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**Technical Expert Panel Summary Report:  
Development of a Discharge to Community Quality  
Measure for Skilled Nursing Facilities (SNFs), Inpatient  
Rehabilitation Facilities (IRFs),  
Long-Term Care Hospitals (LTCHs),  
and Home Health Agencies (HHAs)**

**Deliverables 11 & 14**

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TECHNICAL EXPERT PANEL SUMMARY REPORT:  
DEVELOPMENT OF A DISCHARGE TO COMMUNITY QUALITY MEASURE FOR  
SKILLED NURSING FACILITIES (SNFs), INPATIENT REHABILITATION FACILITIES  
(IRFs), LONG-TERM CARE HOSPITALS (LTCHs), AND HOME HEALTH AGENCIES  
(HHAs)

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## LIST OF ACRONYMS AND SHORT FORMS

CAH	Critical Access Hospital
CMS	Centers for Medicare & Medicaid Services
HHA	Home Health Agency
ICU	Intensive Care Unit
IMPACT Act	Improving Medicare Post-Acute Care Transformation Act of 2014
IRF	Inpatient Rehabilitation Facility
IRF-PAI	Inpatient Rehabilitation Facility-Patient Assessment Instrument
LTCH	Long-Term Care Hospital
MA	Medicare Advantage
MDS	Minimum Data Set
NF	Nursing Facility
OASIS	Outcome and Assessment Information Set
PAC	Post-Acute Care
PPS	Prospective Payment System
QRP	Quality Reporting Program
SNF	Skilled Nursing Facility
RTI	Research Triangle Institute
RUG	Resource Utilization Group
TEP	Technical Expert Panel

## **SECTION 1 INTRODUCTION AND OVERVIEW**

### **1.1 Introduction**

On behalf of the Centers for Medicare & Medicaid Services (CMS), RTI International and Abt Associates convened a Technical Expert Panel (TEP) to seek expert input on the development of a Discharge to Community Quality Measure for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs). Three TEP meetings were held; the first was an all-day, in-person meeting on August 25, 2015, in Baltimore, MD. Two follow-up TEP webinars were held on September 25, 2015, and October 5, 2015.

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

### **1.2 Background**

CMS has contracted with RTI and Abt Associates to develop quality measures reflective of quality of care, resource use and other measures for post-acute care (PAC) settings in order to meet the mandate of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) and to support CMS quality missions. The PAC settings include SNFs, IRFs, LTCHs and HHAs.

The contract names are Development and Maintenance of Symptom Management Measures (HHSM-500-2013-13015I; Task Order HHSM-500-T0001) and Outcome and Assessment Information Set (OASIS) Quality Measure Development and Maintenance (HHSM-500-2013-13001I; Task Order HHSM-500-T0002). As part of its measure development process, CMS asks contractors to convene groups of stakeholders and experts who contribute direction and thoughtful input to the measure contractor during measure development and maintenance.

The objective of the TEP meetings was to seek expert input on the direction and development of a cross-setting discharge to community measure for PAC settings, including standardized items and specifications such as inclusion/exclusion criteria, numerator and denominator definitions, and risk adjusters—patient/resident and facility characteristics that are associated with the outcome. RTI and Abt Associates also sought setting-specific input on measure implementation in each PAC setting, potential unintended consequences of the measure, and future directions of the measure.

### **1.3 Process of TEP Meeting**

#### **1.3.1 TEP Nomination Process**

On July 7, 2015, RTI posted a Call for TEP members and a TEP Nomination Form on the CMS website to initiate the recruitment of TEP members; the TEP nomination period was nine days. 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. At the close of the nomination period, RTI and Abt Associates finalized the TEP composition by selecting 16 of the 45 total nominees who offered a diverse range of clinical, research, and administrative expertise, including expertise in the various PAC settings (SNF, IRF, LTCH, HHA), and knowledge of performance measurement with regard to discharge to community. The TEP composition was chosen to offer a range of perspectives related to quality improvement, patient outcomes, research methodology, data collection and implementation, and health care disparities. In addition, a patient representative was recruited, resulting in a 17-member panel. *Appendix A* provides the TEP composition, with brief biographies of each member.

### **1.3.2 In-Person TEP Meeting**

The all-day, in-person TEP meeting took place in Baltimore, Maryland, on August 25, 2015 (see *Appendix B* for meeting agenda). All 17 TEP members attended the meeting. Discussion was facilitated by the measure lead, Poonam Pardasaney, with support from various members of the RTI and Abt measure development teams, as well as representatives from CMS. The following key topics were covered: (i) environmental scan findings, including measure priority, performance gap, definition of community and discharge to community, related measures, exclusion criteria, and risk adjusters; (ii) proposed measure description, (iii) proposed numerator and denominator definitions, and (iv) proposed measure exclusions. Throughout the meeting, there was active discussion related to the measure conceptualization and proposed measure specifications. The meeting was audio recorded and transcribed by a professional transcriptionist for the purpose of summarizing TEP proceedings in this report.

### **1.3.3 Follow-Up TEP Webinars**

Two follow-up TEP webinars were held on September 25, 2015 and October 5, 2015 (see *Appendix C* and *D* for respective agendas). The first TEP follow-up webinar was used to address measure considerations specific to the HHA setting, and exclusion of patients discharged to hospice. The second webinar was used to follow up on previously discussed issues, including inclusion or exclusion of swing bed stays, stays ending in transfer to the same level of care, and discharges to nursing facilities (NFs) for custodial care, and to discuss risk adjustment and potential unintended consequences. Both of these webinars were recorded, and discussions that took place during these meetings have been incorporated into this report.

### **1.3.4 Coding Worksheet**

Before the second follow-up webinar, RTI distributed a Coding Worksheet to TEP members (see *Appendix E*). The purpose of the worksheet was to better understand differences in NF discharge status coding patterns for patients/residents who lived in a NF at baseline versus those who lived in the community at baseline. RTI asked TEP members to indicate the patient/resident discharge status code for different discharge scenarios presented in the Coding Worksheet. The feedback that TEP members provided on the Coding Worksheet informed discussion during the second follow-up webinar.

## **1.4 Organization of the Report**

The following sections of the report discuss the measure concept and specifications proposed to the TEP, and summarize the feedback obtained from TEP members during all three TEP sessions. *Section 2* summarizes discussion regarding the conceptualization of successful discharge to community, and *Section 3* summarizes discussion regarding the proposed measure description and specifications. *Sections 4* and *5* focus on discussions regarding potential unintended consequences of the measure, and data sources and future directions of the measure, respectively.

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## SECTION 2 CONCEPTUALIZATION OF COMMUNITY & SUCCESSFUL DISCHARGE TO COMMUNITY

### 2.1 Definition of “Community” and “Discharge to Community”

In general, TEP members agreed that “community” should be defined to include non-institutional settings, and that institutional settings do not represent community settings. TEP members agreed that patients/residents discharged to home with or without HHA services should be considered discharged to the community. Assisted living facilities were included in the definition of “community”. TEP members also indicated that discharge to outpatient services would be eligible to be included in the definition of “community”, if such a code existed.

A possible exception to this community definition was discussed, namely, PAC patients/residents who are NF residents at baseline, and return to the NF after their acute/PAC episode. The discussion focused on whether these patients/residents should be considered discharged to the “community” for the purposes of this measure, since these individuals are returning to their baseline residence. Details of this discussion are summarized in *Sections 3.1.1* and *3.2.2*. TEP members distinguished between the concept of discharge to community, and discharge to home/baseline residence, stating that if the goal was to examine return to home/baseline residence following the PAC stay, then discharge to baseline NF residence could be considered discharge to home/baseline residence for the measure. However, if the goal was to examine return to “community” settings, then NFs, which are institutional settings, did not fit the definition of “community”. While return to NF represents return to baseline residence for some patients/residents, it should not be interpreted as return to “community”.

