.	Communication and care coordination	Outcome	The measure numerator is the risk-adjusted estimate of the number of patients/residents 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/ resident characteristics and a statistical estimate of the facility effect beyond case mix.	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/resident 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/residents were treated at the average IRF.	Y	Y	Medicare FFS Claims	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-LTCH-QRP-Final-Rule.pdf (pp. 3-16; 43-58)

(continued)

IRF QRP Quality Measures (continued)

#	Measure Name Description	HHS and CMS Priorities for Improved Quality	Measure Type	Numerator	Denominator	Risk Adjusted Y/N	Exclusion Criteria Y/N	Method of Data Submission	Link to Measure Specifications (page #)
14.	**Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP** The MSPB-PAC measures evaluate PAC providers' resource use relative to the resource use of the national median PAC provider of the same type.	Making care affordable	Cost/ Resource Use	The numerator for a PAC provider's MSPB-PAC measure is the MSPB-PAC Amount. The MSPB-PAC Amount is the average risk-adjusted episode spending across all episodes for the attributed provider, multiplied by the national average episode spending level for all PAC providers in the same setting.	The denominator for a PAC provider's MSPB-PAC measure is the episode-weighted national median of the MSPB-PAC Amounts across all PAC providers in the same setting.	Y	Y	Medicare FFS Claims	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/2016_07_20_mspb_pac_ltch_irf_snf_measure_specs.pdf and https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Copy-of-2016_04_06_mspb_pac_irf_service_exclusions.xlsx

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APPENDIX C
IRF QRP TEP SLIDES

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RTI INTERNATIONAL

Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

Technical Expert Panel

BWI Marriott, MD

Monday, March 27, 2017
8:15 AM – 5:00 PM ET

RTI International

Development and Maintenance of Symptom Management Measures, HHSM-500-2013-13015I

Welcome and Housekeeping Issues

- Welcome and thank you!
- Materials and Agenda
- Restrooms
- Audio recording of meeting for notetaking
- Phone line for CMS and RTI staff
- Lunch (on our own)
- Wifi password: CMS2017

Introductions: TEP Members

1. Mary Ellen DeBardeleben, MBA, MPH, CJCP
2. Karen Green, PT, DPT
3. Brigid Greenberg, PT, MHS
4. Kurtis Hoppe, MD
5. Cristina Huerta, CRRN, MBA-HCM
6. Steven Lichtman, EdD, MAACVPR
7. Stephanie Nadolny, TRS, MHA
8. Pam Roberts, PhD, MSHA, OTR/I, SCFES, FAOTA, CPHQ, FNAP, FACRM
9. Mary Van de Kamp, MS, CCC-SLP
10. Alan Zaph, PT

Introductions: CMS and RTI Teams

CMS	RTI
Christine Grose	Anne Deutsch
Alan Levitt	Magda Ignaczak
Stacy Mandl	Holly Neumann
Tara McMullen	Lauren Palmer
Kelly Miles	Jessica Craig
Teresa Mota	Laura Smith
Charles Padgett	Laurie Coots
Mary Pratt	Terry Eng
Charlayne Van	Sarra Sabouri
Lorraine Wickiser	Lindsey Free
	Tri Le
	Debbie Kulik

TEP Charter

- The TEP Charter orients members to their roles and responsibilities.
- *Meeting Objective:* To obtain input on current quality measures implemented in the IRF QRP as well as future measures.
- List of TEP members
- Any questions about the TEP Charter?

Setting the Stage for Today's Discussions

- Measuring the quality of care for patients treated in IRFs using the measures adopted for the IRF QRP
  - Importance of the quality topic
  - Scientific soundness (date elements, exclusion criteria, numerator/ denominator definitions, risk adjustors)
  - Usability by consumers and providers
- Future measures
  - We have set aside time to hear your ideas about future measures
  - Several measures are undergoing testing at this time and these measure have their own TEPs
- We have different experiences and may have different perspectives on one or more of the quality measures

Agenda

8:15–8:30 am	Welcome and Introductions
8:30–9:30 am	Review of Influenza, Falls, and Drug Regimen Review Quality Measures
9:30–10:15 am	Review of Function and Functional Outcome Quality Measures
10:15–10:30 am	*Break*
10:30–11:15 am	Review of Function and Functional Outcome Quality Measures (Continued)
11:15–12:15 pm	Review of Pressure Ulcer Quality Measure
12:15–1:15 pm	*Break*
1:15–2:15 pm	Review of All-Cause Unplanned and Potentially Preventable Readmission Measures
2:15–3:00 pm	Review of Discharge to Community and MSPB Measures
3:00–3:15 pm	*Break*
3:15–4:45 pm	Discussion of Future Measures
4:45–5:00 pm	Concluding Remarks and Meeting Debrief

7

Inpatient Rehabilitation Facility Quality Reporting Program (IRF-QRP) - Overview

- IRF QRP was established under Section 3004 of the Patient Protection and Affordable Care Act of 2010
- Under the IRF QRP, the Center for Medicare and Medicaid Services requires Medicare-certified IRFs to submit data for quality measures
- Requirement applies to all patients receiving inpatient services in a facility designated as an IRF under Medicare
- Failure to submit quality data may result in a 2 percentage point reduction to the IRF's applicable fiscal year (FY) annual payment update

8

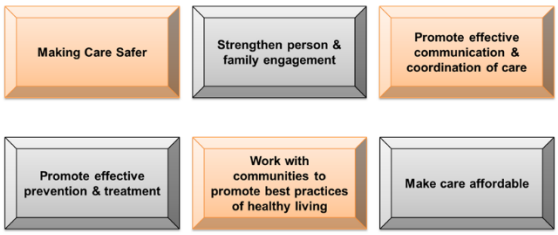
National Quality Strategy Promotes Better Health, Healthcare, and Lower Cost

The strategy is to concurrently pursue three aims:

Better Care	Improve overall quality by making health care more patient-centered, reliable, accessible, and safe
Healthy People / Healthy Communities	Improve population health by supporting proven interventions to address behavioral, social and environmental determinants of health, in addition to delivering higher-quality care
Affordable Care	Reduce the cost of quality healthcare for individuals, families, employers and government

