APPENDIX G
IRF-PAI COORDINATOR'S TRAINING MANUAL

IRF-PAI COORDINATOR

TRAINING MANUAL

Developing Quality Indicators for Inpatient Rehabilitation Facilities

October 2004

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IRF-PAI COORDINATOR TRAINING MANUAL

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OVERVIEW OF CMS' STUDY TO DEVELOP QUALITY INDICATORS FOR INPATIENT REHABILITATION FACILITIES

Study Purpose

This study is developing Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) measures that can be used in the future to measure the quality of care provided to IRF patients. These measures will be important to the Centers for Medicare and Medicaid Services (CMS) and inpatient rehabilitation facilities for monitoring rehabilitation care provided in the inpatient setting.

This Project, Developing Quality Indicators for Inpatient Rehabilitation Facilities, will test the effects of modifying certain items in the current IRF-PAI instrument. The mandatory items which are used to assign patients to payment categories will not be changed but the voluntary items which collect information on patient characteristics, personal circumstances, and other factors that are used in care and discharge planning will be re-evaluated in this study.

The goal of this study is to identify voluntary items that are useful for measuring quality of care or other factors that affect a patient's ability to improve their functional levels or other outcomes. These measures will allow comparisons of expected outcomes across patients in similar case mix groups. RTI, International has worked with CMS and a Technical Expert Panel comprised of expert physicians, therapists, nurses, researchers, providers, and provider associations to:

- Review the voluntary items on the IRF-PAI,
- Identify a draft set of items that should be removed because they are not useful for care planning, assessment, or comparing IRF cases, and
- Develop a small set of measures that can be used to compare patient differences that may affect their probability of improvement.

These changes have been designed to limit the reporting burden on providers and patients while developing meaningful measures that could control for differences in patient acuity, personal circumstances, and other factors that may affect the patients' potential for discharge home with optimal recovery of function.

Overview of the Pilot Study

When. This pilot study will collect data in 9 hospitals **between October and December, 2004**. Hospitals will be asked to collect data on all rehabilitation admissions within the study units for a **3-4 week period,** depending on the number of Medicare admissions to the hospital. These 9 hospitals will vary in terms of their size, geographic location, types of ownerships and affiliations, and whether they are freestanding facilities or rehabilitation units within larger acute hospitals.

What is Asked of Each Hospital? Each hospital will be asked to participate in three components:

1) Identify a Study Coordinator. This coordinator will be the primary liaison between RTI and the hospital. The study coordinator will train staff to complete the new form, oversee the data collection process and provide quality control.
2) Participate in interviews with the hospital's rehabilitation management team immediately prior to the data collection process to answer any questions, develop hospital-specific procedures, if necessary, and provide RTI staff an understanding of the types of patients treated in each hospital.
3) Data collection on all Medicare admissions during a 3-4 week period. A revised IRF-PAI instrument will be used to collect admission and discharge data on this cohort of rehabilitation patients. Because some items are collected at discharge, the actual study period may last up to 6 or 7 weeks. RTI will ask each hospital to identify an IRF-PAI Study Coordinator to oversee the data collection in each hospital and work with us as the data are being collected.

What is being piloted? CMS' goal is to improve the quality measures on the current IRF-PAI tool. **None of the mandatory items related to the payment system that are currently on the IRF-PAI instrument will be changed**. Participating hospitals will be given a tool with modified versions of the voluntary items.

ROLES AND RESPONSIBILITIES OF THE STUDY COORDINATOR

The Coordinator will be the study "point person" at each participating hospital, and will serve as the liaison with RTI project staff for the duration of the study. The coordinator role is critical to the success of the study, as they serve as the primary trainer, data manager, and liaison with the RTI project staff. Responsibilities include the following:

- Train all appropriate hospital staff who complete the IRF-PAI instrument on the new variables;
- Answer staff questions and liaison with RTI staff as needed to ensure consistent data collection methods;
- Collect and track completed IRF-PAI forms;
- Check forms for completeness and return them to RTI. RTI will provide directions and FedEx mailing materials for submitting the information. This is confidential data and must be protected in transit. It can not be emailed;
- Provide feedback on the revised form; and
- Answer any follow-up questions for up to three months after the data are submitted. This is largely to answer questions that may arise as the data are entered into the study system.

IRF-PAI REVISIONS

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EXPLANATION OF CHANGES TO IRF-PAI

Item(s)	Action	New Item Number(s)	Indicator Subject	Explanation/Justification
15	Revised	15	Admission Information	Response 4 was modified to read Intermediate Care/Long Term Care. Response 5 was coded to only refer to **Skilled** Nursing Facilities care.
16 through 20	Replaced	N16 through N21	Admission Information/ Premorbid social network	Replaced items with a new set of items (N16 through N21) adapted from the Living Arrangement and Supportive Assistance items (M0300 through M0380) in the Outcome and Assessment Information Set (OASIS-B1). These new items address TEP members request that the IRF-PAI include questions assessing premorbid social support because the amount of support available affects the probability of a patient being discharged back into the community. Therefore, the TEP recommended these items be included for risk-adjustment purposes in the IRF-PAI instrument. N16 through N19 refer to the pre-hospitalization period. Items N20 through N21 refer to expectations for discharge at both the time of admission and closer to discharge. Slight modifications were made to several of the OASIS items: • N16 - One new response was added to item 5 - Long Term Care Facility. • N19 - Members felt that the items currently on the IRF-PAI measuring prehospital living measures should be included, but that an additional item was needed to assess environmental considerations (i.e., family and social resources available to the discharged patient). • N20 - Two new responses were added to item N20 - 0-self and 6-more than one person.
25	Removed		Comatose	During the first TEP, panel members agreed that the comatose item was not necessary as it did not apply to most IRF patients (i.e. a patient would not be admitted to rehab if in a coma).