### 2.2 Definition of “Successful Discharge to Community”

We asked TEP members to describe how they conceptualize successful discharge from a PAC setting to the community. Below are the key ways in which TEP members defined successful community discharge:

- No rehospitalization in the 30 days following discharge from the PAC to the community;
- Adequate level of functional independence in the community setting;
- Patient/resident needs are successfully met at the community discharge location (e.g., functional, medical, and behavioral needs; supervision needs);
- Patient/resident is safe at the discharge site.

One element of successful discharge discussed by TEP members was whether discharge destination (e.g., home) alone was sufficient to indicate successful discharge, or if service use in a discharge destination should also be considered. TEP members tended to agree that institutionalization is associated with higher resource use relative to discharge to the community. However, one TEP member, representing the LTCH setting, asked whether the level of care or services required in the community setting should be a potential indicator for defining successful discharge, noting that discharge to home may not always translate to lower health care costs (e.g., if a patient/resident was discharged home with 24-hour nursing care, would that be

considered a successful discharge?). This TEP member thought it might be important to incorporate costs of care into the definition of a successful discharge. A few TEP members countered that discharge destination should be distinguished from services received after discharge and, though there is a relationship between cost and services received, post-discharge costs should not be considered when identifying a desirable discharge destination, and was outside the scope of the measure.

TEP members emphasized how a specific patient/resident's clinical needs and personal circumstances are intertwined with the definition of a successful community discharge. Several TEP members agreed that the definition of a successful community discharge depends on the patient/resident's clinical characteristics. Two TEP members gave the example of patients/residents with a hip fracture versus persons with a brain injury, two distinct patient/resident populations for whom a successful community discharge looks very different. In light of this variation among patient/resident characteristics, determining if discharge to community is appropriate for an individual becomes particularly challenging.

## SECTION 3 PROPOSED MEASURE DESCRIPTION AND SPECIFICATIONS

### 3.1 Proposed Numerator Definition

For the purposes of the TEP meeting, the term numerator referred to the subset of patients/residents in the denominator, or target population, who had a favorable outcome: a discharge to community. RTI and Abt proposed to include in the measure numerator all patients or residents in the denominator who are discharged to the community, do not have an unplanned readmission to an acute care hospital or LTCH, and remain alive for at least 30 days following discharge to community. In general, TEP members agreed with this proposed numerator definition.

A few TEP members raised concerns about facilities being held accountable for post-discharge deaths that may be unrelated to the PAC stay, for example a vehicular accident. In response, RTI explained that accidental deaths are expected to be randomly distributed and uncommon events, and are not expected to unfairly affect the measure performance of specific facilities. No further concerns were raised related to this issue.

#### 3.1.1 Proposed Numerator Definition—Baseline NF Residents

There was considerable discussion about patients who are long-term NF residents at baseline, require an acute/PAC stay, and are discharged back to NF residence after the PAC stay. Using this resident scenario, RTI asked TEP members whether discharge from PAC settings to the baseline NF residence should be considered a discharge to community, and thus be eligible for inclusion in the proposed measure numerator. Initially, several TEP members considered such a discharge from PAC setting to baseline NF residence as a discharge to “home,” and stated that this should be considered for inclusion in the measure numerator. This was followed by more nuanced discussions, as outlined below.

Some TEP members distinguished between the concepts of discharge to community and discharge to baseline residence. They stated that if the goal was to measure return to baseline residence following the PAC stay, then it would be appropriate to include discharge to baseline NF residence in the numerator.

One TEP member stated that NFs do not fit the concept of “community,” which refers to independent or non-institutional settings. This TEP member also stated that discharge back to NF may not necessarily align with CMS’s intended direction for this measure of discharge to community.

Two TEP members highlighted that there is a significant difference in resources required for discharging someone to the community versus discharging them back to custodial care in a NF. These TEP members emphasized that facilities should not get the same credit for discharges to custodial care/NF as they would for discharges to community. These TEP members were also concerned about potential unintended consequences associated with including discharges to NF in the measure numerator; they thought that this may incentivize PAC providers to discharge patients/residents to a NF setting earlier in the PAC stay, rather than allowing the patient/resident a longer PAC stay to prepare them for discharge to a non-institutional, community setting.

Facilities would also have a financial incentive for discharging patients/residents to a NF, if discharge to baseline NF was treated as equivalent to discharge to a non-institutional, community setting. These two TEP members expressed strong concerns about including patients/residents discharged back to baseline NF residence in the measure numerator.

Some TEP members also stated that it would be unfair for discharges back to baseline NF residence to count against providers, and were concerned that this could result in systematic bias against SNFs, which accept a large proportion of NF residents.

Several TEP members from the IRF setting argued that baseline NF residents are much more likely to go to a SNF following an acute care stay than they are to go to another PAC setting such as an IRF. These TEP members felt that including in the numerator baseline NF residents discharged back to NF would introduce a positive bias towards SNFs in this measure.

For the current phase of the discharge to community measure, there was agreement that NF discharges will not be included in the measure numerator. For future phases of the measure, most TEP members concluded that, conceptually, it would be fairest if baseline NF residents were excluded from the measure altogether, as it would be problematic to include them in the numerator (given concerns about the face validity of the discharge to community measure), but also unfair to have discharges back to baseline NF residence count against providers. There was additional discussion on the practical feasibility of identifying baseline NF residents and data sources required to identify these residents. A summary of the discussion related to excluding baseline NF residents from the measure denominator is included in *Section 3.2.2* below.

## **3.2 Proposed Denominator Definition**

For the purposes of the TEP meeting, the denominator referred to the target population that would be included in the discharge to community measure. RTI and Abt proposed to include in the measure denominator all Medicare Fee-For-Service patients/residents admitted to a PAC setting within 30 days of discharge from an acute care hospital, with some exclusions applied.

In general, TEP members supported the proposed denominator definition. Some TEP members from multiple settings recommended including Medicare Advantage (MA) patients/residents in the measure denominator. The measure development teams agreed on the importance of including MA patients/residents in the measure and noted that encounter data for MA patients has recently become available. Once these data have been comprehensively tested for reliability and accuracy, CMS can consider including MA patients/residents in the measure. *Sections 3.2.1* through *3.2.6* summarize discussions related to the proposed denominator definitions and denominator exclusions.

### **3.2.1 Proposed Denominator Definition—Prior Acute Care Hospitalization Requirement**

RTI and Abt proposed requiring a prior acute hospitalization in the 30 days preceding index PAC admission, for the PAC admission to be included in the measure denominator. A prior acute hospitalization is required because variables from the prior acute hospitalization are used as risk adjusters for the measure. In general, the TEP was in agreement with this recommendation, particularly for the inpatient PAC settings. However, since this requirement

resulted in exclusion of approximately 56% of HHA episodes, we solicited TEP input on the appropriateness of this requirement for the HHA setting in particular. This topic was discussed at the in-person meeting and first follow-up webinar.