9

The Six Priorities Have Become the Goals for the CMS Quality Strategy



10

IRF QRP – Quality Measures

- CMS has adopted 18 measures for the IRF QRP:
  - 9 IRF Patient Assessment Instrument (IRF-PAI) measures
  - 5 claims-based measures
  - 4 Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) measures (We will not be discussing CDC NHSN measures during this meeting).
- IRF QRP measures are prioritized under the National Quality Strategy (NQS) quality measure domains:

NQS Primary Measure Domain	Number of IRF QRP Adopted Measures
Making Care Safer	8
Person and Family Engagement	1
Effective Communication and Coordination of Care	6
Effective prevention and treatment practices	5
Working with communities	0
Making quality care more affordable	1

11

Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)

12

Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)
Description

This measure reports the percentage of stay-level records in which the patients were assessed and appropriately given the influenza vaccine during the most recent influenza vaccination season.

13

Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)
Numerator and Denominator Definitions

Numerator: Number of patients in the denominator sample who, during the numerator time window, meet any one of the following criteria:
(1) those who received the seasonal influenza vaccine during the most recently-completed influenza season, either in the facility/hospital or outside the facility/ hospital (NQF #0680a);
(2) those who were offered and declined the seasonal influenza vaccine (NQF #0680b); or
(3) those who were ineligible due to contraindication(s) (NQF #0680c).

The numerator time window coincides with the most recently-completed seasonal IVS which begins on October 1 and ends on March 31 of the following year.

Denominator: The denominator consists of patients or short-stay residents 180 days of age and older on the target date of the assessment who were in the facility/hospital for at least one day during the denominator time window.

14

Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)
Discussion

1) The rate of vaccine refusal in IRFs has been approximately 20% for the last two influenza seasons. This refusal rate is higher than that for other PAC settings. What do you think are some of the main reasons for refusal?
2) Do you view this percentage (20%) as high for refusals, and, if so, what are some ways to reduce this percentage?
3) Are there ways that this measure could be more valuable to patients and families?
4) Do you have any other comments or questions about this measure?

15

Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)

16

Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
Description

This quality measure reports the percentage of patients/ residents who experience one or more falls with major injury during the SNF, LTCH, or IRF stay.

17

Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
Numerator and Denominator Definitions

Numerator: The numerator is the number of Medicare (Part A and Part C) patient stays during the selected time window who experienced one or more falls that resulted in major injury.

Denominator: The denominator is the number of Medicare patient stays* (Part A and Part C) during the selected time window, except those who meet the exclusion criteria.

18

Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
TEP Discussion

1) Do you have suggestions for additional training opportunities or training materials?

2) Do you have any other comments or questions about this measure?

19

Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC IRF QRP

20

Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC IRF QRP
Description

This patient assessment-based process quality measure evaluates whether PAC providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified at the admission and throughout the patient stay.

21

Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC IRF QRP
Numerator and Denominator Definitions

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

1) The facility conducted a drug regimen review at the admission (N2001= [0,1]) or patient is not taking any medications (N2001= [9]); and
2) If potential clinically significant medication issues were identified at the admission (N2001 = [1]), then the facility contacted a physician (or physician-designee) by midnight of the next calendar day and completed prescribed/ recommended actions in response to the identified issues (N2003= [1]); and
3) The facility contacted a physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission (N2005 = [1]) or no potential clinically significant medication issues were identified since the admission (N2005 = [9]).

Denominator: The denominator is the number of Medicare patient stays (Part A or MA) during the reporting period.

22

Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC IRF QRP
TEP Discussion Questions

1) Do you have any suggestions for future refinements of the drug regimen review measure?

2) How do you currently monitor adverse events related to medications or high-risk medications?

3) Do you have any other comments or questions about this measure?

23

Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)

24

Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
Description

This quality measure reports the percent of patients/residents with an admission and a discharge functional assessment and a treatment goal that addresses function. The treatment goal provides evidence that a care plan with a goal has been established for the patient/resident.

25

Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
Numerator and Denominator Definitions

Numerator: The numerator is the number of patient/ resident stays with functional assessment data for each self-care and mobility activity and at least one self-care or mobility goal.

Denominator: The denominator is the number of Medicare (Part A and Part C) patient stays.

26

Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)
TEP Discussion

1) Do you have suggestions for additional training opportunities or different types of training materials?
2) Can you tell us about goal-setting in your IRF?
3) Do you have any other comments or questions about this measure?

27

IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)

28

IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Description

This quality measure estimates the risk-adjusted mean change in self-care score between admission and discharge among IRF patients.

29

IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Numerator and Denominator Definitions

Numerator: The measure does not have a simple form for the numerator and denominator. This measure estimates the risk-adjusted change in self-care score between admission and discharge among IRF Medicare patients age 21 or older. The change in self-care score is calculated as the difference between the discharge self-care score and the admission self-care score.

Denominator: The denominator is the number of IRF Medicare patient stays, except those that meet the exclusion criteria.

30

IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Exclusion Criteria

1) Patients with incomplete stays.
Rationale: It can be challenging to gather accurate discharge functional status data for patients who experience incomplete stays. Patients with incomplete stays include patients who are unexpectedly discharged to an acute care setting (Short-stay Acute Hospital, Critical Access Hospital, Inpatient Psychiatric Facility, or Long-term Care Hospital), because of a medical emergency; patients who die or leave an Inpatient Rehabilitation Facility (IRF) against medical advice; patients discharged directly to another IRF and patients with a length of stay less than 3 days.

2) Patients who are independent with all self-care activities at the time of admission.
Rationale: Patients who are independent with all the self-care items at the time of admission are assigned the highest score on all the self-care items, and thus, would not be able to show functional improvement on this same set of items at discharge.

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IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Exclusion Criteria (cont'd)

3) **Patients with the following medical conditions:** coma; persistent vegetative state; complete tetraplegia; locked-in syndrome; or severe anoxic brain damage, cerebral edema or compression of brain.
Rationale: These patients are excluded because they may have limited or less predictable mobility improvement with the selected self-care items.