Item(s)	Action	New Item Number(s)	Indicator Subject	Explanation/Justification
26	Replaced	N27A through N27C	Delirious	TEP members suggested replacing this item with a question that evaluates if patient is oriented to time, person and place. A new question was developed which requires a yes/no answer to the following 3 questions: • Is patient oriented to self (i.e. knows his/her name) • Is patient oriented to place (i.e. knows he/she is in a rehab setting/hospital)? • Is patient oriented to time (i.e. the day, month, and year?)
27	Replaced	N28A	Swallowing	Added an item from the Swallowing Functional Communication Measure (FCM) in ASHA's National Outcomes Measurement System (NOMS). The FCM uses a seven-point rating scale designed to describe the change in an individual's functional communication ability over time, and can be used at admission and again at discharge to depict the amount of change in swallowing abilities after speech and language intervention. The seven-point rating scale and definitions are included as an appendix (Appendix B). This item addresses TEP member's request for a better item for assessing swallowing status because a measure of swallowing should be designed in a way that reinforces the importance of returning people to oral foods if possible, so as not to create an incentive for rehabilitation settings to continue using a feeding tube when it may not be necessary. The TEP suggested that a swallowing item also may be useful to risk adjust functional outcomes and community discharge. Please complete both swallowing items.
28	Removed		Dehydration	During the first TEP, panel members agreed that the dehydration item was not necessary.

Item(s)	Action	New Item Number(s)	Indicator Subject	Explanation/Justification
39	Replaced		FIM "Goal" Item/ Premorbid Physical Functioning	The "Goal" checkboxes were replaced with "3 Months Prior to Onset". The definition of Onset is provided in Appendix C. Adding this item addresses TEP member's request that a measure of premorbid physical functioning be added to the IRF-PAI. The TEP agreed that the level of physical functioning preinjury is important for risk adjusting a change in Functional Independence Measure (FIM) scores. The "Prior to Onset" checkbox was added because panel members decided that any scale used to measure physical functioning should be comparable to scores obtained by the FIM so data can be compared at admission and discharge.
44A	Clarified Responses		Discharge Setting	Clarified that Code 04 refers to long-term care facilities and that Code 05 refers to **skilled** nursing facilities. These match the choices in item 15: Admitted from.
50	Removed		Clearing Airways	TEP members suggested that the weak cough and difficulty clearing airways was not a necessary item.
51	Added/ Revised	50B through 50C Item 51 renumbered to 50A	Pain	A series of items were added to assess whether a patient's pain is being managed by the IRF and whether the pain a patient is experiencing is interfering with the patient's functioning. Several TEP members suggested that a pain management item could be used as a process measure and should be field tested.
52C through 52F	Retained	Item 52A and 52B renumbered to 51A and 51B	Pressure Ulcers/ PUSH Tool	During the first TEP, members suggested removing the PUSH Tool as a quality measure. General agreement by TEP that ulcers could be related to care in prior setting and are unlikely to heal during the short stay in IRF. They should not worsen, however. The PUSH Tool was retained, however, to measure change in ulcer.
53	Removed		Balance	During the first TEP, panel members expressed that the balance item was not useful as it is too difficult to define and measure.
54	Removed		Falls	TEP members did not feel this item adequately assessed patient safety because patients are expected to fall during the rehabilitation process.

Item(s)	Action	New Item Number(s)	Indicator Subject	Explanation/Justification
	Added	N52 (RIC-FAS) N53A through N53D (GDS)	Mood/Depression RIC-FAS Item GDS Item	RTI has identified ***two*** possible items that could be included to assess mood or depression. These new items address TEP members request that the IRF-PAI include an assessment of a patient's mood and/or depressive state as a case mix variable. Both items will be field tested. • **Option 1:** Item N52. This is an item adapted from the RIC Functional Assessment Scale (RIC-FAS) that uses a seven-point rating scale intended for use by IRF staff to determine any disturbances of mood experienced by the patient. The seven-point rating scale is included as an appendix (Appendix D). • **Option 2:** Items N53A through N53D. These questions are adapted from the 1-item and 4-item mood assessment questions on the Geriatric Depression Scale (GDS). These are self-report questions and a patient is asked to: "Give the answer that best describes how you felt over the past week." Count the number of shaded boxes - A through D - and report it in item 53E. Patients with a score of 2 or higher should be referred for a full psychiatric evaluation. Item 53F was added to document whether a patient is able to respond to the questions (i.e., express themselves).
	Added	N54	Mood/Depression	Item could be used as a process measure to assess whether or not IRF staff referred patients with a score of 2 or higher on mood item for a full evaluation. Several TEP members suggested that this item should be field tested because it could indicate whether patients are receiving necessary mental health services. The referral is for any mental health assessment during the stay. This item was created based on a suggestion by TEP members.

Item(s)	Action	New Item Number(s)	Indicator Subject	Explanation/Justification
	Added	N55	Engagement	Added an item to measure a patient's engagement in treatment adapted from the RIC Functional Assessment Scale (RIC-FAS) developed by the Rehabilitation Institute of Chicago. The RIC-FAS uses a seven-point rating scale assessed by staff working with the patient in the IRF. The seven-point rating scale is included as an appendix (Appendix D). Adding this item addresses the TEP member's request that an engagement item be included on the IRF-PAI in order to account for the wide range of factors that influence a patient's level of participation in rehabilitation. Members agreed that there are many different causes of nonparticipation—depression, anxiety, low arousal—all of which can interfere with the patient's ability to benefit from therapy and ultimately lead to poorer outcomes and that a measure was needed to assess whether a patient has the motivation to actively participate in therapy.

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DIRECTIONS FOR COMPLETING THE REVISED IRF-PAI

APPENDIX A
ITEM-BY-ITEM TIPS FOR SCORING OASIS ITEMS

Item N16: Pre-admission Residence (MO300):

1 - Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/significant other)
2 - Family member's residence
3 - Boarding home or rented room
4 - Board and care or assisted living facility
5 - Long-term care facility
6 - Other

DEFINITION:

Identifies where the patient is residing prior to admission.

RESPONSE—SPECIFIC INSTRUCTIONS:

- **1 - Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/significant other):** Dwelling considered to be the patient's own.
- **2 - Family member's residence**: Dwelling considered to belong to family member. Patient may be a temporary or permanent resident.
- **3 - Boarding home or rented room:** Room rented in a larger dwelling. Patient's room may be the only one rented or one of many. No specific health-related services or supervision are provided, though meals can be included.
- **4 - Board and care or assisted living facility:** Some care or health-related services are provided in conjunction with living quarters.
- **5 - Long-term care facility:** Nursing facility where patient lives on a long-term basis. Not a skilled nursing facility.
- **6 - Other:** None of the above.

ASSESSMENT STRATEGIES:

Interview the patient/caregiver regarding others living in the residence, their relationship to the patient, and any services being provided prior to admission.

