



IRF and LTCH Virtual Training Program – Part 1

Social Determinants of Health and New/Revised Items A, B, and D

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Objectives

- Discuss the Social Determinants of Health (SDOH) data elements and their significance in the assessment process.
- Define and discuss the new/revised non-SDOH assessment data elements in Section A: Administrative/Identification Information.
- Define and discuss the new/revised non-SDOH assessment data elements in Section B: Hearing, Speech, and Vision.
- Summarize the implications for these items in your specific care setting.



Overview of Changes

New SDOH Items for IRF and LTCH:

- A1005. Ethnicity.
- A1010. Race.
- A1100. Language (New for IRF/Revised for LTCH).
- A1250. Transportation.
- B1300. Health Literacy.
- D0700. Social Isolation.

New Non-SDOH Items for IRF and LTCH:

- A2121 – A2124. Transfer of Health.
- A1990. Patient Discharged Against Medical Advice (LTCH only).
- B0200. Hearing.
- B1000. Vision.



Social Determinants of Health



What are SDOH?

- SDOH:
 - Are the conditions in which people live, work, learn, and play.
 - Affect a wide range of health risks and outcomes.¹
- SDOH data elements added to the post-acute care (PAC) assessment instruments conform to the 2011 Health and Human Services Data Standards.²

¹ <https://www.cdc.gov/socialdeterminants/about.html>

² <https://aspe.hhs.gov/reports/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-disability-0>



Why Is It Important to Collect SDOH?

Capturing standardized SDOH data helps to:

- Understand factors at the individual, community, and population levels.
- Improve quality of care and health outcomes.
- Document and track health disparities.
- Allow for comparison of SDOH data within and across PAC settings.
- Supports the collecting/sharing of data across certification, policy, and coordination agencies and stakeholders.



SDOH Data Elements – Sections A, B, and D

SDOH Data Elements – Sections A, B, and D

There are four standardized patient assessment data elements in Sections A, B, and D that are reflective of SDOH:

- A1005. Ethnicity.
- A1010. Race.
- A1110. Language.
- A1250. Transportation.
- B1300. Health Literacy.
- D0700. Social Isolation.



Section A: Intent

- Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) Manual:
 - The intent of these items is to document information about the patient.
- LTCH Continuity Assessment Record and Evaluation Data Set (LCDS) Manual:
 - This section obtains key information that uniquely identifies each patient, the long-term care hospital (LTCH) in which the patient receives health care services, and the reason(s) for assessment.



A1005

Ethnicity

A1005. Ethnicity



A1005. Ethnicity	
Are you of Hispanic, Latino/a, or Spanish origin?	
↓	Check all that apply
<input type="checkbox"/>	A. No, not of Hispanic, Latino/a, or Spanish origin
<input type="checkbox"/>	B. Yes, Mexican, Mexican American, Chicano/a
<input type="checkbox"/>	C. Yes, Puerto Rican
<input type="checkbox"/>	D. Yes, Cuban
<input type="checkbox"/>	E. Yes, another Hispanic, Latino, or Spanish origin
<input type="checkbox"/>	X. Patient unable to respond
<input type="checkbox"/>	Y. Patient declines to respond



A1005: Item Rationale



- The ability to improve understanding of and address ethnic disparities in health care outcomes requires the availability of better data related to SDOH, including ethnicity.
- The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provide data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards.
- Collection of ethnicity data is an important step in improving quality of care and health outcomes.



A1005: Item Rationale (cont.)



- Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple PAC settings.
- These categories are NOT used to determine eligibility for participation in any Federal program.



A1005: Steps for Assessment



1. Ask the patient to select the category or categories that most closely correspond to the patient's ethnicity from the list in A1005, Ethnicity.
 - Individuals may be more comfortable if this and the subsequent question is introduced by saying, *"We want to make sure that all of our patients get the best care possible, regardless of their ethnic background."*
2. Respondents should be offered the option of selecting one or more ethnic designations.
3. If a patient is **unable to respond**, a proxy response may be used.



A1005: Steps for Assessment (cont.)



4. If neither the patient nor a proxy is able to provide a response to this item, use medical record documentation.
5. If a patient **declines to respond**, do not code based on a proxy response or medical record documentation.



A1005: Coding Instructions

Complete as close to the time of admission as possible.

Check all that apply.

- If the patient **can provide a response**, check the box(es) indicating the ethnic category or categories identified by the patient.



A1005: Coding Instructions (cont.)



- **Code X, Patient unable to respond**, if the patient was unable to respond.
 - In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used. If response(s) is/are determined via proxy and/or using medical record documentation, check all boxes that apply, including Code X. Patient unable to respond.
 - If the patient was unable to respond and no other resources (proxy input, or medical record documentation) provided the necessary information, Code X. Patient unable to respond, only.



A1005: Coding Instructions (cont. 2)



- **Code Y, Patient declines to respond**, if the patient **declines to respond**.
 - In the cases where the patient declines to respond, Code Y, Patient declines to respond, **only**.
 - If the patient **declines to respond**, do not code based on a proxy input or medical record documentation.



A1010

Race

A1010. Race



A1010. Race	
What is your race?	
↓	Check all that apply
<input type="checkbox"/>	A. White
<input type="checkbox"/>	B. Black or African American
<input type="checkbox"/>	C. American Indian or Alaska Native
<input type="checkbox"/>	D. Asian Indian
<input type="checkbox"/>	E. Chinese
<input type="checkbox"/>	F. Filipino
<input type="checkbox"/>	G. Japanese
<input type="checkbox"/>	H. Korean
<input type="checkbox"/>	I. Vietnamese
<input type="checkbox"/>	J. Other Asian
<input type="checkbox"/>	K. Native Hawaiian
<input type="checkbox"/>	L. Guamanian or Chamorro
<input type="checkbox"/>	M. Samoan
<input type="checkbox"/>	N. Other Pacific Islander
<input type="checkbox"/>	X. Patient unable to respond
<input type="checkbox"/>	Y. Patient declines to respond
<input type="checkbox"/>	Z. None of the above



A1010: Item Rationale



- The ability to improve understanding of and address racial disparities in health care outcomes requires the availability of better data related to SDOH, including race.
- The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and **A1010. Race** provide data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards.