4) **Patients younger than age 21.**
Rationale: There is only limited evidence published about functional outcomes for children.

5) **Patients discharged to hospice.**
Rationale: Patient goals may change during the IRF stay.

6) **Patients who are not Medicare beneficiaries.**

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IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Risk Factors

2633: Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients
Analysis Of GEE Parameter Estimates
Model-Based Standard Error Estimates

Risk Adjustor	Category	Number	Coefficient	Standard Error	95% Confidence Limits		Z	Pr > |Z|
Intercept		4769	22.224	1.88	18.54	25.91	11.83	< .0001
Age	<35 years	22	-2.216	1.25	-4.66	0.23	-1.78	0.0758
Age	35-44 years	54	-0.497	0.80	-2.06	1.07	-0.62	0.5338
Age	45-54 years	169	0.306	0.47	-0.62	1.23	0.65	0.5170
Age	55-64 years	332	-0.029	0.35	-0.71	0.65	-0.08	0.9338
Age	75-84 years	1829	-0.651	0.20	-1.05	-0.25	-3.22	0.0013
Age	85-90 years	692	-1.528	0.27	-2.06	-0.99	-5.6	< .0001
Age	90+ years	191	-2.246	0.45	-3.13	-1.36	-4.96	< .0001
Admission Self-Care - continuous form		4769	0.044	0.10	-0.16	0.24	0.43	0.6663
Admission Self-Care - squared form		4769	-0.016	0.00	-0.02	-0.01	-9.35	< .0001
Primary Diagnosis Group	Stroke	1040	-8.465	1.71	-11.81	-5.12	-4.96	< .0001
Primary Diagnosis Group	Non-Traumatic Brain Dysfunction	209	-2.310	2.05	-6.33	1.71	-1.13	0.2600
Primary Diagnosis Group	Traumatic Brain Dysfunction	194	-4.305	2.00	-8.23	-0.38	-2.15	0.0317
Primary Diagnosis Group	Non-Traumatic Spinal Cord Dysfunction	208	-5.945	2.11	-10.09	-1.80	-2.81	0.0049
Primary Diagnosis Group	Traumatic Spinal Cord Dysfunction	70	-10.715	2.23	-15.08	-6.35	-4.81	< .0001
Primary Diagnosis Group	Progressive Neurological Conditions	158	-9.621	2.20	-13.93	-5.32	-4.38	< .0001

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IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Risk Factors

Risk Adjustor	Category	Number	Coefficient	Standard Error	95% Confidence Limits		Z	Pr > |Z|
Primary Diagnosis Group	Other Neurological Conditions	220	-4.812	2.15	-9.03	-0.60	-2.24	0.0253
Primary Diagnosis Group	Fractures and Other Multiple Trauma	674	-5.262	1.87	-8.92	-1.60	-2.82	0.0048
Primary Diagnosis Group	Amputation	151	-5.513	2.33	-10.09	-0.94	-2.36	0.0182
Primary Diagnosis Group	Other Orthopaedic Conditions	481	-3.787	1.93	-7.57	0.00	-1.96	0.0500
Primary Diagnosis Group	Debility, Cardiorespiratory Conditions	839	-3.922	1.79	-7.43	-0.42	-2.19	0.0283
Primary Diagnosis Group	Medically Complex Conditions	130	-2.214	2.66	-7.43	3.00	-0.83	0.4051
Interaction of admission self-care score and primary diagnosis group	Stroke		0.287	0.07	0.15	0.42	4.25	< .0001
Interaction of admission self-care score and primary diagnosis group	Non-Traumatic Brain Dysfunction		0.054	0.08	-0.11	0.22	0.65	0.5177
Interaction of admission self-care score and primary diagnosis group	Traumatic Brain Dysfunction		0.151	0.08	-0.01	0.31	1.84	0.0663
Interaction of admission self-care score and primary diagnosis group	Non-Traumatic Spinal Cord Dysfunction		0.220	0.09	0.05	0.39	2.52	0.0116
Interaction of admission self-care score and primary diagnosis group	Traumatic Spinal Cord Dysfunction		0.402	0.10	0.20	0.60	3.97	< .0001
Interaction of admission self-care score and primary diagnosis group	Progressive Neurological Conditions		0.337	0.09	0.16	0.52	3.68	0.0002
Interaction of admission self-care score and primary diagnosis group	Other Neurological Conditions		0.166	0.09	0.00	0.34	1.91	0.0563
Interaction of admission self-care score and primary diagnosis group	Fractures and Other Multiple Trauma		0.178	0.08	0.03	0.33	2.35	0.0190

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IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Risk Factors

Risk Adjustor	Category	Number	Coefficient	Standard Error	95% Confidence Limits		Z	Pr > |Z|
Prior Acute or LTCH Primary Diagnosis (Surgical or Medical)	Surgical	2432	0.755	0.20	0.36	1.15	3.73	0.0002
Prior functioning: self-care	Dependent	96	-1.894	0.64	-3.15	-0.64	-2.95	0.0032
Prior functioning: self-care	Some help	901	-0.668	0.26	-1.19	-0.15	-2.52	0.0117
Prior functioning: indoor ambulation	Dependent, Some help	669	-1.026	0.31	-1.62	-0.43	-3.36	0.0008
Prior Mobility Device/Aid	Walker	1620	-0.760	0.19	-1.13	-0.39	-3.98	< .0001
Prior Mobility Device/Aid	Wheelchair/Scooter Full Time/Part Time	666	-0.772	0.28	-1.32	-0.22	-2.76	0.0059
Prior Mobility Device/Aid	Mechanical Lift	27	-4.307	1.13	-6.52	-2.09	-3.81	0.0001
Prior Mobility Device/Aid	Orthotics/Prosthetics	36	-1.673	0.96	-3.55	0.21	-1.75	0.0809
Stage 2 Pressure Ulcer	Present	324	-1.200	0.33	-1.85	-0.55	-3.6	0.0003
Stage 3, 4 or Unstageable Pressure Ulcer	Present	84	-1.230	0.64	-2.49	0.03	-1.91	0.0561
Cognitive Function: Brief Interview for Mental Status score	Moderately Impaired	1038	-0.809	0.22	-1.23	-0.39	-3.76	0.0002
Cognitive Function: Brief Interview for Mental Status score	Severely Impaired	536	-2.179	0.32	-2.80	-1.55	-6.83	< .0001
Communication Impairment	Moderate to Severe	643	-1.449	0.29	-2.02	-0.87	-4.94	< .0001
Bladder Incontinence	Less than daily, Daily, Always incontinent	943	-0.923	0.25	-1.40	-0.44	-3.76	0.0002
Bladder Incontinence	Urinary catheter	929	-0.731	0.24	-1.21	-0.25	-2.99	0.0027
Bowel Incontinence	Always incontinent	144	-1.582	0.52	-2.59	-0.57	-3.07	0.0021
Bowel Incontinence	Less than daily, Daily	596	-0.635	0.28	-1.19	-0.08	-2.26	0.0241