Item N17: Patient Lives With (M0340):
1 - Lives alone
2 - With spouse or significant other
3 - With other family member
4 - With a friend
5 - With paid help (other than home care agency staff)
6 - With other than above

DEFINITION:
Identifies who the patient is living with prior to admission, even if the arrangement is temporary.

RESPONSE—SPECIFIC INSTRUCTIONS:
- "Other family member" could include in-laws, children, cousins, etc.
- "Paid help" would include help provided under a special program (e.g., Medicaid), even though the patient may not be directly paying for this help. Intermittent (e.g., a few hours each day, one to two days a week, etc.) paid help does not classify as help the patient "lives with."

ASSESSMENT STRATEGIES:
This is information all facilities need to know in planning care and services.

Item N18: Assisting Person(s) (M0350): (Mark all that apply.)
1 - Relatives, friends, or neighbors living outside the home
2 - Person residing in the home (EXCLUDING paid help)
3 - Paid help
4 - None of the above
5 - Unknown

DEFINITION:
Identifies the individuals who provide any type of assistance to the patient including the types in N19. If better information becomes available after the initial assessment period, please correct on the discharge PAI submission. This question still refers to the pre-admission period even if corrected later in the study.

RESPONSE—SPECIFIC INSTRUCTIONS:
- **Paid Help** includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family, or a specific program (e.g., a non-agency community program). Any home care agency that provides assistance to the patient would be classified as paid help. A patient living in an assisted living or nursing facility receives assistance from paid help.
- If patient does not receive assistance from others, mark Response 4 – None of the above.

ASSESSMENT STRATEGIES:
If the patient mentions a friend or relative helping or coming to visit, interview to find out more about who helps patient, how often, what helpers do, etc. (applies to Items 18-20). In obtaining the health history, interview to determine whether ADL/IADL assistance is needed. If it is, request information on whether patient received such assistance and from whom.

Item N19: Type of Primary Caregiver Assistance in the 3 months prior to the current onset (Adapted from M0380): (Mark all that apply.)
1 - ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
2 - IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances)
3 - Environmental support (housing, home maintenance)
4 - Psychosocial support (socialization, companionship, recreation)
5 - Advocates or facilitates patient's participation in appropriate medical care
6 - Financial agent, power of attorney, or conservator of finance
7 - Health care agent, conservator of person, or medical power of attorney
8 - Unknown

DEFINITION:
Identifies categories of assistance provided by the primary caregiver (identified in Item N18).

RESPONSE—SPECIFIC INSTRUCTIONS:
- **3 - Environmental support:** Includes home repair and upkeep, mowing lawn, shoveling snow, and painting.
- **4 - Psychosocial support:** Includes frequent visits or phone calls, going with patient for outings, church services, other events.
- **5 -Advocates or facilitates patient's participation in appropriate medical care:** Takes patient to medical appointments, follows up with filling prescriptions or making subsequent appointments, etc.
- **6 - Financial agent, power of attorney, or conservator of finance:** Legal arrangements that exist for finances.
- **7 - Health care agent, conservator of person, or medical power of attorney:** Legal arrangements that exist for health care
- **8 - Unknown**

ASSESSMENT STRATEGIES:
Interview questions about types of assistance are likely to produce answers that relate to ADLs and IADLs. More specific questions need to address other aspects of assistance. At start of care, discussion of advance directives can provide information about existing legal arrangements for decision-making.

Item N20: Primary Caregiver likely to take lead responsibility for providing or managing the patient's care once patient is discharged **(Adapted from M0360)**:
0 - Self
1 - Spouse or significant other
2 - Daughter or son
3 - Other family member
4 - Friend or neighbor or community or church member
5 - Paid help
6 - More than one person
7 - Unknown

DEFINITION:
Identifies the person who is likely to be "in charge" of providing and coordinating the patient's care once patient is discharged. A case manager hired to oversee care, but who does not provide any assistance is not considered the primary caregiver. This person may employ others to provide direct assistance, in which case "paid help" is considered the primary caregiver.

RESPONSE—SPECIFIC INSTRUCTIONS:
- If one person assumes lead responsibility for managing care, but another will provide the most frequent assistance, assess further to determine if one should be designated as primary caregiver or if Response 6 – More than one person is most appropriate.
- **Paid help** includes all individuals who will be paid to provide assistance to the patient, whether paid by the patient, family, or a specific program (e.g., community program).
- If the primary caregiver will be the patient himself (or herself), mark Response 0 - Self.

ASSESSMENT STRATEGIES:
Interview to determine who the patient thinks is most likely to be the primary caregiver after discharge. For example, ask, "Of the people who are likely to help you, is there one person who is 'in charge' of making sure things get done?" "Who would you call if you needed help or assistance?" Assess this at both admission and discharge. The admission item will provide information about the patient's pre-admission social support network; the discharge item will identify the patient's actual social support network.

Item N21: How Often could the patient receive assistance from the primary caregiver **(Adapted from M0370)**

1 - Several times during day and night
2 - Several times during day
3 - Once daily
4 - Three or more times per week
5 - One to two times per week
6 - Less often than weekly
7 - Unknown

DEFINITION:

Identifies the frequency of all help available from the primary caregiver (identified in Item N20). If more than 1 person is identified, use the sum of the combined expected frequency of assistance.

RESPONSE—SPECIFIC INSTRUCTIONS:

- Responses are arranged in order of most to least assistance received from primary caregiver.
- Please check "7 - Unknown" if the patient has no primary caregiver.

ASSESSMENT STRATEGIES:

Ask, in various ways, how often the primary caregiver could provide various types of assistance (e.g., "How often could your daughter come by? Could she go shopping for you every week? When she is here, could she do the laundry?"). As you proceed through the assessment (particularly the ADLs and IADLs), several opportunities arise to learn details of the help available to the patient.

APPENDIX B
ITEM N28A: CODING FOR SWALLOWING

Note: *In Levels 3–5, some patients may meet only one of the "and/or" criteria listed. If you have difficulty deciding on the most appropriate level for an individual, use dietary level as the most important criterion (unless dietary level is the result of dentition and not swallowing). Dietary levels at Levels 6 and 7 should be judged only on swallow function, and any influence of poor dentition should be disregarded. Definitions of dietary and cueing levels are on the next two pages of this appendix.*

LEVEL 7: The individual's ability to eat independently is not limited by swallow function. Swallowing would be safe and efficient for all consistencies. Compensatory strategies are effectively used when needed.