A1010: Item Rationale (cont.)

- Collection of race data is an important step in improving quality of care and health outcomes.
- Standardizing self-reported data collection for race allows for the comparison of data within and across multiple PAC settings.
- These categories are NOT used to determine eligibility for participation in any Federal program.



A1010: Steps for Assessment



1. Ask the patient to select the category or categories that most closely correspond to the patient's race from the list in A1010, Race.
 - Individuals may be more comfortable if this and the preceding question are introduced by saying, *"We want to make sure that all of our patients get the best care possible, regardless of their racial background."*
2. Respondents should be offered the option of selecting one or more racial designations.
3. If a patient is **unable to respond**, a proxy response may be used.



A1010: Steps for Assessment (cont.)



4. If neither the patient nor a proxy is able to provide a response to this item, use medical record documentation.
5. If a patient **declines to respond**, do not code based on a proxy response or medical documentation.



A1010: Coding Instructions

Complete as close to the time of admission as possible.

Check all that apply.

- If the patient **can provide a response**, check the box(es) indicating the race category or categories identified by the patient.



A1010: Coding Instructions (cont.)



- **Code X, Patient unable to respond**, if the patient **was unable to respond**.
 - In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used. If response(s) is/are determined via proxy and/or using medical record documentation, check all boxes that apply, including Code X. Patient unable to respond.
 - If the patient is unable to respond and no other resources (proxy input, or medical record documentation) provided the necessary information, Code X. Patient unable to respond, only.

A1010: Coding Instructions (cont. 2)



- **Code Y. Patient declines to respond**, if the patient **declines to respond**.
 - In the cases where the patient declines to respond, Code Y, Patient declines to respond, **only**.
 - If the patient **declines to respond**, do not code based on a proxy input or medical record documentation.
- **Code Z, None of the above**, if the patient reports or it is determined from proxy or medical record documentation that none of the listed races apply to the patient.



A1110

Language

A1110. Language



A1110. Language

Enter Code

☐

A. What is your preferred language?

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

- 0. No
- 1. Yes
- 9. Unable to determine

A1110: Item Rationale



- Language barriers can lead to social isolation, depression, and patient safety issues.
- Language barriers can interfere with accurate assessment.

A1110: Steps for Assessment

1. Ask for the patient's preferred language.
2. Ask **if** the patient ~~if he or she~~ needs or wants an interpreter to communicate with a doctor or health care staff.
3. If the patient **themselves** – or with the assistance of an **interpreter** – is unable to respond to **A1110A, What is your preferred language?** or **A1110B, Do you need or want an interpreter?** ~~ask a family member, significant other, guardian or legally authorized representative~~ a proxy response is permitted.



A1110: Steps for Assessment (cont.)

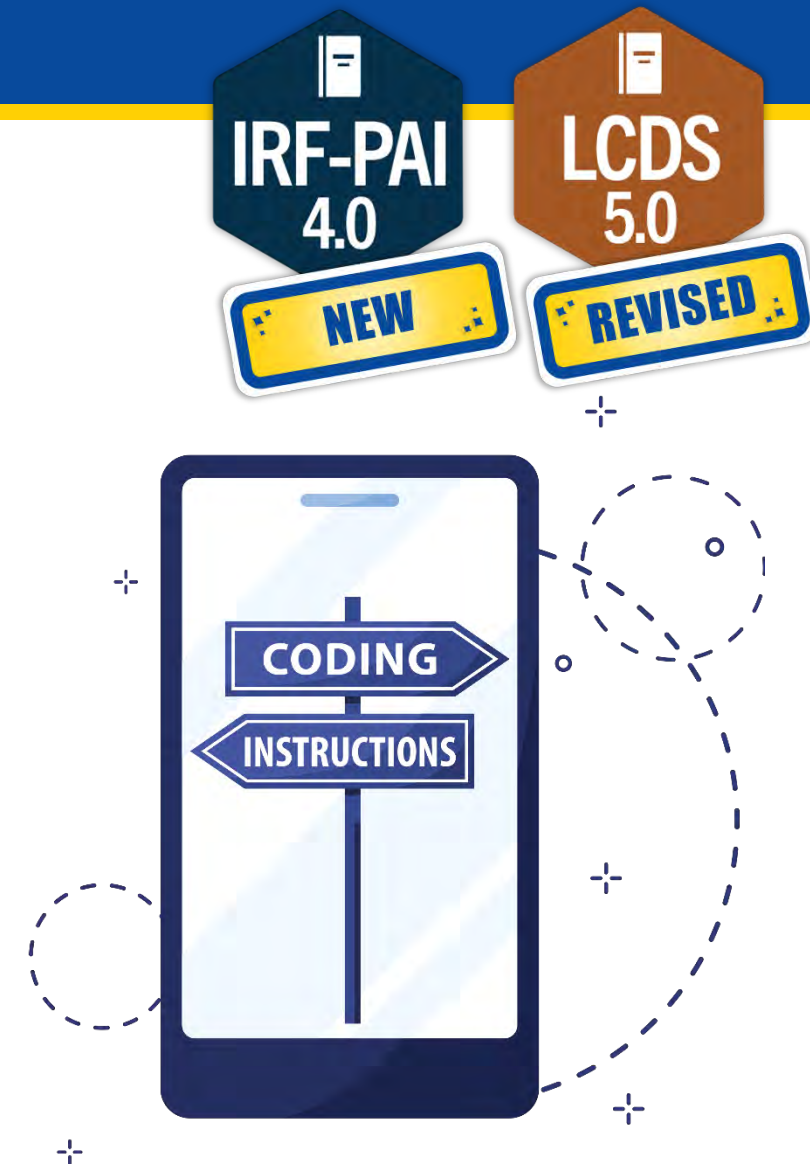
4. ~~If none of these sources is available, neither the patient nor a proxy is able to provide a response to A1110A or A1110B, medical review record of evidence of need for an interpreter documentation may be used.~~
5. ~~If an interpreter is wanted or needed, request one and note the preferred language in A1100B, Preferred Language.~~