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IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Risk Factors

Risk Adjustor	Category	Number	Coefficient	Standard Error	95% Confidence Limits		Z	Pr > |Z|
Swallowing Ability	Modified Food Consistency	443	-0.562	0.30	-1.14	0.02	-1.89	0.0584
Swallowing Ability	Tube/Parenteral Feeding	100	-1.056	0.62	-2.26	0.15	-1.71	0.0864
Comorbidity	Major Infections: Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock (HCC2), Other Infectious Diseases (HCC7)	975	-0.722	0.21	-1.13	-0.31	-3.46	0.0005
Comorbidity	Central Nervous System Infections: Bacterial, Fungal, and Parasitic Central Nervous System Infections (HCC3), Viral and Late Effects Central Nervous System Infections (HCC4)	41	-1.235	0.89	-2.99	0.52	-1.38	0.1671
Comorbidity	Metastatic Cancer and Acute Leukemia (HCC8)	75	-2.171	0.66	-3.47	-0.87	-3.28	0.0010
Comorbidity	Diabetes: Diabetes with Chronic Complications (HCC18), Diabetes without Complication (HCC19), Type I Diabetes Mellitus (HCC20)	1521	-0.716	0.18	-1.07	-0.36	-3.9	< .0001
Comorbidity	Other Significant Endocrine and Metabolic Disorders (HCC23)	168	-0.827	0.45	-1.71	0.05	-1.84	0.0660
Comorbidity	Intestinal Obstruction/Perforation (HCC33)	132	-1.012	0.51	-2.01	-0.02	-1.99	0.0466
Comorbidity	Delirium and Encephalopathy (HCC50)	448	-0.710	0.29	-1.28	-0.14	-2.45	0.0142
Comorbidity	Dementia: Dementia With Complications (HCC51), Dementia Without Complications (HCC52)	703	-1.368	0.25	-1.86	-0.87	-5.42	< .0001
Comorbidity	Tetraplegia* (HCC70)	27	-2.604	1.13	-4.82	-0.39	-2.31	0.0210
Comorbidity	Paraplegia (HCC71)	39	-0.829	0.93	-2.65	0.99	-0.89	0.3729
Comorbidity	Multiple Sclerosis (HCC77)	21	-1.561	1.25	-4.00	0.88	-1.25	0.2100

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IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Risk Factors

Risk Adjustor	Category	Number	Coefficient	Standard Error	95% Confidence Limits		Z	Pr > |Z|
Comorbidity	Parkinson's and Huntington's Diseases (HCC78)	143	-0.817	0.49	-1.78	0.14	-1.67	0.0958
Comorbidity	Mononeuropathy, Other Neurological Conditions/Injuries (HCC81)	392	-0.469	0.30	-1.06	0.12	-1.55	0.1211
Comorbidity	Angina Pectoris (HCC88)	25	-1.974	1.14	-4.20	0.26	-1.73	0.0829
Comorbidity	Coronary Atherosclerosis/Other Chronic Ischemic Heart Disease (HCC89)	1208	-0.336	0.19	-0.71	0.04	-1.75	0.0801
Comorbidity	Hypertensive Heart Disease (HCC94)	75	-2.164	0.66	-3.46	-0.87	-3.28	0.0010
Comorbidity	Hemiplegia/Other Late Effects of CVA: Hemiplegia/Hemiparesis (HCC103), Late Effects of Cerebrovascular Disease Except Paralysis (HCC105)	254	-0.922	0.37	-1.65	-0.19	-2.47	0.0134
Comorbidity	Kidney Transplant Status (HCC132)	32	-1.359	1.02	-3.37	0.65	-1.33	0.1847
Comorbidity	Dialysis and Chronic Kidney Disease - Stage 5: Dialysis Status (HCC134), Chronic Kidney Disease, Stage 5 (HCC136)	150	-1.971	0.48	-2.91	-1.03	-4.1	<.0001
Comorbidity	Urinary Obstruction and Retention (HCC142)	553	-0.700	0.27	-1.23	-0.17	-2.59	0.0096
Comorbidity	Chronic Ulcer of Skin, Excluding Pressure Ulcer (HCC161)	59	-0.823	0.75	-2.30	0.66	-1.09	0.2755
Comorbidity	Amputations: Traumatic Amputations and Complications (HCC173), Amputation Status, Lower Limb/Amputation Complications (HCC189), Amputation Status, Upper Limb (HCC190)	62	-0.795	0.74	-2.24	0.65	-1.08	0.2801

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IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Discussion

1) Do you have any suggestions for future refinements of this functional outcome measure, including additional risk adjusters that we should examine?

2) Do you have any other comments or questions about this measure?

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IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)

39

IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
Description

This quality measure estimates the risk-adjusted mean change in mobility score between admission and discharge among IRF patients.

40

IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
Numerator and Denominator Definitions

Numerator: The measure does not have a simple form for the numerator and denominator. This measure estimates the risk-adjusted change in mobility score between admission and discharge among IRF patients age 21 and older. The change in mobility score is calculated as the difference between the discharge mobility score and the admission mobility score.