LEVEL 6: Swallowing is safe, and the individual eats and drinks independently and may rarely require cueing. The individual usually self-cues when difficulty occurs. May need to avoid specific food items (e.g., popcorn and nuts), or require additional time (due to dysphagia).

LEVEL 5: Swallowing is safe with minimal diet restriction and/or occasionally requires cueing to use compensatory strategies. The individual may occasionally self-cue. All nutrition and hydration needs are met by mouth at mealtime.

LEVEL 4: Swallowing is safe, but usually requires moderate cues to use compensatory strategies, and/or the individual has moderate diet restrictions and/or still requires tube feeding and/or oral supplements.

LEVEL 3: Alternative method of feeding required as individual takes less than 50% of nutrition and hydration by mouth, and/or swallowing is safe with moderate cues to use compensatory strategies and/or requires maximum diet restrictions.

LEVEL 2: Individual is not able to swallow safely by mouth for nutrition and hydration, but may eat food of some consistency by mouth with consistent maximal cues in therapy only. Alternative method of feeding required.

LEVEL 1: Individual is not able to swallow anything safely by mouth. All nutrition and hydration is received through non-oral means (e.g., nasogastric tube, PEG).

SOURCE: ASHA. (2003). National Outcomes Measurement System (NOMS): Adult Speech-Language Pathology User's Guide.

ITEM N28A. SWALLOWING – DIETARY RESTRICTIONS

Note: *Each level of swallowing items refers to dietary restrictions. Restrictions in both solids and liquids should be considered. Please review the following descriptions of dietary restrictions and diet level reductions for use in scoring item N28A.*

Dietary Levels/Restrictions

Maximum restrictions:	Diet is two or more levels below a regular diet status in solid and liquid consistency.
Moderate restrictions:	Diet is two or more levels below a regular diet status in either solid or liquid consistency (but not both), OR diet is one level below in both solid *and* liquid consistency.
Minimum restrictions:	Diet is one level below a regular diet status in solid *or* liquid consistency.

Diet Reduction Levels

Solids

Regular:	No restrictions.
Reduced one Level:	Meats are cooked until soft, with no tough or stringy foods. Might include meats like meat loaf, baked fish, and soft chicken. Vegetables are cooked soft.
Reduced two levels:	Meats are chopped or ground. Vegetables are of one consistency (e.g., soufflé, baked potato) or are mashed with a fork.
Reduced three levels:	Meats and vegetables are pureed.

Liquids

Regular:	Thin liquids; no restrictions.
Reduced one level:	Nectar, syrup; mildly thick.
Reduced two levels:	Honey; moderately thick.
Reduced three levels:	Pudding; extra think.

SOURCE: ASHA. (2003). National Outcomes Measurement System (NOMS): Adult Speech-Language Pathology User's Guide.

N28A. Swallowing- Dietary Restrictions (continued)

To rate a patient, use dietary level as most important determinant. Consider restrictions only due to swallowing problems.

1) Determine dietary food restrictions:

Liquid (level of liquids permitted)	Solid (level of solid food permitted)		Dietary Restrictions	Rating
No restrictions	No restrictions	→	None	7
No restrictions	No restrictions	→	Needs to avoid specific foods - or- need extra time	6
No restrictions	Soft meats and vegetables	→	Minimum	5
No restrictions	Chopped ground meats and vegetables -or- Pureed meats and vegetables	→	Moderate	4
Mildly thick: nectar, syrup	No restrictions	→	Minimum	5
Mildly thick: nectar, syrup	Soft meats and vegetables	→	Moderate	4
Moderate honey thick -or- Extra pudding thick	No restrictions	→	Moderate	4
Moderately honey thick -or- Extra pudding thick	Chopped ground meats and vegetables -or- Pureed meats and vegetables	→	Maximum	3
Swallows liquids and/or solids *only while in therapy*		→	Maximum; Therapy only	2
Complete restriction: unable to swallow any liquids or solids safely		→	Total	1

N28A. Swallowing- Dietary Restrictions (continued)

2) Determine Frequency and Intensity of Cueing:

Frequency		Intensity		Rating for Cueing
Rare: less than 20% of the time	and	Minimal: subtle and only one type	→	6
Occasionally: 20 to 49% of the time	and	Minimal: subtle and only one type	→	5
Usually: 50 to 79% of the time	and	Moderate: combination of cueing types, some may be intrusive	→	4
Consistent: 80 to 100% of the time	and	Moderate: combination of cueing types, some may be intrusive	→	3
Consistent: 80 to 100% of the time	and	Maximal: multiple cues, obvious to non-clinicians	→	2

Cueing types: auditory, visual, pictorial, tactile or written.

3) Determine amount of non-oral tube feedings and oral supplements.

Tube feedings/oral supplements		Rating
All nutrition and hydration needs met by mouth	→	7, 6 or 5: see diet restrictions and cueing
Requires tube feeding and/or oral supplements, but less than 50% of the time.	→	4
Patient takes less than 50% of nutrition and hydration by mouth (50+ % by alternative method)	→	3
Requires alternative method of feeding, but alternative feeding is not 100% of intake	→	2
All (100%) nutrition and hydration is received through non-oral means (e.g., NG, PEG tube)	→	1

ITEM N28A: SWALLOWING – CUEING LEVELS

Each level of the swallowing item contains references to the intensity and frequency of the cueing method and use of compensatory strategies that are required to assist the patient in becoming functional and independent. Both the amount and intensity of the cueing must be considered in scoring N28A. Familiarize yourself with the following descriptors and refer to them when scoring this item.

Frequency of Cueing

Consistent:	Required 80-100% of the time.
Usually:	50 -79% of the time.
Occasionally:	20-49% of the time.
Rarely:	Less than 20% of the time.

Intensity of Cueing

Maximal:	Multiple cues that are obvious to nonclinicians. Any combination of auditory, visual, pictorial, tactile, or written cues.
Moderate:	Combination of cueing types, some of which may be intrusive.
Minimal:	Subtle and only one type of cueing.

SOURCE: ASHA. (2003). National Outcomes Measurement System (NOMS): Adult Speech-Language Pathology User's Guide.

ITEM N28A. SWALLOWING SCALE

Note: Use dietary level as most important criterion. Consider dietary restrictions only due to swallowing problems.