A1110: Coding Instructions

IRF and LTCH: Complete as close to the time of admission as possible.

LTCH only: Complete only if A0250 = 01 Admission.



A1110A: Preferred Language



A. What is your preferred language?

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

A1110. Language

A. What is your preferred language?

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Enter Code

☐

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

- 0. No
- 1. Yes
- 9. Unable to determine

A1110A: Coding Instructions

- Enter the preferred language the patient primarily speaks or understands ~~after interviewing the patient, family members, significant others, guardians, or legally authorized representatives, observing the patient and listening, and reviewing the medical record.~~
- If the patient or any available source cannot or does not identify preferred language, enter a dash (“-”) in the first box. A dash indicates, “no information.” CMS expects dash use to be a rare occurrence.



A1110B: Patient Needs or Wants an Interpreter



B. Do you need or want an interpreter to communicate with a doctor or health care staff?

- 0. No
- 1. Yes
- 9. Unable to determine

A1110. Language

<div>Enter Code</div> <div><input type="checkbox"/></div>	A. What is your preferred language?
	<div><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/></div>
	B. Do you need or want an interpreter to communicate with a doctor or health care staff? <ul style="list-style-type: none">0. No1. Yes9. Unable to determine

A1110B: Coding Instructions

- **Code 0, No**, if the patient ~~(or family member, significant other, guardian or legally authorized representative, or medical record, if the patient is unable to communicate)~~ indicates that ~~he or she does not want~~ there is no need or ~~want to use~~ of an interpreter to communicate with a doctor or health care staff.
 - If the patient is unable to indicate the need or want of an interpreter, proxy input may be used.
 - If the patient is unable and a proxy response is not available, then medical record documentation may be used.



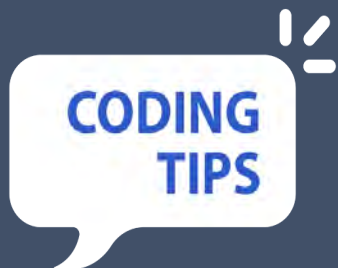
A1110B: Coding Instructions (cont.)



- **Code 1, Yes**, if the patient ~~(or family member, significant other, guardian, legally authorized representative, or medical record, if the patient is unable to communicate)~~ indicates ~~that he or she~~ the needs or wants ~~to use~~ of an interpreter to communicate with a doctor or health care staff. ~~Specify~~ Ensure that preferred language is indicated ~~by proceeding to A1100B and entering the patient's preferred language.~~
 - If the patient is unable to indicate the need or want of an interpreter, proxy input may be used.
 - If the patient is unable and a proxy response is not available, then medical record documentation may be used.

A1110B: Coding Instructions (cont. 2)

- **Code 9. Unable to determine**, if ~~none of these~~ no sources can identify whether the patient wants or needs an interpreter.



An organized system of signing such as American Sign Language (ASL) can be reported as the preferred language if the patient needs or wants to communicate in this manner.



A1250

Transportation

A1250. Transportation



A1250. Transportation (from NACHC©)	
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	
↓ Check all that apply	
<input type="checkbox"/>	A. Yes, it has kept me from medical appointments or from getting my medications
<input type="checkbox"/>	B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
<input type="checkbox"/>	C. No
<input type="checkbox"/>	X. Patient unable to respond
<input type="checkbox"/>	Y. Patient declines to respond
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A1250: Item Rationale



- Access to transportation for ongoing health care and medication access needs is essential to effective care management.
- Understanding patient transportation needs can help organizations assess barriers to care and facilitate connections with available community resources.



A1250: Steps for Assessment



1. Ask the patient:
 - *“In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?”*
 - *“In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?”*
2. Patient should be offered the option of selecting more than one “yes” designation, if applicable.
3. If the patient is unable to respond, a proxy response may be used.



A1250: Steps for Assessment (cont.)



4. If neither the patient nor a proxy is able to provide a response to this item, medical documentation may be used.
5. If the patient declines to respond, do not code based on proxy input or medical documentation.



A1250: Coding Instructions

Complete as close to the time of admission as possible and within three days of discharge.

Check all that apply.



A1250: Coding Instructions (cont.)



- **Code A**, if the patient indicates that lack of transportation has kept the patient from medical appointments or from getting medications.
- **Code B**, if the patient indicates that lack of transportation has kept the patient from non-medical meetings, appointments, work, or from getting things that the patient needs.
- **Code C**, if the patient indicates that a lack of transportation has not kept the patient from medical appointments, getting medications, non-medical meetings, appointments, work or getting things that the patient needs.



A1250: Coding Instructions (cont. 2)



- **Code X, Patient unable to respond**, if the patient was unable to respond.
 - In the cases where the patient is unable to respond, a response may be determined via proxy input. If a proxy is not able to provide a response, medical record documentation may be used. If response(s) is/are determined via proxy input, and/or medical record documentation, check all boxes that apply, including Code X. Patient unable to respond.
 - If the patient was unable to respond and no other resources (proxy, or medical record documentation) provided the necessary information, Code X. Patient unable to respond, only.