Previously, a prior acute care hospital stay had been required in the institutional PAC setting measures in order to provide a more robust risk adjustment model. However, because only 44% of HHA episodes from January through December 2013 had a prior acute care hospitalization within 30 days of admission to the HHA, Abt decided to assess the impact of removing the prior acute care hospitalization requirement. Abt first examined the distribution of time elapsed between hospital discharge and HHA admission. Abt had previously considered increasing the allowed period of time between acute hospital discharge and HHA admission; however, analysis revealed that this did not significantly increase the number of HHA episodes with a prior hospitalization. The Abt team then evaluated the percentage of HHA episodes with a prior hospitalization, by agency size. It was determined that HHA episodes from smaller agencies were less likely to have a prior hospitalization and would be greatly affected by this requirement. Furthermore, Abt compared the demographic characteristics of HHA episodes with and without an initial acute care hospitalization stay and showed that the population with a prior hospitalization had a higher proportion of males and tended to be older. Finally, Abt compared post-discharge outcomes for HHA episodes with and without a prior hospitalization. The hospital admission rate after discharge was substantially greater for HHA episodes with a prior hospitalization.

At the first follow-up webinar, Abt presented the proposed decision to remove the prior acute care hospitalization requirement for the HHA setting discharge to community measure. TEP members were supportive of the decision to remove the requirement and noted, as such, the measure would represent a larger number of HHA episodes.

### **3.2.2 Proposed Denominator Definition—Baseline NF Residents**

Many TEP members agreed that, ideally, we would exclude baseline NF residents from the measure. If these residents were included in the measure, the options of either excluding or including them in the measure numerator are not ideal (see *Section 3.1.1*). However, we discussed that, because the measure currently uses claims data, we cannot definitively determine if a patient/resident lived in a NF at baseline. This was further corroborated by the feedback we received on a coding worksheet that was distributed to TEP members. The coding worksheet requested that TEP members list the discharge status code for a variety of potential discharge scenarios, in order for RTI to better understand the differences in NF discharge status coding patterns for patients/residents who lived in a NF at baseline as compared with patients/residents who lived in the community at baseline. Input received on the coding worksheet, as well as additional discussion during the TEP meetings, indicated that significant variation exists in coding NF discharges within and across IRF, LTCH, and SNF settings. One TEP member pointed out that, given TEP members are very aware of issues of coding and the discharge to community measure, coders in PAC settings may be a more appropriate target sample to learn about current discharge status coding practices. TEP members agreed that current discharge status coding practices probably do not clearly distinguish NF discharges based on the patient's/resident's baseline residence (community or NF).

Given that baseline NF residents could not be identified and excluded in the first phase of measure development, RTI proposed improving discharge status coding accuracy, particularly for NF discharges, through consultation with coders on current practices as well as provider education on appropriate coding. For future phases of the measure, RTI proposed two approaches for identifying baseline NF residents. The first approach was to use assessment data to identify baseline NF residents; currently the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) is the only PAC item set that contains an item related to pre-hospital baseline living setting. We proposed the possibility of adding a similar item to the assessment datasets for the LTCH, SNF, and HHA settings. TEP members strongly supported the possibility of adding a pre-hospital baseline living setting item to all PAC assessment datasets. In addition to allowing identification of baseline NF residents for the discharge to community measure, TEP members indicated that such an item would be valuable to clinicians for overall care planning, prognosis determination, as well as for predicting patient/resident outcomes for other quality measures, such as functional status measures.

The second proposed approach for identifying baseline NF residents was to link Minimum Data Set (MDS) and claims data, and look for prior MDS assessments to identify baseline NF residents. One TEP member suggested using a combination of both approaches (assessment item and linked MDS-claims data) to identify baseline NF residents to improve reliability of this information. Another TEP member recognized the legislative timeline associated with adding new items to assessment datasets; this TEP member suggested that, until an assessment item could be added to all PAC datasets, use of a linked MDS-claims dataset for identifying baseline NF residents may be essential.

Once baseline NF residents could be identified, we proposed four options for addressing them in this measure: (1) exclude them from the measure, (2) include them in the measure and add a variable to risk adjust for them, (3) consider other measure modifications for them, or (4) consider a separate measure for them. Most TEP members agreed that baseline NF residents should be excluded from the measure, as return to a NF reflects a return to baseline, but not a true “discharge to community.” However, several TEP members highlighted the importance of tracking outcomes for these patients/residents and recommended doing so through separate measures in the future.

### **3.2.3 Proposed Denominator Definition—Swing Bed Stays**

One point of discussion for the denominator definition was the inclusion of swing-bed stays in the denominator. This was discussed at the in-person meeting and second follow-up webinar. RTI presented preliminary analyses of observed discharge to community rates in SNFs, Critical Access Hospital (CAH) swing beds, and non-CAH swing beds demonstrating differences in discharge patterns between SNFs and swing beds (both CAH and non-CAH). Based on the difference in observed discharge to community rates, RTI asked the TEP whether there were reasons that swing bed discharge to community outcomes should be examined separately from SNF discharge to community outcomes. RTI also asked whether swing bed facilities face unique or different challenges in successfully discharging residents to the community compared with SNFs.

At the in-person meeting, several TEP members thought that the measure should not differentiate between SNF and swing bed stays. They noted that if the goal of the cross-setting measure is to examine discharge destination outcomes across all possible PAC settings, then the same standards should be established for all PAC settings. One TEP member, representing the LTCH setting thought that the distinction between rural versus non-rural facilities is more meaningful than the distinction between swing beds and non-swing beds, stating that there is greater selection bias at urban LTCHs compared with rural LTCHs that might have to take in any patient that is referred to them. For this reason, the TEP member thought that patient populations can differ in rural and urban LTCHs. They further noted that the distinction between rural and non-rural facilities applies to all PAC settings, not just the SNF setting. Another TEP member suggested that such facility-level variation could be addressed through risk adjustment.

The TEP also discussed some practical considerations for including CAH and non-CAH swing beds in the measure. One TEP member representing the LTCH setting noted that, from a sample size perspective, it might not be possible for the measure to differentiate between SNFs and swing beds given that swing-bed sample sizes are so small.

TEP members noted several unique characteristics of swing beds that might impact their discharge to community rates. One TEP member stated that acute readmissions occur more often in swing beds because the transition back to acute care is easier compared with other PAC settings; the transfer occurs within the same facility. A couple of TEP members indicated that swing bed staff often have more of an acute care focus and swing bed facilities often have a larger volume of resources to address acute medical needs (e.g., wound care and intravenous antibiotics). These staffing and resource differences give swing beds a larger capacity to handle higher-acuity patients, and thus, swing beds might naturally admit patients who are more likely to have acute readmissions. However, some of this discussion was focused on non-CAH swing beds.

At the second TEP follow-up webinar, TEP members unanimously agreed with RTI's proposed decision to include non-CAH swing bed stays, but exclude CAH swing bed stays from the measure. This decision was proposed based on differences in payment and quality reporting requirements among non-CAH and CAH swing beds: non-CAH swing beds, unlike CAH swing beds, are subject to SNF Quality Reporting Program (QRP) quality data submission per the IMPACT Act, are reimbursed under the SNF Prospective Payment System (PPS), and submit MDS data. RTI also presented that this decision harmonizes with other SNF QRP quality measures, and allows assessment data to be added more easily to the measure in the future, if the decision were made to do so.

### **3.2.4 Proposed Denominator Definition—Transfers to the Same Level of Care**

TEP members provided several reasons why a patient/resident might be transferred to the same level of care. TEP members representing all settings pointed to patient/resident/family preferences as a common reason for patient/resident transfer. Geographical preferences, such as being closer to a family support system, were reported as a very common reason for transfers. TEP members also stated that the patient/resident or their family might request a transfer because they are dissatisfied with their current provider or their current direction of care. Other TEP members mentioned general change in condition as a reason a patient/resident might transfer to

the same level of care, if the facility is no longer able to provide the specialty services the patient/resident needs. In the case of HHAs, one TEP member noted that an agency might run out of resources to match a patient/resident's specific needs or requests and thus have to transfer the patient/resident to a different agency.