Level	Liquid Restriction	Solid Restriction	Support Needed	Cueing Needed to Use Compensatory Strategy
7	No restrictions	No restrictions	None	None Independent Use of strategies
6	No restrictions	No restrictions; May avoid some specific food items	Rarely (less than 20% of the time) requires minimal support; May require extra time	Rarely (less than 20% of the time) when needed
5	Mildly thickened: nectar, syrup consistency	No restrictions	Occasional (20 to 49% of the time) requires minimal support	Occasionally (20 to 49% of the time) when needed
5	No restrictions	Soft diet: soft meats and vegetables		
4	Moderately or extra thickened: honey or pudding consistency	No restrictions	Usually (50 to 79% of the time) requires moderate support	Usually (50 to 79% of the time) requires cues to use strategies
4	No restrictions	Ground or puree diet: chopped or pureed meets and vegetables	May require non-oral or oral supplements	
4	Mildly thickened: nectar, syrup consistency	Soft diet: soft meats and vegetables		
3	Moderately or extra thickened: honey or pudding consistency	Ground or puree diet; takes less than 50% of nutrition orally	Consistently (80 to 100% of the time) requires moderate support Alternate feeding method required	Consistently (80 to 100% of the time) requires cues to use strategies
2	NPO In therapy only	NPO In therapy only	Consistently requires maximum support Alternate feeding method required	Not used
1	NPO	NPO	Total	Not used

APPENDIX C
ITEM 39: FIM ™ INSTRUMENT: 3 MONTHS PRIOR TO ONSET

***Note**: The time of Onset may vary for each Impairment Group. Please identify the patient's most typical dependent level during the 3 months prior to the onset of the condition being treated. This item will not be used as a change score but as a patient-specific benchmark for risk-adjustment.*

Stroke*

Date of admission to acute hospital. If this is not the patient's first stroke, enter the date of the most recent stroke.

Brain Dysfunction

Traumatic

Date of Injury

Brain Dysfunction (continued)

Non-traumatic

Most recent date of: Date of surgery (e.g., removal of brain tumor) or date of diagnosis

Neurological conditions

Multiple Sclerosis

Date of exacerbation.

All Remaining Neurological Conditions

Date of diagnosis

Spinal Cord Dysfunction

Traumatic

Date of injury

Non-traumatic

Most recent date of: Date of surgery (e.g., tumor) or date of diagnosis

Amputation

Date of most recent surgery

Arthritis

Date of diagnosis (if arthroplasty, see impairment group "Orthopaedic Conditions")

Pain Syndromes

Date of onset related to cause (e.g., fall, injury)

Orthopaedic Conditions

Fractures

Date of fracture

Replacement

Date of surgery

Cardiac Disorders

More recent date of: Date of diagnosis (event) or date of surgery (e.g., bypass, transplant)

Pulmonary Disorders

COPD

Date of initial diagnosis (not exacerbation)

Pulmonary Transplant

Date of surgery

Burns

Date of burn(s)

Congenital Deformities

Date of birth

Other Disabling Impairment

Date of diagnosis

Major Multiple Trauma

Date of trauma

Developmental Disabilities

Date of birth

Debility*

Date of acute hospital admission

Medically Complex Conditions*

Infections

Date of admission to acute hospital

Neoplasms

Date of admission to acute hospital

Nutrition

Date of admission to acute hospital

Circulatory
Date of admission to acute hospital

Respiratory
Date of admission to acute hospital

Terminal Care
Date of admission to acute hospital

Skin Disorders
Date of admission to acute hospital

Medical/Surgical
Date of admission to acute hospital

Other Medically Complex Conditions
Date of admission to acute hospital

* Note: If there was no admission to an acute hospital prior to the admission to the inpatient rehabilitation facility, consider the onset period to be the diagnosis of the impairment which led to the admission to the rehabilitation facility.

APPENDIX D
ITEMS N52 AND N55: USING THE RIC-FAS

Rating Principles

Similar to the FIM Instrument, RIC-FAS V is intended to measure a patient's actual level of functioning, regardless of diagnosis or impairment, rather than what a patient could or should be doing if certain circumstances were different. For example, an experienced clinician is well aware that a depressed patient could function at a higher level if not depressed. Nevertheless, when using RIC-FAS, the patient is assessed on the basis of the actual level of functioning at the time of assessment.

If there are changes in ratings when a patient is in a different environment or during different days, record the lowest score.

Ratings should be based on the best available information. Direct observation of a patient's behavior is preferred; however, credible reports of behavior may be gathered from the patient, other staff members, family, and friends. The medical record may also provide additional information about behaviors.

SOURCE: RIC Functional Assessment Scale, Version 5, Rehabilitation Institute of Chicago© 1998.

Item N52. RIC-FAS Versions: Coding for RIC-FAS Mood/Depression Item

Depression *includes a disturbance of mood characterized by feelings of sadness, hopelessness, worthlessness, and a pervasive loss of interest in usual activities. Moderate to severe depression may also be characterized by* ***changes in cognitive functioning*** *(e.g., reduced concentration) and/or* ***vegetative signs*** *such as decreased energy level, sleep/appetite disturbance, loss of libido, motor retardation, and somatic complaints that are not directly due to the patient's physical condition or age.*

Scale Points	Level	Behavioral Definition
7	No Problem	No evidence of depression.
6	Minimal Problem	Minimal signs of depressed mood are present (e.g. patient infrequently experiences sadness; patient expresses periodic concern or worry regarding future). Vegetative signs and cognitive changes attributable to depression are not present.
5	Mild Problem	Mild signs of depressed mood are present (e.g. patient occasionally experiences sadness and/or hopelessness; patient experiences difficulty "pushing myself" to engage in therapies and classes). Vegetative signs and cognitive changes attributable to depression are not present.
4	Mild to Moderate Problem	Mild-moderate signs of depressed mood are present (e.g. patient often reports sadness and/or hopelessness). Patient may demonstrate difficulty concentrating. Mild vegetative signs may also be present.
3	Moderate Problem	Moderate signs of depressed mood are present (e.g., patient frequently experiences sadness hopelessness without suicidal ideation; patient experiences anhedonia). Vegetative signs and/or cognitive changes attributable to depression are present (e.g., patient experiences sleep disturbance, appetite disturbance, and/or memory problems). Depression may interfere with and limit functioning.
2	Moderate to Severe Problem	Moderate-severe signs of depressed mood are present (e.g. subject consistently experiences sadness and/or hopelessness with transient suicidal ideation). Vegetative signs and/or cognitive changes attributable to depression are present. Depression interferes with and limits functioning.
1	Severe Problem	Extreme signs of depressed mood are present even with interventions (e.g., patient consistently experiences extreme hopelessness or anhedonia; patient reports suicidal ideation or suicidal intent). Vegetative signs and/or cognitive changes attributable to depression are prominent. Patient is unable to participate meaningfully in treatment.
0	Unable to Assess	