A1250: Coding Instructions (cont. 3)

- **Code Y, Patient declines to respond**, if the patient declines to respond.
 - In the cases where the patient declines to respond, Code Y, Patient declines to respond, only.
 - If the patient **declines to respond** do not code based on proxy input or medical record documentation to complete this item.

B1300

Health Literacy

B1300. Health Literacy



B1300. Health Literacy (from Creative Commons©)	
How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	
Enter Code	
<input type="text"/>	0. Never
	1. Rarely
	2. Sometimes
	3. Often
	4. Always
	7. Patient unable to respond
	8. Patient declines to respond
<i>The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.</i>	








B1300: Rationale

- Similar to language barriers, low health literacy interferes with communication between provider and patient.
- Health literacy can also affect the ability for patients to understand and follow treatment plans, including medication management.
- Poor health literacy is linked to lower levels of knowledge of health, worse outcomes, the receipt of fewer preventive services, and higher medical costs and rates of emergency department use.



patients with low
HEALTH LITERACY...

 Are more likely to visit an EMERGENCY ROOM	 Have more HOSPITAL STAYS	 Are less likely to follow TREATMENT PLANS	 Have higher MORTALITY RATES
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www.cdc.gov/phpr 

B1300: Definition



Health Literacy



Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

B1300: Steps for Assessment



This item is intended to be a patient self-report item. No other source should be used to identify the response.

1. Ask the patient, *“How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?”*

B1300: Coding Instructions

IRF and LTCH: Complete as close to the time of admission as possible and within three days of discharge.

LTCH Only: Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.



B1300: Coding Instructions (cont.)



- **Code 0, Never**, if the patient indicates never needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 1, Rarely**, if the patient indicates rarely needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 2, Sometimes**, if the patient indicates sometimes needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.



B1300: Coding Instructions (cont. 2)



- **Code 3, Often**, if the patient indicates often needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 4, Always**, if the patient indicates always needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 7, Patient declines to respond**, if the patient declines to respond.
- **Code 8, Patient unable to respond**, if the patient was unable to respond.

D0700

Social Isolation

D0700. Social Isolation



D0700. Social Isolation	
How often do you feel lonely or isolated from those around you?	
Enter Code	<div>0. Never</div> <div>1. Rarely</div> <div>2. Sometimes</div> <div>3. Often</div> <div>4. Always</div> <div>7. Patient declines to respond</div> <div>8. Patient unable to respond</div>



D0700: Item Rationale



- Social isolation:
 - Tends to increase with age.
 - Is a risk factor for physical and mental illness.
 - Is a predictor of mortality.

D0700: Definition



Social Isolation



Social isolation refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area.

D0700: Steps for Assessment



This item is intended to be a patient self-report item. No other source should be used to identify the response.

1. Ask the patient, “*How often do you feel lonely or isolated from those around you?*”

D0700: Coding Instructions

IRF and LTCH: Complete as close to the time of admission as possible and within three days of discharge.

LTCH Only: Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.



D0700: Coding Instructions (cont.)



- **Code 0, Never**, if the patient indicates never feeling lonely or isolated from others.
- **Code 1, Rarely**, if the patient indicates rarely feeling lonely or isolated from others.
- **Code 2, Sometimes**, if the patient indicates sometimes feeling lonely or isolated from others.



D0700: Coding Instructions (cont. 2)



- **Code 3, Often**, if the patient indicates often feeling lonely or isolated from others.
- **Code 4, Always**, if the patient indicates always feeling lonely or isolated from others.
- **Code 7, Patient declines to respond**, if the patient declines to respond.
- **Code 8, Patient unable to respond**, if the patient was unable to respond.



Non-SDOH Data Elements

A1990

Patient Discharged Against Medical Advice

A1990. Patient Discharged Against Medical Advice



A1990. Patient Discharged Against Medical Advice?	
Enter Code	0. No 1. Yes



A1900: Item Rationale



- Allows identification of unplanned discharges that occurred against medical advice.
- Defined as situations where the patient elects to leave the facility prior to the managing physician's recommendation for discharge.
- Discharges against medical advice are a predictor for 30-day readmissions and may also put patients at greater risk for adverse clinical outcomes.



A1900: Steps for Assessment



1. Confirm the patient's record does not contain a discharge order from the managing physician.



A1900: Coding Instructions and Tip



- Complete only if A0250 = 11 Unplanned discharge.
 - **Code 0, No**, if the patient was not discharged against medical advice.
 - **Code 1, Yes**, if the patient was discharged against medical advice.



Although not required, individual facilities may elect to use their own Discharge Against Medical Device form to be signed by the patient and/or family.

A2121–A2124

Transfer of Health Information

A2121-A2124: Important Terms



At the Time of Discharge



At the Time of Discharge

- This is the period of time as close to the actual time of discharge as possible. This time may be based on facility, State, or Federal guidelines for data collection at discharge.

Current Reconciled Medication List



Current Reconciled Medication List

- This refers to a list of the patient's current medications at the time of discharge that was reconciled by the facility prior to the patient's discharge.

A2121-A2124: Important Terms (cont.)



Means of Providing a Current Reconciled Medication List



Means of Providing a Current Reconciled Medication List

- Providing the current reconciled medication list at the time of discharge can be accomplished by any means, including active means (e.g., by mail, electronically, or verbally) and more passive means (e.g., a common electronic health record (EHR), giving providers access to a portal).

A2121-A2124: Important Terms (cont. 2)



Electronic Health Record



EHR/Electronic Medical Record (EMR)

- An EHR, sometimes referred to as an Electronic Medical Record (EMR), is an electronic version of a patient's medical history that is maintained over time.