In the case of transfers to the same level of care, RTI and Abt proposed excluding the first or intervening provider(s) from the measure and including only the final provider. At the in-person meeting, TEP members expressed conflicting opinions about this proposed denominator exclusion. Several TEP members expressed concern about excluding the first/intervening provider(s) from the measure; they thought that the first/intervening provider(s) should be held accountable for quality of care during the transfer process, as well as for the patient/resident's post-discharge outcomes. Several TEP members noted that transfers are a critical, high-risk time for patients/residents and that facilitating a successful transfer is the responsibility of both providers involved. Additionally, one TEP member suggested that excluding the first provider would prevent them from receiving credit for the care they provided to the patient/resident. Some TEP members also felt that excluding the first/intervening provider(s) may have potential unintended consequences, incentivizing providers to transfer patients/residents anticipated to have undesirable discharge to community outcomes.

The following are some suggestions provided by TEP members at the in-person meeting for incorporating the first/intervening provider(s) in the measure: (i) Hold the first/intervening provider(s) accountable for unplanned readmissions and death in the 30-day post-discharge period: each provider involved in the episode of care would be held accountable for their respective 30-day post-discharge windows; (ii) If the first/intervening provider(s) is held accountable for negative outcomes in the 30-day post discharge window, then we should also consider crediting these providers for a successful discharge to community from the final provider of care.

During the first TEP follow-up webinar, TEP members discussed the issue of transfers to the same level of care in the specific context of the HHA setting. The discussion was focused on determining how to handle HHA episodes where the patient was treated by multiple HHAs. The Abt team noted that multiple HHAs treated the same patient during two percent of HHA episodes. Three options were presented to the TEP for consideration:

1. Hold the first/interim agencies responsible for the final agency's discharge.
2. Only include the final agency accountable for the discharge.
3. Exclude episodes of care from the measure where the patient is treated by multiple agencies.

Overall, the TEP did not support the idea of holding the first/interim agencies accountable for the final discharge, saying that it would be unfair to measure an agency's outcome where the final discharge was out of their control. Three TEP members supported the option of considering the final provider but also thought these patients were likely "problem patients" and could be less likely to return to the community. Two TEP members supported the idea of excluding these patients from the measure. The measure development teams then presented a potential unintended consequence where agencies might transfer patients to other agencies in order to have a patient excluded from the measure. Abt also noted that transfer rates

could be monitored over time to observe if this became an issue. Abt agreed to continue investigating this issue before making a final decision on whether to include the final provider or exclude these episodes from the measure.

During the second follow-up TEP webinar, RTI continued the discussion on transfers to the same level of care focusing on the SNF, IRF, and LTCH settings, and presented RTI's inclination to include only the final provider in the measure. However, in preliminary analysis examining four years of LTCH and IRF data, RTI found that the final provider typically got excluded because no prior acute care hospitalization was found in the 30 days preceding admission to the final provider. Thus, a large proportion of IRF and LTCH patients with transfers would be excluded from this measure because of the final provider not meeting the prior acute care hospitalization requirement.

To address the issue of IRF, SNF, and LTCH patients/residents with transfers being excluded because of the final provider not meeting the requirement of prior acute care hospitalization in the past 30 days, RTI proposed two options:

1. When looking for a prior acute stay for patients/residents with transfers, extend the lookback period to be longer than 30 days before the final PAC admission; or
2. Include the final provider as long as the first PAC admission is within 30 days of prior acute discharge.

TEP members did not support the first option of extending the lookback period for a prior acute discharge. Several TEP members expressed support for the second option of including the final provider in cases of transfer, as long as the first PAC admission is within 30 days of the prior acute discharge. However, at least one TEP member suggested that the pattern of transfers may be different for SNF residents and that there may be increased likelihood of additional SNF transfers which occur after 30 days of the prior acute discharge.

TEP members expressed concern that the population with transfers may constitute a unique patient/resident population. One TEP member suggested analyzing readmission rates for transferred patients/residents; if readmission rates are higher, PAC providers who accept transfers may be unduly punished for taking on these patients/residents. Additionally, the TEP member suggested that, with a longer length of stay, the SNF resident is more at risk of becoming a long-stay resident. This TEP member suggested a longer time period than the preceding 30 days to allow for the different transfer patterns among SNF residents.

### **3.2.5 Proposed Denominator Definition—Discharges to Hospice**

RTI and Abt proposed to exclude from the denominator patients/residents discharged to hospice from their index PAC stay, and presented their rationale for this exclusion. Terminally ill persons represent a unique population with a different trajectory from patients/residents who are not terminally ill. For non-hospice PAC patients/residents, whose goal is to return to baseline or independent living, death is an undesirable outcome. Persons receiving hospice care at home, however, have a goal of dying comfortably at home. With the current specifications for this measure, to be in the numerator, patients/residents have to remain alive for 30 days following discharge from PAC stay to community. Patients/residents admitted to hospice after a PAC discharge have a higher likelihood of death in the 30 days post-PAC discharge, which

would be reflected as a bad outcome for the facility. Additionally, RTI shared that discharges from PAC to hospice care are relatively rare, with the rate being approximately 0.3 percent in the IRF setting, approximately one percent in the SNF setting, approximately four percent in the LTCH setting, and approximately two percent in the HHA setting.

At the in-person meeting, some TEP members disagreed with the proposed exclusion of patients/residents discharged to hospice from the denominator. TEP members representing multiple settings argued that hospice is an appropriate and desirable outcome for many patients/residents and that discharging these patients/residents to hospice reflects patient-centered care. Thus, they felt that PAC facilities should be credited for hospice home discharges by including these patients/residents in the numerator. One TEP member worried that excluding hospice discharges from the denominator might facilitate an already widespread bias against dying as an appropriate outcome for some patients/residents.

To address the concern about the low likelihood of terminally ill hospice patients remaining alive in the 30 days post discharge (a requirement of the proposed numerator), several TEP members suggested that patients/residents discharged to home with hospice care be exempt from this numerator criterion of remaining alive in the 30-day post-discharge period. They suggested that these patients/residents discharged to home with hospice care be included in the measure numerator regardless of whether or not they die in the 30 days post discharge.

At the first follow-up webinar, RTI presented to the TEP further information regarding patients/residents discharged to home or facility with hospice care, including discharge planning and goals of care, data on post-discharge death rates, and recommendations of clinical experts in hospice care whose input RTI had solicited. RTI presented data showing that a large proportion of hospice patients died in the 30-day post-discharge window; the rates of 30-day post-discharge death ranged from 45.3 percent to 82.3 percent for hospice discharges from IRF, LTCH, and HHA settings. In contrast, 30-day post-discharge death rates for non-hospice discharges in these settings ranged from 1.3 percent to 4.9 percent. RTI shared that hospice selection is a complex decision involving patient and family preferences and requires forgoing of curative treatment by the patient/family. RTI also highlighted that the decision of discharging to hospice home or hospice facility is made by the hospice agency, not the PAC setting and it also took into consideration the availability of hospice services in the region where the patient/resident lived. RTI reemphasized the difference in goals of care for patients/residents discharged to hospice compared with non-hospice discharges. Further, RTI noted that it would be conceptually confusing to include in the same numerator patients/residents who were successfully rehabilitated to live in the community and patients who are dying and prefer to die at home. Based on the above information and in alignment with hospice expert consultant input, RTI and Abt proposed to exclude discharges to hospice from the measure. At the end of the first TEP follow-up webinar, TEP members agreed that hospice discharges should be excluded from this measure. TEP members recommended consideration of separate discharge measures for the hospice population in future measure development.