Item N55: Coding for Engagement Item

Engagement *includes the cognitive and emotional resources to comprehend the hospital environment, tolerate the typical frustrations of the setting and participate actively in the prescribed program. This concept is distinguished from reduced ability to participate which results from physical limitations.*

Scale Points	Level	Behavioral Definition
7	No Problem	Participates actively in therapies and other rehabilitation activities; consistently appreciates value of therapies; consistently places frustrations in perspective.
6	Minimal Problem	Participates actively in therapies/activities; infrequently questions value of therapies/activities or infrequently has difficulty dealing with frustrations.
5	Mild Problem	Requires occasional encouragement to participate in therapies/activities; occasionally questions value of therapies or occasionally has difficulty dealing with frustrations; occasionally late for therapy.
4	Mild to Moderate Problem	Requires ongoing encouragement to participate in therapies/activities; often questions value of therapies or has difficulty dealing with frustrations; may frequently arrive late for therapy (15 minutes/2 times a week)
3	Moderate Problem	Requires frequent encouragement to participate in therapies and other program activities; frequently questions value of therapies/activities or has difficulty dealing with frustrations; team spends much time explaining rehabilitation goals and rationale rather than executing treatment plan.
2	Moderate to Severe Problem	Requires consistent encouragement to participate in therapies; does not seem to value therapies or activities and continuously has difficulty dealing with frustrations. Frequently misses therapy (daily).
1	Severe Problem	Refuses to participate in therapies or other program activities even with interventions; requests discharge.
0	Unable to Assess	

TRAINING EXAMPLES

Swallowing: Examples for Rating (N28A)

1. Mrs. P. recently had a hip fracture when she fell at home. She reports to the nurse that she needs a mechanical soft diet because her dentures are still broken.

   Answer: 7 - No swallowing problem – Food consistency restrictions due to dentures, not a swallowing problem. Mrs. P. is eating independently and poor dentition does not factor in as swallowing problem.

2. Mr. R. is admitted to the rehabilitation facility for treatment of left hemiparesis following a stroke one week ago. He also had a stroke 6 months ago, and continues to have swallowing problems from the initial stroke. He cannot swallow thin liquids safely, but uses a thickening agent so that his fluids are mildly thick. The only assistance that he needs with eating is opening the thickening agent packet.

   Answer: Level 5 - Minimum food consistency restriction with use of a thickening agent to create mildly thick fluids. Because Mr. R. is on a full oral diet and only needs mildly thickened liquids (reduced one level), he is a Level 5.

3. Mr. G. is currently on a diabetic diet due to type II diabetes, and a mechanical soft diet due to poor dentition.

   Answer: Level 7 – Complete Independence – no swallowing problems. Food consistency restrictions due to poor dentition.

4. Mrs. H. does not have any dietary restrictions, but sometimes needs to swallow 2 or 3 times so that the food clears her throat due to difficulty with pharyngeal peristalsis. She requires verbal cues less than 10 percent of the time to use the compensatory strategy of extra swallows to clear the food.

   Answer: Level 6 - Mrs. H. swallows all types of food consistencies, but requires one type of cuing (verbal) less than 10% of the time (rarely).

5. Mr. L. does not have any food consistency restrictions. When he is tired, he may need verbal reminders that he needs to swallow more than once to clear his food from the throat. This occurs about 20 to 30 percent of the time.

   Answer: Level 5: Mr. L. needs minimal cues (one type) cues between 20 to 30 percent of the time (occasional).

6. While Mrs. N. eats, a helper provides verbal and tactile cuing so that Mrs. N. does not lift her fork to her mouth until she has swallowed what was in her mouth. The helper provides cuing about 60 to 70 percent of the time.

   Answer: Level 4– Mrs. N. usually (50 to 79% of the time) needs moderate cuing more than one type) to eat safely.

7. Mr. S. is unable to swallow liquids safely; he needs extra thick liquids (e.g., pudding consistency). Solid foods must be chopped or ground and vegetables must be one consistency. He eats meals without assistance, but a nurse administers water through his PEG tube 4 times a day to ensure he is adequately hydrated.

   Answer: Level 3 - Mr. S. has maximum dietary restriction (3 levels below regular liquid status AND 2 levels below regular solids status) and needs alternate feeding.

8. Mrs. I. must eat slowly and swallow multiple times to be sure that the food clears her throat. Her meats and vegetables are cooked until soft, and she is restricted to mildly thick liquids.

   Answer: Level 4 - Mrs. I. has moderate diet restrictions. Solid and liquid consistency restrictions: Mildly thick liquids and soft meats and vegetables. Mrs. I. is one level below solid AND liquid consistency.

9. Mr. S. is unable to swallow thin liquids safely. Her liquids must be extra thick. She does not need any supplemental nutrition and fluids.

   Answer: Level 4 –Liquid restrictions only, moderate restrictions. Mr. S. is 2 or more levels below liquid consistency.

10. Mrs. Y.'s food intake is limited to foods such as applesauce, yogurt and pureed meats. About 60 percent of her calories and fluid needs are received from PEG feedings, which are administered by her husband.

    Answer: Level 3 – More than half of her nutrition/hydration is administered via a PEG tube. Maximum dietary restrictions. Diet is 3 levels below a regular diet.

11. Mrs. Y.'s liquid and food intake is limited to moderately thick liquids and pureed solids. She takes in enough food and liquid by mouth and no longer receives non-oral supplements.

    Answer: Level 3 – Maximum restriction both solid and liquid restrictions that are reduced 3 and 2 levels. Even though Mrs. Y. is able to maintain all nutrition/hydration by mouth, she still has maximum dietary restrictions.

12. Mr. A. eats between 5 to 8 bites of food during his therapy session with the swallowing therapist. He gets essentially all his nutrition and fluids through his gastrostomy tube, which is administered by a nurse.