Denominator: The denominator is the number of IRF Medicare patient stays, except those that meet the exclusion criteria.

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IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
Discussion

1) Do you have any suggestions for future refinements of this functional outcome measure, including additional risk adjusters that we should examine?

2) Do you have any other comments or questions about this measure?

42

IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)

43

IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
Description

This quality measure estimates the percentage of IRF patients who meet or exceed an expected discharge self-care score.

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IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
Numerator and Denominator Definitions

Numerator: The numerator is the number of patients in an IRF with a discharge self-care score that is equal to or higher than the calculated expected discharge self-care score.

Denominator: The denominator is the number of IRF Medicare patient stays, except those that meet the exclusion criteria.

45

IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
Discussion

1) Do you have any suggestions for future refinements of this functional outcome measure, including additional risk adjusters that we should examine?

2) Do you have any other comments or questions about this measure?

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IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)

47

IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
Description

This quality measure estimates the percentage of IRF patients who meet or exceed an expected discharge mobility score.

48

IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
Numerator and Denominator Definitions

Numerator: The numerator is the number of patients in an IRF with a discharge mobility score that is equal to or higher than a calculated expected discharge mobility score.

Denominator: The denominator is the number of IRF Medicare patient stays, except those that meet the exclusion criteria.

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IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
Discussion

1) Do you have any suggestions for future refinements of this functional outcome measure, including additional risk adjusters that we should examine?

2) Do you have any other comments or questions about this measure?

50

Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)

51

Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)
Description

This quality measure reports the percent of patients/short-stay residents with Stage 2-4 pressure ulcers that are new or worsened since admission.

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Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)
Numerator and Denominator Definitions

Numerator: The numerator is the number of stays for which the IRF-PAI indicates one or more Stage 2-4 pressure ulcer(s) that are new or worsened at discharge compared to admission.

Denominator: The denominator is the number of Medicare patient stays* (Part A and Part C) with an IRF-PAI assessment, except those that meet the exclusion criteria.

53

Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)
Discussion

1) From your perspective, are there additional training needs for providers regarding the pressure ulcer quality measure?
2) What types of training or training materials would be helpful to providers regarding completion of pressure ulcer assessment items?
3) This measure is currently reported on IRF/LTCH Compare. Are there ways that this measure could be more valuable to patients and families?

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Agenda

8:15–8:30 am	Welcome and Introductions
8:30–9:30 am	Review of Influenza, Falls, and Drug Regimen Review Quality Measures
9:30–10:15 am	Review of Function and Functional Outcome Quality Measures
10:15–10:30 am	*Break*
10:30–11:15 am	Review of Function and Functional Outcome Quality Measures (Continued)
11:15–12:15 pm	Review of Pressure Ulcer Quality Measure
12:15–1:15 pm	*Lunch*
1:15–2:15 pm	Review of All-Cause Unplanned and Potentially Preventable Readmission Measures
2:15–3:00 pm	Review of Discharge to Community and MSPB Measures
3:00–3:15 pm	*Break*
3:15–4:45 pm	Discussion of Future Measures
4:45–5:00 pm	Concluding Remarks and Meeting Debrief

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Readmission Measures Adopted for the IRF QRP

1) All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs
   - NQF endorsed in 2014 (NQF #2502)
   - Adopted FY 2016
   - Publicly reported on *IRF Compare*
2) Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRFs – IMPACT Act
3) Potentially Preventable Within Stay Readmission Measure for IRFs
   - Adopted FY 2017
   - Confidential feedback reports – Oct 2017
   - Public reporting – Oct 2018

*Specifications are aligned except where noted

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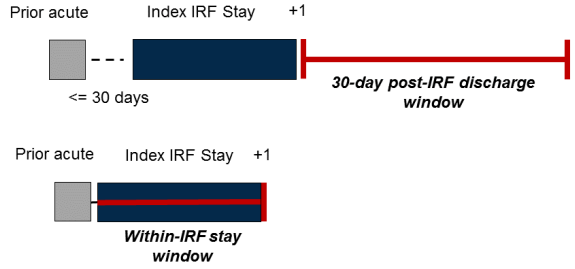
Overview of Readmission Measure Specifications

- Readmission windows



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Overview of Readmission Measure Specifications

- Measures exclude patients (not exhaustive list)
  - With no hospital stay prior to IRF admission
    - Post-dc measures: Within 30 days prior to index IRF
    - Within-stay: Within 1 day prior to index IRF
  - Not continuously enrolled in Part A FFS Medicare
  - Post-IRF discharge exclusions:
    - Who died during IRF stay
    - Were transferred at end of IRF stay
- Measures calculated on 2 CYs of claims data

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Risk-Adjustment

- Models compute probabilities of readmission with explanatory variables (i.e., risk adjusters)
- Source of principal diagnosis is the prior acute hospital claim
- Comorbidities from either the secondary diagnoses on the prior acute hospital claim or other claims in year prior to IRF admission

Risk Adjusters:

- Demographics: Age/sex and original reason for Medicare entitlement
- Principal diagnosis, grouped clinically using AHRQ's CCS codes
- Surgical indicators; procedures grouped using AHRQ's Clinical Classification Software (CCS)
- Comorbidities, clustered using CMS Hierarchical Condition Categories (HCCs)
- Prior Utilization: prior hospital LOS; prior acute ICU/CCU utilization; count of prior short-term discharges in the prior year
- IRF Case-Mix Groups – captures RIC and admission motor function

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Measure Calculation

- Consistent with other PAC and hospital readmission measures
- Use a hierarchical modeling approach to estimate a multi-level model with patient-stays clustered at the IRF level. A provider effect is estimated.
- Calculate a standardized risk ratio (SRR) as:
  - Numerator: the risk-adjusted number of *predicted* readmissions for an IRF's patient-stays, including a provider effect
  - Denominator: the risk-adjusted *expected* number of readmissions for same patients, excluding the provider effect
- SRR is then multiplied by the mean observed readmission rate in order to calculate the Risk-Standardized Readmission Rate (RSRR)

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Definition of Planned Readmissions

- IRF QRP hospital readmission measures **exclude** planned readmissions
- We use the CMS Planned Readmission Algorithm
  - List of procedure codes (ICD-9/ICD-10) that constitute planned admissions. If any of a defined set of acute principal diagnoses is present the admission reverts to unplanned.
- With TEP input, RTI International developed list of additional procedures common to PAC population for which readmissions would be considered planned.