### **3.2.6 Proposed Denominator Definition—Other Exclusions**

RTI proposed to exclude SNF residents with a length of stay of 100 days or greater from the measure denominator. RTI's rationale for this exclusion is that residents exhaust their

Medicare SNF coverage at 100 days, and discharge on day 100 or later may be related to exhaustion of benefits rather than the PAC's discharge decision. Because these residents may not be adequately prepared for the community, but must be involuntarily discharged as a result of Medicare coverage rules, the SNF should not be held accountable for their subsequent status. One TEP member asked whether a maximum length of stay limit would be applied to the other PAC settings as well, similar to the length of stay requirement of less than 100 days for SNFs. RTI clarified that the exclusion was based on exhaustion of Medicare Part A benefits, rather than a specific length of stay. Patients in IRF, LTCH, and SNF settings would be excluded if their Medicare Part A coverage had been exhausted. TEP members agreed with this exclusion.

One TEP member asked whether we had considered excluding patients/residents with extremely short lengths of PAC stay. He shared that in his research he excluded patients/residents whose length of stay was less than 3 days, as it is difficult for a facility or agency to take responsibility for someone who has only been there for a few days. RTI responded that when a PAC setting admits a patient/resident they have shared responsibility along with the discharging facility to ensure that the patient/resident is ready for PAC admission; the discharging facility is responsible to ensure that the patient/resident is ready for discharge to the next setting, and the admitting facility is responsible to ensure that patient/resident is ready for admission to their setting. RTI highlighted the focus on transitions of care, and shared responsibility and communication during transitions. For these reasons, no measure exclusions were being considered for patients/residents with a short length of stay. The TEP accepted this explanation and no further concerns were raised related to this issue.

RTI proposed to exclude patients/residents discharged against medical advice from the measure denominator. TEP members agreed with this exclusion. One TEP member noted that agencies tend to underreport discharges against medical advice because of the financial implications for the patient/resident when this discharge status is selected, making the patient/resident responsible for their medical bill. The TEP member emphasized the importance of incorporating patient choice into decisions about care planning and discharge destination, and wished there were another way, besides coding discharge against medical advice, to indicate that the discharge destination was not recommended by the facility, but was the patient/resident's preference.

### **3.3 Risk Adjustment**

The following list of risk adjusters under consideration was presented to TEP members:

- Sociodemographics (age, sex).
- Disability as original reason for Medicare entitlement.
- Medicare-Medicaid dual status.
- Variables related to the acute care stay in past 30 days (length of stay, Intensive Care Unit [ICU] use, ICU length of stay).

- Ventilator use (LTCH).
- Clinical conditions.
  - Principal diagnosis from prior acute stay.
  - Comorbidities (based on diagnoses in the year prior to PAC admission).
  - Surgery, procedures during prior acute stay.
  - Dialysis.
  - IRF case-mix groups (IRF only).
  - Activities of daily living (HHA only).
- Prior acute care use in past year.
  - Number of prior acute discharges.
  - Number of prior hospital days.

TEP members had no objections to the risk adjusters on this list, but emphasized additional key factors influencing discharge destination outcomes for which risk adjustment would be important:

- **Social support:** TEP members across multiple settings pointed to the availability of family support as one of the largest factors influencing whether or not a patient/resident is discharged to their home. TEP members noted that, if a patient/resident lived alone before the acute event, and would live alone after discharge, they would need to be functioning at a higher level in order to return home following their PAC stay. TEP members noted that this information about the availability of family support to a patient/resident could not be ascertained from claims data.
- **Functional status:** Several TEP members mentioned the importance of addressing both physical function and cognitive function, specifically Alzheimer's disease/dementia diagnoses, through risk adjustment. TEP members again pointed to data source limitations related to functional status, in the claims as well as in the assessment instruments. One TEP member questioned how the activity of daily living information for HHAs would be obtained; the Abt team clarified that this information is available in claims. The TEP member noted that Resource Utilization Group (RUG) information is available in SNF claims and might be a useful starting point to consider function for SNF residents. Another TEP member recommended looking into case mix groups for the HHA and IRF settings.

## SECTION 4 POTENTIAL UNINTENDED CONSEQUENCES

### 4.1 Potential Unintended Consequences

TEP members discussed the following potential unintended consequences of this measure:

- A few TEP members cautioned that this measure may discourage PAC providers from accepting patients/residents perceived to have a low likelihood of successful discharge to community, which could result in decreased patient access.
- One TEP member expressed concern that this measure might lead providers to make decisions about discharge destination based on how those decisions would affect their measure score. This TEP member felt that the ultimate consideration when making decisions about discharge destination should be patient/resident and family preference.
- TEP members noted that discharge to community is not the appropriate or desired outcome for all patients/residents. This measure might urge providers to discharge patients/residents to the community even when that is not the appropriate outcome for those persons.
- If discharge to a NF is eventually included in the numerator, TEP members worried that this might result in a decreased incentive to return baseline NF residents to the community, even if home discharge might be appropriate and possible for some residents. They noted that discharging a patient/resident to custodial care at a NF requires significantly less resources than discharging a patient/resident to the community. If discharge to NF is considered a positive outcome for baseline NF residents, providers would have no incentive to incur the extra costs of discharging that person to the community.
- TEP members noted that if only the final provider in a transfer is included in this measure, this might provide an incentive to providers to transfer complex patients/residents with poor anticipated outcomes so that they are not held accountable for those patient/residents' outcomes.

Throughout the TEP meetings, there was discussion about exclusion criteria and risk adjustment to help avoid potential unintended consequences of the measure.

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## SECTION 5 DATA SOURCES AND FUTURE DIRECTIONS OF THE MEASURE

### 5.1 Data Sources and Future Directions of the Measure

RTI and Abt explained that the first phase of the measure would be a claims-based measure. However, we solicited TEP input regarding future directions of the measure including data sources for measure specification. TEP members provided several suggestions, outlined below, for enhancing the measure in the future by adding assessment data.

- TEP members discussed the use of assessment data to identify baseline NF residents, to help distinguish between baseline NF residents being discharged back to NF, and baseline community dwellers being discharged from PAC to NF and becoming newly institutionalized. Most TEP members agreed that once baseline NF residents can be identified, they should be excluded from the measure.
- TEP members suggested the use of assessment data for risk adjustment for patient/resident characteristics such as functional status and social support, which influence a patient/resident's likelihood of successful discharge to the community.
- TEP members listed several possible criteria for determining if a discharge to community was successful (see *Section 2.2*), many of which were highly related to patients'/residents' preference and home environment. Claims data may not be able to provide the level of detail on patient-level characteristics necessary to determine if a discharge was successful.

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## APPENDIX A TEP MEMBERS

### ► Susan Adams, PhD, BSN, RN

Vice President of Alliance Integration  
*Masonicare*  
*Wallingford, CT*

Susan Adams currently serves as Vice President of Alliance Integration with Masonicare, Connecticut's largest provider of senior healthcare, senior living, homecare, and hospice. Her responsibilities include the building of provider networks and clinical integration. Dr. Adams also serves on the LeadingAge Home Health Task Force, the National Association for Home Care and Hospice (NAHC) Board of Directors, and the Board of Directors for the Connecticut Association of Home Health and Hospice. Her experience includes more than twenty years as a healthcare professional, with more than ten of those years in the fields of home health and hospice.