Portal



Portal

- A portal is a secure online website that gives providers, patients, and others convenient, 24-hour access to personal health information from anywhere with an internet-connection.

A2121

Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge



A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge At the time of discharge to another provider, did your facility provide the patient’s current reconciled medication list to the subsequent provider?	
Enter Code <input type="text"/>	<p>0. No – Current reconciled medication list not provided to the subsequent provider → <i>Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge</i></p> <p>1. Yes – Current reconciled medication list provided to the subsequent provider</p>



A2121: Item Rationale



- The transfer of a current reconciled medication list at the time of discharge can improve care coordination and quality of care, can help subsequent providers reconcile medications, and may mitigate adverse outcomes related to medications.
- Communication of medication information at discharge is critical to ensure safe and effective transitions from one health care setting to another.



A2121: Steps for Assessment



1. Determine if the patient was discharged to one of the subsequent providers.
2. If yes, determine if, at the time of discharge, your facility provided a current reconciled medication list to the patient's subsequent provider.



A2121 – A2122: Subsequent Provider for IRF

Based on the discharge locations in 44D, subsequent providers are defined as any of the following:

- 02 - Short-term General Hospital.
- 03 - Skilled Nursing Facility (SNF).
- 04 - Intermediate Care.
- 06 - Home under care of organized home health service organization.
- 50 - Hospice (home).
- 51 - Hospice (medical facility).
- 61 - Swing Bed.
- 62 - Another Inpatient Rehabilitation Facility.
- 63 - Long-Term Care Hospital (LTCH).
- 64 - Medicaid Nursing Facility.
- 65 - Inpatient Psychiatric Facility.
- 66 - Critical Access Hospital (CAH).
- 99 - Not Listed.



A2121 – A2122: Subsequent Provider for LTCH

Based on the discharge locations in A2105, subsequent providers are defined as any of the following:

- 02. Nursing home (long-term care facility).
- 03. Skilled nursing facility (SNF, swing bed).
- 04. Short-term General Hospital (acute hospital, IPPS).
- 05. Long-Term Care Hospital (LTCH).
- 06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit).
- 07. Inpatient Psychiatric Facility (psychiatric hospital or unit).
- 08. Intermediate Care Facility (ID/DD facility).
- 09. Hospice (home/non-institutional).
- 10. Hospice (institutional facility).
- 11. Critical Access Hospital (CAH).
- 12. Home under care of organized home health service organization.
- 99. Not Listed.



A2121: Coding Instructions

IRF: Within three days of discharge, complete as close to the time of discharge as possible.

LTCH: Complete as close to the time of discharge as possible, and only if A0250 = 10 or 11 (Planned or Unplanned discharge respectively).



A2121: Coding Instructions (cont.)



- **Code 0, No**, if at discharge to a subsequent provider, your facility did not provide the patient's current reconciled medication list to the subsequent provider, or the patient was not discharged to a subsequent provider.
- **Code 1, Yes**, if at discharge to a subsequent provider, your facility did provide the patient's current reconciled medication list to the subsequent provider.



A2121: Coding Tips



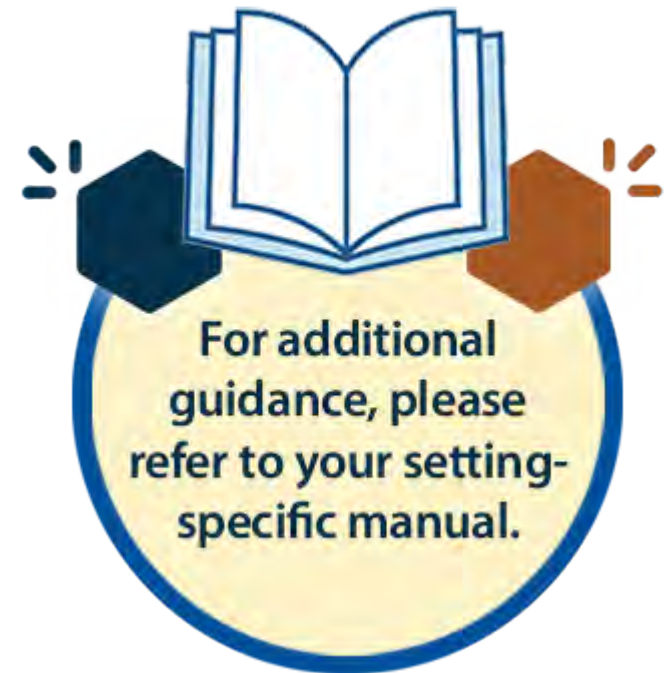
- While the patient may receive care from other providers after discharge from the facility, such as primary care providers, other outpatient providers, and treatment centers, these locations are not considered to be subsequent providers for the purposes of coding this item.
- Your facility should be guided by current standards of care and any applicable regulations and guidelines (e.g., Conditions of Participation) in determining what information should be included in a current reconciled medication list.