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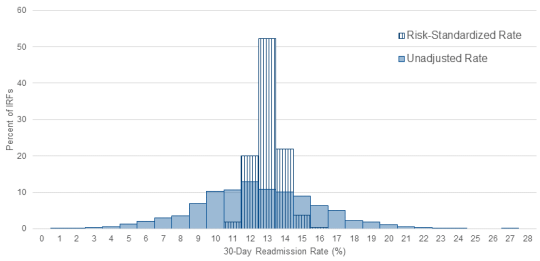
Distribution of Observed and Risk-Standardized All-Cause Readmission Rates Post-IRF Discharge



	All IRFs (N=1,166) Mean (SD)
Observed readmission rate	12.4% (3.6%)
Risk-standardized readmission rate	13.1% (0.8%)

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Source: RTI International analysis of Medicare claims data, 2013-2014. (RTI program reference: jc21)

Definition of Potentially Preventable Readmissions (PPR)

- In order for a readmission to be considered potentially preventable, it must be:
  - Unplanned
  - Coded as the principal diagnosis on readmission claim (some exceptions)

Conceptual framework: PPR refers to a readmission that should be avoidable with adequately planned, explained, and implemented post discharge instructions, including the establishment of appropriate follow-up ambulatory care

Grouped PPRs:

1. Inadequate management of chronic conditions (e.g. CHF, hypertension)
2. Inadequate management of infections (e.g. septicemia, bacterial pneumonia)
3. Inadequate management of other unplanned events (e.g. acute renal failure)

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IRF Post-Discharge PPRs

PPR Category PPR Condition Type	Number of PPR in IRF Sample	% PPR in IRF Sample	% of PPR
Inadequate management of chronic conditions	**10,062**	**1.77%**	**31.40%**
Adult asthma*	291	0.05%	0.91%
Chronic obstructive pulmonary disease (COPD)*	1,748	0.31%	5.45%
Congestive heart failure (CHF)*	6,391	1.13%	19.94%
Diabetes short-term complication*	633	0.11%	1.98%
Hypertension*/Hypotension	999	0.18%	3.12%
Inadequate management of infections	**14,701**	**2.59%**	**45.88%**
Influenza	129	0.02%	0.40%
Bacterial pneumonia*	2,820	0.50%	8.80%
Urinary tract infection*/ Kidney infection	2,867	0.50%	8.95%
C. difficile infection	1,162	0.20%	3.63%
Septicemia (except in labor)	6,540	1.15%	20.41%
Skin and subcutaneous tissue infections	1,183	0.21%	3.69%
Inadequate management of other unplanned events	**7,282**	**1.28%**	**22.72%**
Dehydration*/ Electrolyte imbalance	1,658	0.29%	5.17%
Aspiration pneumonitis (food/vomitus)	1,176	0.21%	3.67%
Acute renal failure*	2,837	0.50%	8.85%
Arrhythmia	1,416	0.25%	4.42%
Intestinal impaction	103	0.02%	0.32%
Pressure Ulcers	92	0.02%	0.29%
Total - Post-Discharge Potentially Preventable Readmissions	**32,045**	**5.64%**	**100.00%**
Total - All Cause, Unplanned Readmissions	**74,160**	**13.06%**	-

Notes: N = 567,850 in 2013-2014 IRF Sample, * Ambulatory Care Sensitive Condition
Source: RTI International analysis of Medicare claims data, 2013-2014. (RTI program reference: nc10_irf.xlsx)

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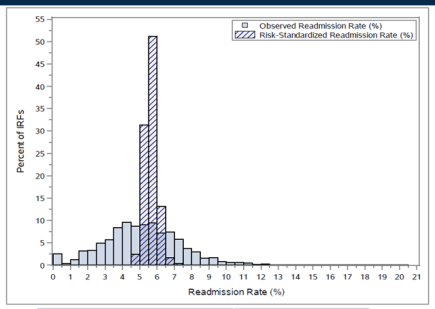
Distribution of Observed and Risk-Standardized PPR Rates Post-IRF Discharge



	All IRFs (N=1,166) Mean (SD)
Observed readmission rate	5.2% (2.3%)
Risk-standardized readmission rate	5.7% (0.4%)

65

Source: RTI International analysis of Medicare claims data, 2013-2014. (RTI program reference: jc29_histo3.pdf)

Definition of Within Stay PPRs

Conceptual framework: Within-Stay: PPRs should be avoidable with sufficient medical monitoring and appropriate patient treatment

Grouped PPRs:

1. Inadequate management of chronic conditions (e.g. CHF, hypertension)
2. Inadequate management of infections (e.g. septicemia, bacterial pneumonia)
3. Inadequate management of other unplanned events (e.g. acute renal failure)
4. **Inadequate injury prevention *only during PAC stay (e.g. lower extremity fracture)**