Dr. Adams received her Master of Science in Health Services Administration from St. Joseph's College and her Doctorate in Health Service Management from La Salle University.

### ► Greg Arling, PhD

Professor, School of Nursing  
Research Associate, Center for Aging and the Life Course  
*Purdue University*  
*West Lafayette, IN*

Greg Arling is a Professor in the School of Nursing and a Research Associate for the Center for Aging and the Life Course at Purdue University. He has extensive experience in assessing and reporting on quality of care in the nursing home setting, incorporating both methodological and implementation perspectives into his research. Dr. Arling has studied care transitions of nursing home residents. This research has contributed to the development of a community discharge measure for nursing facilities in Minnesota, which is currently being added to the Minnesota Nursing Home Report Card.

Dr. Arling received his Master of Science in Sociology and Doctorate in Sociology from the University of Illinois, and he did post-doctoral research in Health Systems Engineering at the University of Wisconsin- Madison.

### ► Dawn Butler, JD, MSW

Director, IU Geriatrics GRACE Training and Resource Center  
*Indiana University*  
Adjunct Faculty  
*Indiana University School of Social Work*  
*Indianapolis, IN*

Dawn Butler is the Director of the IU Geriatrics GRACE Training and Resource Center, where she provides direction and leadership in the development, implementation, operation, strategic

planning, and public relations of the center. She also designs, implements, and coordinates dissemination and training programs to prepare health care professionals and organizations to implement GRACE Team Care, a model of geriatric care management for low-income seniors and their physicians.

Ms. Butler received her Master of Social Work from Indiana University and her Juris Doctor degree from McKinney School of Law.

► **Michelle Camicia, MSN, CRRN, CCM**

Director of Operations  
*Kaiser Foundation Rehabilitation Center*  
Nurse Consultant  
*Vallejo Kaiser Medical Center*  
*Vallejo, CA*

Michelle Camicia is the Director of Operations for Kaiser Permanente's Northern California regional inpatient rehabilitation hospital, where she is responsible for nursing, physical, occupational, speech, & recreation therapy, case management, psychology & research operations. Her cross-setting experience includes leadership, consulting, research, and education across the continuum of care, particularly in post-acute care settings.

Ms. Camicia received her Master of Science in Nursing Administration from Sonoma State University and is currently enrolled in the Nursing Science and Healthcare Leadership Doctorate program at the University of California's Betty Irene Moore School of Nursing.

► **Susan Hinck, PhD, APRN, GCNS-BC**

Director, Quality Assurance Program  
*Haven Home Health and Therapy*  
*Ozark, MO*

Susan Hinck is the Administrator and Director of the Quality Assurance Program at Haven Home Health and Therapy, a rural home health agency and hospice in Missouri, where she provides oversight for all quality improvement initiatives. Dr. Hinck has extensive experience as a clinician, university professor, researcher, and administrator across post-acute care settings.

Dr. Hinck received her Master of Nursing from the University of Kansas and her Doctorate in Nursing from Saint Louis University.

► **Amol Karmarkar, PhD**

Assistant Professor, Rehabilitation Sciences  
Fellow, Sealy Center on Aging  
*University of Texas Medical Branch*  
*Galveston, TX*

Amol Karmarkar is an Assistant Professor in the Division of Rehabilitation Sciences at the University of Texas Medical Branch, where he has been involved in several research projects on health services utilization and outcomes in the context of post-acute care, primarily using

administrative claims data. He also serves on the Advisory Committee for AcademyHealth's Disability Research Interest Group.

Dr. Karmarkar received his Master of Science in Rehabilitation Science from the University of Buffalo. He received his Doctorate in Health & Rehabilitation Sciences and subsequent post-doctoral training from the University of Pittsburgh. He also received his Master of Public Health in Epidemiology from the University of Texas Medical Branch.

► **Suzanne Kauserud, FACHE, MBA, PT**

Vice President  
*Carolinas Rehabilitation*  
Surveyor  
*CARF*  
*Charlotte, NC*

Suzanne Kauserud is the Vice President of Carolinas Rehabilitation, where she is responsible for facility operations and for ensuring clinician compliance with quality reporting requirements. Carolinas Rehabilitation is part of Carolinas HealthCare System, a large organization which spans the entire healthcare continuum, including LTCH, SNF, IRF, and HHA settings. Ms. Kauserud is also an Administrative Surveyor for the Commission on Accreditation of Rehabilitation Facilities (CARF). She has previously worked as a physical therapist in several different post-acute care settings and is currently the Chair of the Quality Committee for the American Medical Rehabilitation Providers Association (AMPRA).

Ms. Kauserud received her Bachelor of Science in Physical Therapy from the University of Florida, and her Master of Business Administration from Florida Atlantic University.

► **David Key, DPT**

Senior Vice President of Operations, Case Management & Utilization Review  
*Select Medical Corporation*  
*Mechanicsburg, PA*

David Key is the Senior Vice President of Operations responsible for Case Management & Utilization Review at Select Medical Corporation, where he provides leadership to the care and business management functions of 112 hospitals in 28 states that make up the Select Medical's Specialty Hospital Division. Dr. Key has used his 13 years of experience in the post-acute healthcare industry, as well as various corporate leadership roles, to lead the development of dashboards that monitor Key Performance Indicators and provide real-time tools and resources to support front-line operations. He leads a team currently focused on opportunities for innovations related to Care Management to ensure appropriate and medically recurring care plan progression, as well as safe transitions of care.

Dr. Key received his Master of Physical Therapy from the University of Delaware, and his Doctor of Physical Therapy from Temple University.

► **Natalie Leland, PhD, OTR/L, BCG, FAOTA**

Assistant Professor

*University of Southern California, T.H Chan Division of Occupational Science and Occupational Therapy; Davis School of Gerontology  
Los Angeles, CA*

Natalie Leland is an Assistant Professor at the University of Southern California with a joint appointment in the T.H. Chan Division of Occupational Science and Occupational Therapy and the Davis School of Gerontology. She is also an Adjunct Assistant Professor of Health Services Policy & Practice at Brown University's School of Public Health. Dr. Leland has over ten years of clinical experience working in post-acute care as an occupational therapist and has significant experience in conducting rehabilitation health services research.

Dr. Leland received her Bachelor of Science in Occupational Therapy from the University of New Hampshire, and her Master of Science and Doctorate in Gerontology from the University of Massachusetts, Boston.

► **Cathy Lipton, MD, CMD**

Senior Medical Director

*Optum Complex Population Management*

Adjunct Clinical Assistant Professor of Medicine, Division of Geriatric Medicine

*Emory University School of Medicine, Department of Internal Medicine  
Atlanta, GA*

Cathy Lipton is a Senior Medical Director at Optum Complex Population Management, where she oversees health care for high acuity/high risk populations (both institutional and community dwellers) enrolled in Medicare Special Needs Plans. She is a member of the AHCA Clinical Practice Committee, acting as Chair of the Subcommittee to Reduce Adverse Events and Care Planning.

Dr. Lipton received her Doctor of Medicine from Emory University School of Medicine.

► **Rachel Manchester, BSN, MBA, MHA**

Regional Director of Home Health Quality

*Providence Senior and Community Services  
Seattle, WA*

Rachel Manchester is the Director of Clinical Quality for Providence Senior and Community Services, where she is involved in community engagement for safe care transitions from acute care settings to the continuum of care. She has previously worked as a case manager, clinician, supervisor and administrator in the home health setting. Ms. Manchester has served as a member on the Home Care Association of Washington board and is actively involved in policy making in Olympia.