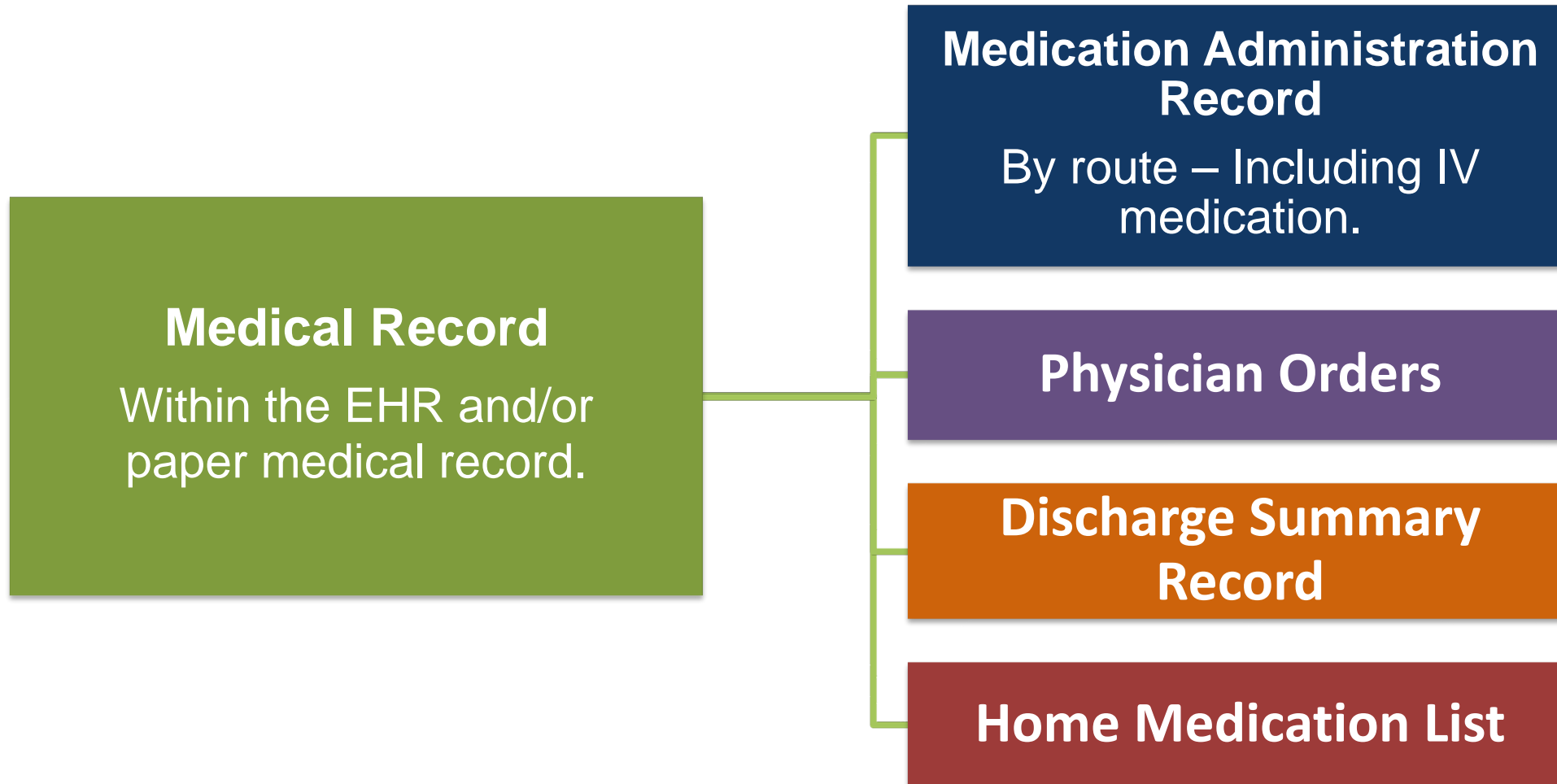
Additional Considerations for Important Medication List Content



- Other key elements may exist on a reconciled medication list, including but not limited to:
 - Demographic information.
 - Allergies and/or adverse reactions.
 - Special instructions.
 - Purpose or indication for use.
 - Current prescribed and over-the-counter medications.
- While this information serves as guidance, the completeness of the medication list is left to the discretion of the provider and patient.



A2121: Documentation Sources



A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider



A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider	
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.	
Route of Transmission	Check all that apply ↓
A. Electronic Health Record	<input type="checkbox"/>
B. Health Information Exchange	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>



A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider (cont.)



- For the purposes of this training, we will review **A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider** in full and later in the presentation very briefly summarize **A2124. Route of Current Reconciled Medication List to Patient** as the routes of transmission are the same for both data elements.



Please note: These data elements are being presented sequentially in this training. The order is slightly different in the manual, but content is unchanged.

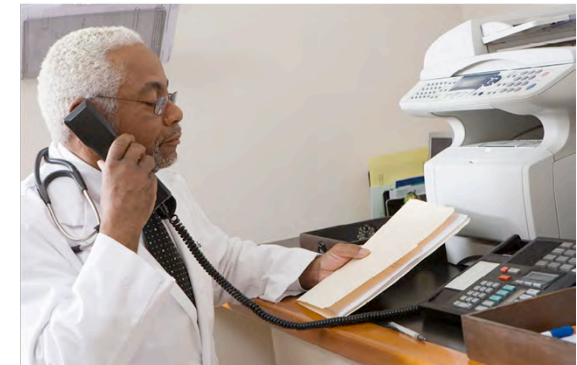
A2122: Item Rationale

This item collects important data to monitor how medication lists are transmitted at discharge.



A2122: Steps for Assessment

Identify all routes of transmission that were used to provide the patient's current reconciled medication list to the subsequent provider.



A2122: Coding Instructions

IRF: Within three days of discharge, complete as close to the time of discharge as possible.

LTCH: Complete as close to the time of discharge as possible, and only if A0250 = 10 or 11 (Planned or Unplanned discharge respectively). Select the codes that correspond to the routes of transmission used to provide the medication list to the subsequent provider.



A2122: Coding Instructions (cont.)



- Select the codes that correspond to the routes of transmission used to provide the medication list to the subsequent provider.
 - **Check A2122A, Electronic Health Record**, if your facility has an EHR, sometimes referred to as an electronic medical record (EMR) and used it to transmit or provide access to the reconciled medication list to the subsequent provider.
 - This would include situations where both the discharging and receiving provider have direct access to a common EHR system.
 - Checking this route does not require confirmation that the subsequent provider has accessed the common EHR system for the medication list.