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IRF Within Stay PPRs

PPR Category PPR Condition Type	Number of PPR in IRF Sample	% PPR in IRF Sample	% of PPR
Inadequate management of chronic conditions	**5,493**	**0.91%**	**21.89%**
Adult asthma*	91	0.02%	0.36%
Chronic obstructive pulmonary disease (COPD)*	639	0.11%	2.55%
Congestive heart failure (CHF)*	3,781	0.62%	15.07%
Diabetes short-term complication*	230	0.04%	0.92%
Hypertension*/Hypotension	752	0.12%	3.00%
Inadequate management of infections	**9,982**	**1.65%**	**39.78%**
Influenza	70	0.01%	0.28%
Bacterial pneumonia*	1,886	0.31%	7.52%
Urinary tract infection*/ Kidney infection	1,097	0.18%	4.37%
C. difficile infection	432	0.07%	1.72%
Septicemia (except in labor)	6,249	1.03%	24.90%
Skin and subcutaneous tissue infections	248	0.04%	0.99%
Inadequate management of other unplanned events	**8,135**	**1.34%**	**32.42%**
Dehydration*/ Electrolyte imbalance	701	0.12%	2.79%
Aspiration pneumonitis (food/vomitus)	1,765	0.29%	7.03%
Anticoagulant complications (within-stay only)	230	0.04%	0.92%
Acute delirium (within-stay only)	10	0.00%	0.04%
Acute renal failure*	1,736	0.29%	6.92%
Arrhythmia	2,017	0.33%	8.04%
Deficiency and Other Anemia (within-stay only)	1	0.00%	0.00%
Intestinal impaction	50	0.01%	0.20%
Pressure ulcers	71	0.01%	0.28%
Deep Vein Thrombosis/Pulmonary Embolism (within-stay only)	1,554	0.26%	6.19%

Notes: N = 606,333 in 2013-2014 IRF Sample, * Ambulatory Care Sensitive Condition
Source: RTI International analysis of Medicare claims data, 2013-2014. (RTI program reference: RTI program reference: nc10wis_irf.xlsx)

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IRF Within Stay PPRs (cont'd)

PPR Category PPR Condition Type	Number of PPR in IRF Sample	% PPR in IRF Sample	% of PPR
Inadequate injury prevention	**1,483**	**0.24%**	**5.91%**
Head Injury (within-stay only)	621	0.10%	2.47%
Upper Extremity Fracture (within-stay only)	108	0.02%	0.43%
Lower Extremity Fracture (within-stay only)	754	0.12%	3.00%
Total - Post-Discharge Potentially Preventable Readmissions	**25,093**	**4.14%**	**100.00%**
Total - All Cause, Unplanned Readmissions	**57,837**	**9.54%**	**-**

Notes: N = 606,333 in 2013-2014 IRF Sample, * Ambulatory Care Sensitive Condition
Source: RTI International analysis of Medicare claims data, 2013-2014. (RTI program reference: RTI program reference: nc10wis_irf.xlsx)

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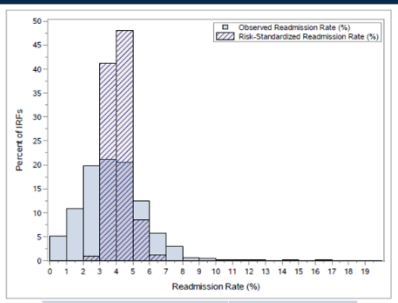
Distribution of Observed and Risk-Standardized PPR Rates Within IRF Stay



	All IRFs (N=1,166) Mean (SD)
Observed readmission rate	3.7% (1.9%)
Risk-standardized readmission rate	4.2% (0.6%)

Source: RTI International analysis of Medicare claims data, 2013-2014. (RTI program reference: db50_hist3.pdf, db53_1314wis_s1.xlsx, db53_1314wis_s2.xlsx)

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IRF QRP Readmission Measures
TEP Discussion Questions

1) We have received feedback that more detailed information (i.e. patient- or stay-level) is needed to use these readmission measures for quality improvement. CMS is working on this issue, but we would benefit from your feedback. What specific information would be most useful and how would it be useful?

2) Are there ways that these measures could be more valuable to patients and families?

3) Other questions and/or comments?

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Discharge to Community

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Discharge to Community–PAC IRF QRP: Description

- This measure reports an IRF's risk-standardized rate of Medicare FFS patients who are discharged to the community (DTC), and do not have an unplanned (re)admission to an acute care hospital or LTCH in the 31 days following discharge, and who remain alive during the 31 days following discharge.
- Dichotomous outcome (DTC = yes/no)
- Some patient exclusions applied to maintain data integrity & measure validity (e.g., discharges to psychiatric hospital or hospice, AMA discharges)
- The measure does not benchmark a 100% DTC rate

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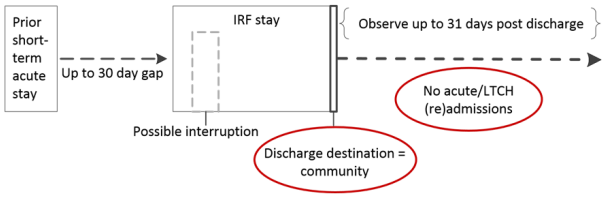
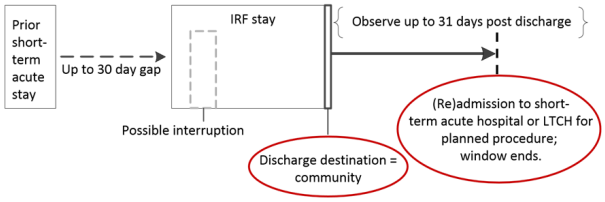
Discharge to Community Outcome = YES



Discharge destination is community and there are no acute/LTCH readmissions in the post-discharge observation window.

73

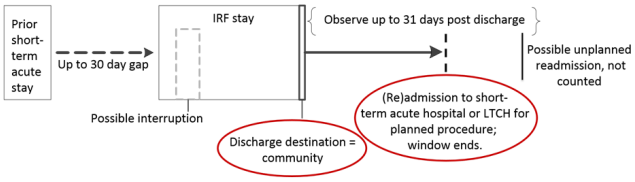
Discharge to Community Outcome = YES



Discharge destination is community and there is a planned acute/LTCH readmission in the post-discharge observation window.

74

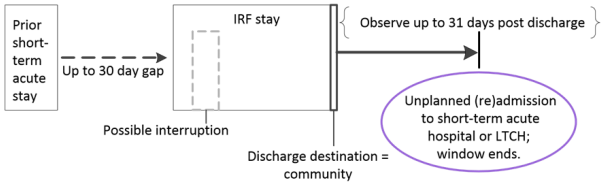
Discharge to Community Outcome = YES



Discharge destination is community followed by a planned acute/LTCH readmission in the observation window. Only the first readmission post-discharge is assessed; an unplanned readmission following a planned readmission is not counted.