Ms. Manchester received her Bachelor of Science in Nursing from the University of Washington and her Master of Business Administration and Master of Health Care Administration from the University of Phoenix.

► **Keyonna Mayo, BS**

Patient Representative

*Mentor for Women Embracing Abilities Now (W.E.A.N.) and The Dana and Christopher Reeve Foundation  
Baltimore, MD*

On November 22, 2005, Keyonna was in an automobile accident on her way to Baltimore from the Eastern Shore. At the time, she was a senior at the University of Maryland Eastern Shore. She was at the R. Cowley Shock Trauma Center for three weeks, before she was sent to University of Maryland Rehabilitation and Orthopedic Institute for two and a half months. While at UMROI, she learned that she has paraplegia. Before her injury, Keyonna was a preschool teacher. In 2006, she completed her final requirement for a bachelor's degree in Human Ecology with a concentration in Child Development. Around that time, she was introduced to Women Embracing Abilities Now (W.E.A.N.) a nonprofit organization that plans different events and workshops for women. She is now a mentor for W.E.A.N. and The Dana and Christopher Reeve Foundation, giving hope and encouragement to women dealing with various degrees of disabilities. She feels that the health care system, in general, has to find a better way of bridging the gap to facilitate a patient's transition to home.

► **Subhadra Nori, MD**

Regional Director

*Queens Health Network, Rehabilitation Medicine Department  
Elmhurst, NY*

Subhadra Nori is the Regional Medical Director of the Rehabilitation Medicine Department for Queens Health Network, which comprises of Elmhurst Hospital Center and Queens Hospital Center, where she oversees the operations both administratively and clinically. The inpatient unit at Queens Hospital Center was awarded with a Program Evaluation Model (PEM) Award by UDSMR four times for achieving excellence in clinical outcomes. Dr. Nori is currently an Assistant Professor at Icahn School of Medicine at Mount Sinai. She has years of experience in the IRF setting and has received numerous honors and awards for her work in quality improvement and teaching.

Dr. Nori received her Bachelor of Medicine and Bachelor of Surgery from Osmania Medical College and Institute of Medical Sciences in Hyderabad, India. She is double-boarded in PMR and Electromyography.

► **Terrence O'Malley, MD**

Physician (Internist/Geriatrician)

*Massachusetts General Hospital  
Boston, MA*

Terrence O'Malley is an internist/geriatrician in an active clinical practice in a SNF with previous clinical experience in the emergency room, primary care practice, home, IRF, and LTCH settings. He has served as the Medical Director for a primary care practice, three SNFs, and a home health agency. He is a member of the Massachusetts Transitions of Care Steering Committee and the co-chair of the Transitions and Care Coordination Sub-Committee of the MA

Health Data Consortium. Additionally, at the national level, he co-led the ONC Standards and Interoperability Work groups for Transitions of Care and Longitudinal Coordination of Care and most recently, co-leads the Electronic Long Term Services and Supports (eLTSS) work group.

Dr. O'Malley received his Doctor of Medicine from Cornell University Medical College.

► **Lori Popejoy, PhD, APRN, GCNS-BC, FAAN**

Associate Professor

*University of Missouri, Sinclair School of Nursing  
Columbia, MO*

Lori Popejoy is an Associate Professor at Sinclair School of Nursing and a core faculty member at MU Informatics Institute. She has years of experience as a practicing nurse, care coordinator, and researcher, particularly in the SNF and HHA setting. She been involved in a number of studies related to discharge planning and care transition and is currently the principal investigator for the AHRQ funded study, SNF to Home: Reengineering SNF Discharge.

Dr. Popejoy received her Master of Science and Doctorate in Nursing from the University of Missouri.

► **John Votto, DO, FCCP**

President & CEO

*Hospital for Special Care  
New Britain, CT*

John Votto, a pulmonologist by training, is the President & CEO of Hospital for Special Care, as well as Chief of Staff, where he oversees both clinical and administrative tasks. He is also a Professor of Clinical Medicine at the University of Connecticut School of Medicine. He is the immediate past President of the National Association of Long Term Hospitals (NALTH) and has years of research experience centered around pulmonary rehabilitation, long term ventilator care and outcomes studies related to both.

Dr. Votto received his Doctor of Osteopathic Medicine from the Kansas City College of Osteopathic Medicine.

► **Christy Whetsell, RN, BSN, MBA, ACM**

Director of Case Management

*Mid-Atlantic Regional and MountainView Rehabilitation Hospital*

President

*American Case Management Association  
Morgantown, WV*

Christy Whetsell is the Director of Case Management for the Mid-Atlantic Regional and MountainView Rehabilitation Hospital, where she has focused on improving transitions between different discharge healthcare settings. She is the President of the American Case Management Association (ACMA) and has assisted in the development of a community transition tool, as well as in the development of other measures related to discharge processes.

Ms. Whetsell received Bachelor of Science in Nursing from West Virginia University School of Nursing, and her Master of Business Administration from the University of Phoenix.

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**APPENDIX B  
TEP IN-PERSON MEETING AGENDA**

**Development of a Discharge to Community Measure for  
Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs),  
Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs)**

**Technical Expert Panel Meeting Agenda**

<b>Tuesday, August 25, 2015</b> <b>8:30 AM – 4:00 PM EST</b> <b>BWI Airport Marriott</b> <b>1743 W Nursery Rd, Linthicum Heights, MD 21090</b>	<b>Dial-in Information</b> <b>AT&amp;T line: 1-888-706-0584</b> <b>Access code: 3495727</b>
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Time	Agenda Item	Lead(s)
8:30AM - 8:55 AM	Welcome and Introductions TEP charter Review of Agenda	RTI/Abt/CMS
8:55 AM - 9:10 AM	Project Objectives, IMPACT Act Overview, TEP Objectives	RTI
9:10 AM - 10:00 AM	Environmental Scan Discussion of Concept of Community and Discharge to Community	RTI/Abt
10:00 AM - 10:10 AM	Break	
10:10 AM - 12:00 PM	Proposed Measure Specifications Overview of Preliminary Data, Proposed Measure Description, Proposed Numerator and Denominator Definitions	RTI/Abt
12:00 PM - 1:00 PM	Lunch Break	
1:00 PM - 3:00 PM	Proposed Measure Specifications (Continued) Proposed Denominator Exclusions & Exceptions; Risk Adjusters	RTI/Abt
3:00 PM - 3:10 PM	Break	
3:10 PM - 3:45 PM	Potential Unintended Consequences, Final Discussions & Recommendations	RTI/Abt
3:45 PM - 4:00 PM	Concluding Remarks & Meeting Summary	RTI/Abt/CMS

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**APPENDIX C  
FIRST FOLLOW-UP WEBINAR AGENDA**

**Development of a Discharge to Community Measure for  
Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs),  
Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs)**