A2122: Coding Instructions (cont. 2)



- **Check A2122B, Health Information Exchange**, if your facility participates in a Health Information Exchange (HIE) and used the HIE to electronically exchange the current reconciled medication list with the subsequent provider.
- **Check A2122C, Verbal**, if the current reconciled medication list information was verbally communicated (e.g., in-person, telephone, video conferencing) to the subsequent provider.



A2122: Coding Instructions (cont. 3)



- **Check A2122D, Paper-Based**, if the current reconciled medication list was transmitted to the subsequent provider using a paper-based method, such as a printout, fax, or e-fax.
- **Check A2122E, Other Methods**, if the current reconciled medication list was transmitted to the subsequent provider using another method not listed above (e.g., texting, email, CDs).



A2122: Coding Tips



- The route of transmission usually is established with each subsequent provider depending on how they are able to receive information from your facility.
- The route(s) may not always be documented in the patient's record.
- It will be helpful to understand and document how your facility typically transmits information to each subsequent provider at discharge to prepare for coding this item.
- More than one route of transmission may apply. Check all that apply.

A2123

Provision of Current Reconciled Medication List to Patient at Discharge

A2123. Provision of Current Reconciled Medication List to Patient at Discharge – LCDS



PLANNED
DISCHARGE

A2123. Provision of Current Reconciled Medication List to Patient at Discharge	
At the time of discharge, did your facility provide the patient’s current reconciled medication list to the patient, family and/or caregiver?	
Enter Code	0. No – Current reconciled medication list not provided to the patient, family and/or caregiver → Skip to B0100, Comatose
	1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver

UNPLANNED
DISCHARGE

A2123. Provision of Current Reconciled Medication List to Patient at Discharge	
At the time of discharge, did your facility provide the patient’s current reconciled medication list to the patient, family and/or caregiver?	
Enter Code	0. No – Current reconciled medication list not provided to the patient, family and/or caregiver → Skip to C1310, Signs and Symptoms of Delirium (from CAM®)
	1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver

A2123. Provision of Current Reconciled Medication List to Patient at Discharge – IRF-PAI



A2123. Provision of Current Reconciled Medication List to Patient at Discharge

At the time of discharge, did your facility provide the patient’s current reconciled medication list to the patient, family and/or caregiver?

Enter Code <input type="text"/>	<p>0. No – Current reconciled medication list not provided to the patient, family and/or caregiver → <i>Skip to B1300, Health Literacy</i></p> <p>1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver</p>
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A2123: Item Rationale



- Communication of medication information to the patient at discharge is critical to ensuring safe and effective discharges.
- The item, collected at the time of discharge, can improve care coordination and quality of care, aids in medication reconciliation, and may mitigate adverse outcomes related to medications.
- It is recommended that a reconciled medication list that is provided to the patient, family, and/or caregiver use consumer-friendly terminology and plain language to ensure that the information provided to patients and caregivers is clear and understandable.



A2123: Steps for Assessment



1. Determine if the patient was discharged to a Home setting (01) or Not Listed location (99) based on discharge location response in item 44D for IRFs or item A2105 for LTCHs.
2. If yes, determine if, at the time of discharge, your facility provided the patient's medication list to the patient, family and/or caregiver.



A2123: Coding Instructions

IRF: Within three days of discharge, complete as close to the time of discharge as possible.

LTCH: Complete as close to the time of discharge as possible, and only if A0250 = 10 or 11 (Planned or Unplanned Discharge, respectively).



A2123: Coding Instructions (cont.)



- **Code 0, No**, if at discharge to a home setting, or a not listed location, your facility did not provide the patient's current reconciled medication list to the patient, family, and/or caregiver. Or the patient was discharged to a subsequent provider.
- **Code 1, Yes**, if at discharge to a home setting, or a not listed location, your facility did provide the patient's current reconciled medication list to the patient, family, and/or caregiver.



A2123: Coding Tips



Home setting is based on a select group of discharge locations:

- LCDS A2105. Discharge Location:
 - 01. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements).
 - 99. Not Listed.
- IRF-PAI 44D. Patient's discharge destination/living setting:
 - 01. Home (private home/apt, board/care, assisted living, group home, transitional living, other residential care arrangements).
 - 99. Not Listed.

A2123: Coding Tips (cont.)



Patient/Family/Caregiver:

- The recipient of the current reconciled medication list can be the:
 - Patient.
 - Family member.
 - Other caregiver.
- It is not necessary to provide the current reconciled medication list to all of these recipients in order to code 1, Yes.

A2124

Route of Current Reconciled Medication List Transmission to Patient

A2124. Route of Current Reconciled Medication List Transmission to Patient



A2124. Route of Current Reconciled Medication List Transmission to Patient	
Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver.	
Route of Transmission	Check all that apply ↓
A. Electronic Health Record (e.g., electronic access to patient portal)	<input type="checkbox"/>
B. Health Information Exchange	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>



A2124: Overview

- In A2124 the Coding Rationale, Instructions and Tips are the same as what was reviewed for **A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider.**
- The Step for Assessment in A2124 is the same as in A2122 except that it pertains to identifying all routes of transmission used to provide the patient's current reconciled medication list to the **patient, family, and/or caregiver** rather than the subsequent provider.



B0200

Hearing, Speech, and Vision

Section B: Hearing, Speech, and Vision



B0200. Hearing

Enter Code

Ability to hear (with hearing aid or hearing appliances if normally used)

0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

ADMISSION
ONLY

B1000. Vision

Enter Code

Ability to see in adequate light (with glasses or other visual appliances)

0. **Adequate** - sees fine detail, such as regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

Section B: Hearing, Speech, and Vision – Intent

The intent of these items is to document the patient's ability to hear (with assistive devices, if they are used) understand and communicate with others, and the patient's ability to see objects nearby in their environment.