    Answer: Level 2 – A nurse administers essentially all of his nutrition/fluid intake via gastrostomy tube. All nutrition and hydration are received by G-tube. Mr. A. can tolerate some consistency in therapy only. Presumably a patient like this who could only take a few bites during session is needed max cues.

13. Mr. S., with a history of Parkinson's disease, was referred for a speech, language, and swallowing evaluation because of some choking incidents and deterioration in his medical condition. Oral motor examination revealed mild weakness in lingual and labial strength and function. Bedside swallowing examination revealed the presence of dysphagia, characterized by pocketing, delayed initiation of the swallow, and weakness of the laryngeal mechanism. Mr. S is able to tolerate a mechanical soft diet with syrup-thick liquids when using a chin-down technique. He is at risk for aspiration.

    Answer: Level 4 - Mr. S. has a moderate restriction in his diet level, as indicated by the mechanical soft diet and the thick syrupy liquids (down one level in both solid and liquid consistency).

14. At discharge, Mr. S.'s swallowing problem had improved partly due to a change in medication. Mr. Sheffield was able to resume a regular diet with thin liquids and on the occasional instances when he encountered difficulty; he was able to independently use compensatory strategies.

    Answer: Level 7. Mr. S. has resumed a regular diet, is able to use compensatory strategies independently when needed, and is not dependent on any external assistance to make him independent.

15. At discharge, Mr. W. is eating a regular diet and drinking thin liquids. However, due to poor dentition, he is unable to manage meats well.

    Answer: Level 7. Mr. W. is able to eat a regular diet and does not exhibit any clinical signs of dysphagia. His difficulty eating meats is due to poor dentition and is not a result of any swallowing disorder.

16. Ms. M. eats breakfast and lunch independently each day. She is on a regular diet with thin liquids (although she still can't eat her beloved cornbread). She needs overall additional time to eat. Due to increased fatigue at the end of the day, she uses compensatory strategies for the evening meal.

    Answer: Level 6. Needs additional time due to dysphagia and avoids specific food items (cornbread). Uses compensatory strategies when needed.

17. Mr. R. drools profusely, and has an ineffective voluntary cough. Suctioning is used to manage his secretions, and he has decreased safety awareness. He has an NG for all PO intake.

    Answer: Level 1. Not able to swallow anything by mouth. All nutrition and hydration via NG-tube.

18. Mr. P. has multiple sclerosis. He has had a recent exacerbation that required hospitalization to increase his overall strength. With minimal cueing, he is tolerating ground foods, but his intake is reduced due to his need for additional time to complete the meal as a result of both his oral and limb weakness. He, therefore, gets between-meal oral supplements.

    Answer: Level 4. Mr. P. has moderate dietary restrictions (2 or more levels below solid consistency only) and requires oral supplement.

Mood/Depression (RIC FAS): Examples for Rating (Item N52)

Depression includes a disturbance of mood characterized by feelings of sadness, hopelessness, worthlessness, and a pervasive loss of interest in usual activities. Moderate to severe depression may also be characterized by *changes in cognitive functioning* (e.g., reduced concentration) and/or *vegetative signs* such as decreased energy level, sleep appetite disturbance, loss of libido, motor retardation, and somatic complaints that are not directly due to the patient's physical condition or age.

1. Mrs. J. is recovering from a hip fracture she experienced 4 days ago. She expressed concern and sadness to her daughter once, telling her that she is worried about returning home, because she didn't want to fall again. Mrs. J. does not have any difficulty with sleeping or changes in her appetite or concentration level.

   Answer: Level 6 - Minimal Problem – Mrs. J. has expressed concern once in 4 days (infrequent) about the future. No vegetative signs or cognitive changes.

2. Mr. B.'s wife reports that he is sad that he cannot take care of himself, and that he has not been eating well or sleeping well since his stroke. Mr. B.'s therapists and nurses have remarked that Mr. B. will often say "I can't do it" when he is asked to practice self-care and mobility tasks. With encouragement he will try some tasks, but his depressed mood does interfere with daily activities and his rehabilitation program. Overall, staff agree that he is frequently sad, but he has had some good moments.

   Answer: Level 3 - Moderate Problem – Mr. B. is frequently sad, he experiences some sleep and appetite disturbances.

3. Mrs. W. told one of her nurses and one of her therapists that she does not want to be a burden on her daughters. She reports that she often feels hopeless about her future, and wonders if "everyone would be better off if I was in an old folks home, because my girls wouldn't need to worry about me." She participates in therapy activities, but at times need encouragement to practice skills. She reports that she is feeling "OK," but that she doesn't always feel like eating much of her meals.

   Answer: Level 4 - Mild to Moderate Problem – Mrs. W. expresses hopelessness often, and reports appetite disturbances.

Engagement (RIC FAS): Examples for Rating (Item N55)

Engagement includes the cognitive and emotional resources to comprehend the hospital environment, tolerate the typical frustrations of the setting and participate actively in the prescribed program. This concept is distinguished from reduced ability to participate which results from physical limitations.

1. Mr. W. actively participates in therapy and other program activities. On occasion, he has difficulty performing new skills in therapy, and he has angry outbursts. With some encouragement from the therapist, he is ready to resume therapy after a few minutes.

   Answer: 5 – Mild Problem: Mr. W. occasionally has difficulty dealing with frustrations and needs encouragement.

2. Mrs. M. often refuses to perform tasks that are requested of her during therapy sessions. She explains that therapy is "useless for an old lady like me." The nursing staff report that although Mrs. M. has the ability to dress her upper body with moderate assistance, the nurses essentially dress Mrs. M. in the morning so that she arrives to her therapy session on time. With ongoing encouragement from the nursing staff, she performs her daily tasks in the evening when there is more time.

   Answer: Level 4 – Mild to Moderate Problem - Mrs. M. needs ongoing encouragement, often refuses to perform tasks in therapy.

3. Mr. H. participates actively in therapy and other activities on the patient care unit. He expresses some frustration when he has difficulty performing daily activities, but acknowledges that he needs to keep trying if he wants to get it right. Staff agree that Mr. H. consistently puts his frustrations in perspective.

   Answer: 7 – No Problem – Mr. H. participates actively in rehabilitation program and places frustrations in perspective

STUDY ADMINISTRATION

Data Collection Process

Each participating hospital will have a two-day site visit on or after October 11, 2004. Data collection will begin on day three, the first day following the site visit. The revised IRF-PAI should be used for each new admission between the first day of the study and continuing for 3-4 weeks, and again at the time of discharge for each of these patients. Data collection will end when the last patient of that cohort is discharged, approximately 6 weeks from the study's beginning.