**Technical Expert Panel Follow-Up Webinar  
Agenda**

<b>Friday, September 25, 2015</b> <b>1:00 PM – 3:00 PM EST</b>	<a href="https://www.connectmeeting.att.com">https://www.connectmeeting.att.com</a> <b>Meeting Number: 1-888-706-0584</b> <b>Access Code: 3495727</b>
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Time	Agenda Item	Presenter
1:00 - 1:15 PM	<b>Welcome, Presentation Overview, Meeting Objectives</b>	<b>RTI</b>
1:15 - 1:25 PM	<b>Review of Project Objectives, IMPACT Act &amp; Measure Specifications</b>	<b>RTI</b>
1:25 - 1:55 PM	<b>Home Health Measure Discussion</b> - Requirement of Prior Acute Care Hospitalization	<b>Abt</b>
1:55 - 2:10 PM	<b>Home Health Measure Discussion</b> - Multiple HHA Providers	<b>Abt</b>
2:10 - 2:25 PM	<b>Home Health Measure Discussion</b> - Additional Topics from TEP members	<b>Abt</b>
2:25 - 2:45 PM	<b>Discharges to Hospice (Home or Facility)</b>	<b>RTI</b>
2:45 - 3:00 PM	<b>Wrap Up &amp; Next Steps</b>	<b>RTI</b>

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**APPENDIX D  
SECOND FOLLOW-UP WEBINAR AGENDA**

**Development of a Discharge to Community Measure for  
Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs),  
Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs)**

**Technical Expert Panel Webinar  
Meeting Agenda**

<b>Monday, October 5, 2015</b> <b>10:00 AM - 12:30 PM EST</b>	<a href="https://www.connectmeeting.att.com">https://www.connectmeeting.att.com</a> <b>Meeting Number: 1-888-706-0584</b> <b>Access Code: 3495727</b>
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Time	Agenda Item
10:00 AM - 10:15 AM	Welcome, Presentation Overview, Review of Measure Specifications
10:15 AM - 10:45 AM	Patients with transfers to same level of care
10:45 AM - 11:05 AM	Swing beds
11:05 AM - 11:35 AM	Discharges to nursing facility
11:35 AM - 11:55 AM	Risk adjustment
11:55 AM - 12:15 PM	Potential unintended consequences
12:15 PM - 12:30 PM	Wrap-up & final comments

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## APPENDIX E TEP CODING WORKSHEET

### Development of a Discharge to Community Measure for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies

#### Technical Expert Panel Discharge Status Coding Worksheets for SNF, IRF, and LTCH Settings

#### Instructions

Please complete the coding worksheets included in this document and return to [ehaines@rti.org](mailto:ehaines@rti.org) by **Friday, October 2<sup>nd</sup> at 12:00 PM ET**. You can either:

- Enter the codes within this Word document, save the file, and send it via email; or
- Print the form, enter the codes manually, scan the document, and send it via email.

#### Background

RTI International is currently developing a discharge to community measure for skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs), under a contract with the Centers for Medicare & Medicaid Services (CMS). In developing this measure, RTI seeks to understand discharge status coding practices on Medicare Fee-For-Service claims for patients discharged from a post-acute setting (SNF, IRF, or LTCH) to a long-term care nursing facility (NF) setting. In particular, RTI seeks to understand discharge status coding practices for patients who resided in a NF prior to the medical event leading to the post-acute care (PAC) admission, and those who resided in the community prior to the medical event. To this end, RTI seeks input from Technical Expert Panel members in coding various PAC discharge scenarios in the coding worksheets below.

A nursing home commonly provides two levels of services: (i) Medicare-covered post-acute skilled care, referred to as SNF care; and (ii) non-Medicare-covered custodial long-term care, referred to as NF care. Only SNF services are included under post-acute care. In the coding worksheets below, we distinguish between SNF and NF levels of care. To help us to properly interpret the discharge status codes, we are asking you how a PAC discharge status would be coded for various patterns of acute and PAC stays. Our ultimate goal is to determine when the discharge status code is equivalent to being discharged home.

#### Coding Worksheets

RTI requests TEP members to code various PAC discharge scenarios in the coding worksheets below, all of which end in discharge to a NF setting. For your reference, we have included valid values for the “Patient Discharge Status Code” variable in Appendix A. Please

enter the appropriate value of “Patient Discharge Status Code” for each scenario. Discharge scenarios are provided for SNF, IRF, and LTCH settings; please code discharge scenarios for PAC settings that are relevant to your experience.

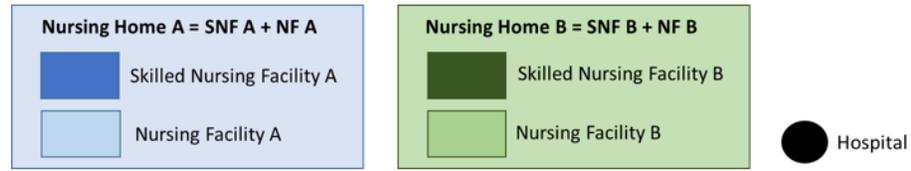
In each scenario, the first arrow represents the patient’s or resident’s baseline pre-hospital living setting; the last box represents the discharge destination from PAC. The black disk represents an acute hospital stay. SNF A and NF A (represented by dark and light blue boxes, respectively) fall under a single nursing home A, providing both levels of care. SNF B and NF B (represented by dark and light green boxes, respectively) fall under a single nursing home B.

### Coding Worksheet 1. Discharges from SNF Setting



SNF Scenarios	Patient Discharge Status Code
	
	
	
	
	
	

## Coding Worksheet 2. Discharges from IRF Setting



IRF Scenarios	Patient Discharge Status Code

### Coding Worksheet 3. Discharges from LTCH Setting



LTCH Scenarios	Patient Discharge Status Code

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## Appendix A of TEP Coding Worksheet. Patient Discharge Status Code

Short SAS Name: STUS\_CD

The code used to identify the status of the patient as of the CLM\_THRU\_DT.

Source: <http://www.resdac.org/cms-data/variables/patient-discharge-status-code>

### Codes:

Code	Code value
0	Unknown Value (but present in data)
01	Discharged to home/self care (routine discharge).
02	Discharged/transferred to other short term general hospital for inpatient care.
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care—(For hospitals with an approved swing bed arrangement, use Code 61—swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04—ICF.
04	Discharged/transferred to intermediate care facility (ICF).
05	Discharged/transferred to another type of institution for inpatient care (including distinct parts). NOTE: Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'
06	Discharged/transferred to home care of organized home health service organization.
07	Left against medical advice or discontinued care.
08	Discharged/transferred to home under care of a home IV drug therapy provider. (discontinued effective 10/1/05)
09	Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
20	Expired (did not recover - Christian Science patient).
21	Discharged/transferred to Court/Law Enforcement
30	Still patient
40	Expired at home (hospice claims only)
41	Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
42	Expired - place unknown (Hospice claims only)
43	Discharged/transferred to a federal hospital (eff. 10/1/03)
50	Hospice - home (eff. 10/96)
51	Hospice - medical facility (eff. 10/96)

(continued)

<b>Code</b>	<b>Code value</b>
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01)
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)
63	Discharged/transferred to a long term care hospitals. (eff. 1/2002)
64	Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare (eff. 10/2002)
65	Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code). (eff. 1/2005)
66	Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/06)
69	Discharged/transferred to a designated disaster alternative care site (eff. 10/2013)
70	Discharged/transferred to another type of health care institution not defined elsewhere in code list.
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
81	Discharged to home or self-care with a planned acute care hospital readmission (eff. 10/2013)
82	Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission (eff. 10/2013)
83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (eff. 10/2013)
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (eff. 10/2013)
85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (eff. 10/2013)
87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (eff. 10/2013)
88	Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission (eff. 10/2013)
89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (eff. 10/2013)

(continued)

<b>Code</b>	<b>Code value</b>
90	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
91	Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission (eff. 10/2103)
92	Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (eff. 10/2013)
93	Discharged/transferred to a psychiatric hospital/distinct part unit of a hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (eff. 10/2013)
95	Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission (eff. 10/2013)