75

Discharge to Community Outcome = NO



Discharge destination is community but there is an unplanned acute/LTCH (re)admission in the post-discharge observation window.

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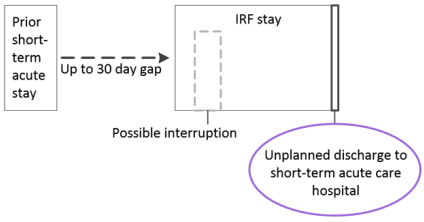
Discharge to Community Outcome = NO



Unplanned discharge to a short-term acute care hospital determines the discharge to community outcome (No). There is no post-discharge observation period.

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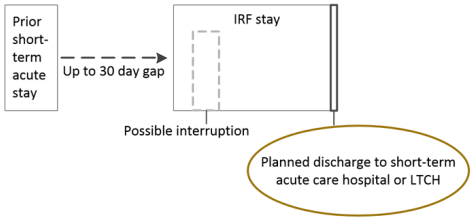
Planned Acute/LTCH Discharges Excluded from the Measure



Observation excluded from the measure because the patient has a planned discharge from IRF to acute care hospital or LTCH.

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Discharge to Community–PAC IRF QRP: Calculation

- ***Numerator = Risk-adjusted predicted number of DTC:***
  - Sum of predicted probability of DTC for each patient, risk-adjusted for patient characteristics & facility effect.
- ***Denominator = Risk-adjusted expected number of DTC:***
  - Represents the risk-adjusted predicted number of DTC if the same patients were treated at the average facility.
- ***Standardized Risk Ratio (SRR):***
  - Ratio of predicted-to-expected number of DTC
  - Measure of degree to which DTC rate is higher or lower than what would otherwise be expected.
- ***Risk-standardized DTC rate for each facility:***
  - SRR * national patient-level DTC rate

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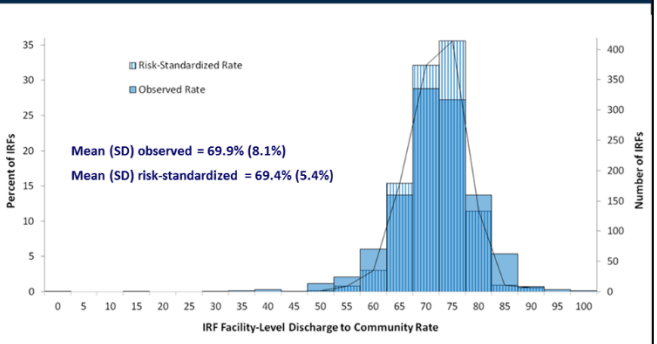
IRF Discharge to Community Rates, 2012-2013



Based on CY 2012-2013 Medicare FFS claims data from 1,164 IRFs. Facility-level number of IRF stays ranged from 1 to 6,760, with a mean of 484.0 and median of 329.0. Source: RTI analysis (RTI pgm reference: EG09 DTC-IRF_RA model_01).

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Discharge to Community–PAC IRF QRP: Discussion

1) Do you have any suggestions for future refinements of the discharge to community measure, including additional risk adjusters?
2) In your experience, do SES factors affect the DTC outcome, including determination of discharge destination? If yes:
   a) Please discuss how;
   b) How could this be captured in existing data sources?
3) On average, what proportion of IRF patients reside in a long-term nursing facility at baseline, prior to their hospitalization and IRF stay?

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Medicare Spending per Beneficiary

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Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP Definition

The MSPB-PAC measures evaluate PAC providers' resource use relative to the resource use of the national median PAC provider of the same type.

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Medicare Spending per Beneficiary (MSPB)–PAC IRF QRP Numerator and Denominator Definitions

Numerator: The numerator for a PAC provider's MSPB-PAC measure is the MSPB-PAC Amount. The MSPB-PAC Amount is the average risk-adjusted episode spending across all episodes for the attributed provider, multiplied by the national average episode spending level for all PAC providers in the same setting.

Denominator: The denominator for a PAC provider's MSPB-PAC measure is the episode-weighted national median of the MSPB-PAC Amounts across all PAC providers in the same setting.

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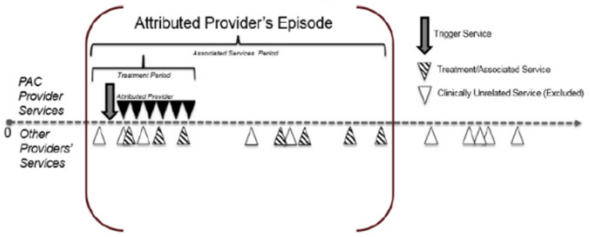
Medicare Spending per Beneficiary (MSPB) – PAC IRF QRP
Episode Window

Figure 1. MSPB-PAC Episode Window



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Medicare Spending per Beneficiary (MSPB) – PAC IRF QRP
Discussion

1) What characteristics are important to measure and include in risk adjustment model for this measure?
2) Other comments or questions?

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Agenda

8:15–8:30 am	Welcome and Introductions
8:30–9:30 am	Review of Influenza, Falls, and Drug Regimen Review Quality Measures
9:30–10:15 am	Review of Function and Functional Outcome Quality Measures
10:15–10:30 am	*Break*
10:30–11:15 am	Review of Function and Functional Outcome Quality Measures (Continued)
11:15–12:15 pm	Review of Pressure Ulcer Quality Measure
12:15–1:15 pm	*Lunch*
1:15–2:15 pm	Review of All-Cause Unplanned and Potentially Preventable Readmission Measures
2:15–3:00 pm	Review of Discharge to Community and MSPB Measures
3:00–3:15 pm	*Break*
3:15–4:45 pm	Discussion of Future Measures
4:45–5:00 pm	Concluding Remarks and Meeting Debrief

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Future Measures
Discussion

1) What other outcomes from claims data should be considered for the IRF QRP?

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THANK YOU

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