The revised IRF-PAI forms are color-coded.

- Yellow = Admissions
- Pink = Discharge

The Coordinator will work with appropriate hospital staff to develop the best process for completing the revised IRF-PAI forms. A copy of the revised form will be placed in each new admission's records so it can be referred to during the assessment process.

Track Sheet

A Track Sheet is also provided to record patient names, Medicare health insurance numbers, admission and discharge dates, and dates that the forms are shipped to RTI.
(See Page 55)

Feedback and Support Listserve

Feedback from the Coordinators is an important part of this study. We are very interested in your opinion about the strengths and weaknesses of the revised form and welcome any suggestions for improvement. In some cases, such as the swallowing and depression items, we are testing pairs of items to see which should be included in the final form. Please use the **Feedback** form to send us your comments on a weekly basis along with the revised IRF-PAI forms and Track Sheet copies. A sample of the study Feedback form is on page 56.

An IRF-PAI **Listserve** is available to provide support for Coordinators during the study. Please enter your questions into the listserve and RTI project staff will answer them on a daily basis. The listserve enables us to have an on-going conversation with study coordinators and provides the benefit of immediate problem-solving and information sharing among Coordinators and project staff.

Listserve address: RTI-IRFPAI-L@PUBLISTSRV.RTI.ORG

Data Submission

Please review each form for completeness before shipping them to RTI on a weekly basis. Retain a copy of each IRF-PAI for your records and submit the originals to RTI. We would like to have the Feedback forms and a copy of the Track Sheets used during the week. We will also need hardcopies of the data you submit electronically at discharge to CMS on these patients. Please staple or clip the revised form with a copy of the CMS submission for each patient.

Please ship the following to Deborah Osber, using the FedEx labels from RTI:

- Completed revised IRF-PAIs (originals)
- Copies of the IRF-PAI data electronically submitted to CMS on these patients (attached to the pink discharge forms)
- Copies of the week's Tracking Sheets
- Feedback forms

Directions for Using the FedEx Labels

The FedEx labels have been preaddressed for your convenience. You need only to complete Section 1 with the date, your name, address, phone number, your hospital's account number, and the yellow shaded sections that apply for shipping (size of package, how shipped, etc.) It is not necessary for you to fill out any other account numbers. We have done that for you.

This package can be left at your usual FedEx drop area, dropped in any FedEx box or called in for pickup at 1-800-GoFedEx (1-800-463-3339).

For any problems with shipping, please contact our project secretary:
Nanci Pepoli at 781/788-8100 x192 or npepoli@rti.org.

IRF-PAI STUDY TRACK SHEET

Site: _____ Coordinator: _____ Page: _____

Study ID	Patient Name	HIC #*	Admit Date	Date FedX'd	Discharge Date	Date FedX'd
001						
002						
003						
004						
005						
006						
007						
008						
010						
011						
012						
013						
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024						
025						
026						

* If patient's Medicare # changes during the study, please provide both the old and new numbers.

REVISED IRF-PAI STUDY FEEDBACK

Site: _____

Coordinator: _____

We welcome your comments on the form's strengths and weaknesses, including any suggestions you and your staff may have regarding its use or content.

Date Comment

SITE VISIT OVERVIEW

The site visit at your hospital will occur on _____.

Each participating hospital will have a two-day site visit by a two-person team of RTI project staff. The first day will include interviews with your hospital's rehabilitation management team and a meeting with you to finalize the training and data collection procedures. The second day is primarily devoted to training your staff to use the revised IRF-PAI through a series of one-hour training sessions.

Interviews

The site visit team and Coordinator will meet with the hospital management team including the Directors of Rehabilitation, Quality, Nursing, Therapy, and Case Management during the first day to introduce the study, answer any questions from management, and discuss the issues involved in IRF-PAI administration at the site. Coordinators may include other individuals who play an important role in IRF-PAI administration, such as unit supervisors or the Director of MIS, as each site is organizationally unique. Ideally all individuals can attend one group interview, but schedules and individual preferences may require more than one meeting. Interviews are expected to last an hour at most.

Training Sessions

- ***Kick-off Meeting***
  Prior to the management team interviews, the site visit team will meet with the Coordinator (and their back-up person, if available) for up to one and a half hours to review the plan for administering the revised IRF-PAI. This allows adequate time for discussing the logistics of this study, addressing any questions about study administration, and any remaining planning needs for the staff trainings. It is recommended that the Kick-off take place during the first site visit day. It should occur prior to any staff trainings.

- ***Staff Trainings***
  All staff affected by the IRF-PAI revisions will need to be trained to use the new instrument. We anticipate that this will include all therapists, case workers, and nurses on all three shifts. (The site visit team is prepared to come in during the night shift at the end of the first site visit day.) The Coordinator will arrange the times and places for group trainings, which will last about an hour. Ideally training can take place in a room with a VCR.

  Trainings will begin with an introduction of the study by the site visit team, followed by the changes in the IRF-PAI, instructions on how to complete the revised items, and practice examples lead by the Coordinator. The site visit team will provide all needed materials for the trainings, including the Staff Training Booklet, copies of the revised forms, and the training video created from the September Coordinators Training at RTI.

REVIEW AND SUMMARY

This CMS effort to improve the data that will be used to monitor quality of care in the inpatient rehabilitation facilities will affect all Medicare participating Inpatient Rehabilitation Facilities. Thank you for taking this important opportunity to help shape Medicare policy. In summary, this study will involve:

- 9 hospitals nationally distributed
- Data collection on all new admissions during a 3-4 week study enrollment period
- Use of a modified IRF-PAI (admission and discharge data on select items)
- Contributing to Federal policymaking procedures for monitoring quality of care

RTI CONTACT INFORMATION

We look forward to working with you on this important Federal initiative. If you have any questions or concerns, please feel free to contact me at the information listed below:

Barbara Gage, Ph.D.
Principal Investigator
RTI, International
781-788-8100 x151
Bgage@rti.org

THANK YOU FOR YOUR PARTICIPATION IN THIS IMPORTANT AND EXCITING STUDY TO IMPROVE THE IRF-PAI!

CENTERS FOR MEDICARE AND MEDICAID SERVICES

RTI, INTERNATIONAL