B0200

Hearing

B0200. Hearing



B0200. Hearing	
Enter Code	<p>Ability to hear (with hearing aid or hearing appliances if normally used)</p> <ul style="list-style-type: none">0. Adequate - no difficulty in normal conversation, social interaction, listening to TV1. Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or setting is noisy)2. Moderate difficulty - speaker has to increase volume and speak distinctly3. Highly impaired - absence of useful hearing



B0200: Item Rationale

- Problems with hearing can contribute to sensory deprivation, social isolation, and mood and behavior disorders.
- Unaddressed communication problems related to hearing impairment can be mistaken for confusion or cognitive impairment.



B0200: Steps for Assessment



1. Ensure that the patient is using their normal hearing appliance if they have one. Hearing devices may not be as conventional as a hearing aid. Some patients by choice may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids. Ensure that the hearing appliance is operational.
2. Interview the patient and ask about hearing function in different situations (e.g., hearing staff or family members, talking to visitors, using telephone, watching TV, participation in group discussion).



B0200: Steps for Assessment (cont.)



3. Observe the patient during your verbal interactions and when interacting with others throughout the day.
4. Think through how you can best communicate with the patient. For example, you may speak more clearly, use a louder tone, speak more slowly, or use gestures. The patient may need to see your face to understand what you are saying, or you may need to take the patient to a quieter area for them to hear you. All of these are cues that there is a hearing problem.
5. Review the medical record.
6. Consult the patient's family, caregivers, direct care staff, activities personnel, and speech or hearing specialists as needed.



B0200: Coding Instructions

IRF and LTCH: Complete as close to the time of admission as possible.

LTCH Only: Complete only if A0250 = 01 Admission.



B0200: Coding Instructions (cont.)



- **Code 0, Adequate**, No difficulty hearing in normal conversation and social interactions, or listening to TV. The patient hears all normal conversational speech and telephone or group conversations.
- **Code 1, Minimal Difficulty**, if difficulty in some environments (e.g., when a person speaks softly or the setting is noisy). The patient hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations. The patient's hearing is adequate after environmental adjustments are made, such as reducing background noise by moving to a quiet room or by lowering the volume on television or radio.



B0200: Coding Instructions (cont. 2)



- **Code 2, Moderate Difficulty**, Speaker has to increase volume and speak distinctly. Although hearing-deficient, the patient compensates when the speaker adjusts tonal quality and speaks distinctly; or the patient can hear only when the speaker's face is clearly visible.
- **Code 3, Highly Impaired**, Absence of useful hearing. The patient hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face-to-face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

B0200: Coding Tips



- Patients who are unable to respond to a standard hearing assessment due to cognitive impairment will require alternate assessment methods. The patient can be observed in their normal environment. Do they respond (e.g., turn their head) when a noise is made at a normal level? Does the patient seem to respond only to specific noise in a quiet environment? Assess whether the patient responds only to loud noise or do they not respond at all.

B1000

Vision

B1000. Vision



B1000. Vision	
Enter Code	<p>Ability to see in adequate light (with glasses or other visual appliances)</p> <ul style="list-style-type: none">0. Adequate - sees fine detail, such as regular print in newspapers/books1. Impaired - sees large print, but not regular print in newspapers/books2. Moderately impaired - limited vision; not able to see newspaper headlines but can identify objects3. Highly impaired - object identification in question, but eyes appear to follow objects4. Severely impaired - no vision or sees only light, colors or shapes; eyes do not appear to follow objects



B1000: Item Rationale



- A person's reading vision often diminishes over time.
- If uncorrected, vision impairment can limit the enjoyment of everyday activities such as reading newspapers, books or correspondence, and maintaining and enjoying other activities. It also limits the ability to manage personal business, such as signing consent forms.
- Moderate, high, or severe impairment can contribute to sensory deprivation, social isolation, and depressed mood.

Definitions



Adequate Lighting



Lighting that is sufficient or comfortable for a person with normal vision to see fine detail.

B1000: Steps for Assessment



1. Ask family, caregivers, and/or direct care staff over all shifts, if possible, about the patient's usual vision patterns at admission (e.g., is the patient able to see newsprint, menus, greeting cards?).
2. Then, ask the patient about their visual abilities.
3. Test the accuracy of your findings:
 - Ensure that the patient's customary visual appliance for close vision is in place (e.g., eyeglasses, magnifying glass).
 - Ensure adequate lighting.

B1000: Steps for Assessment (cont.)



- Ask the patient to look at regular-sized print in a book or newspaper. Then, ask the patient to read aloud, starting with larger headlines and ending with the finest, smallest print. If the patient is unable to read a newspaper, provide material with larger print, such as a flyer or large textbook.
- When the patient is unable to read aloud (e.g., due to aphasia, illiteracy), you should test this by another means, such as, but not limited to:
 - Substituting numbers or pictures for words that are displayed in the appropriate print size (regular-size print in a book or newspaper).

B1000: Coding Instructions

IRF and LTCH: Complete as close to the time of admission as possible.

LTCH Only: Complete only if A0250 = 01 Admission.



B1000: Coding Instructions (cont.)



- **Code 0, Adequate**, if the patient sees fine detail, including regular print in newspapers/books.
- **Code 1, Impaired**, if the patient sees large print, but not regular print in newspapers/books.
- **Code 2, Moderately Impaired**, if the patient has limited vision and is not able to see newspaper headlines but can identify objects nearby in their environment.



B1000: Coding Instructions (cont. 2)



- **Code 3, Highly Impaired**, if the patient's ability to identify objects nearby in their environment is in question, but the patient's eye movements appear to be following objects (especially people walking by).
- **Code 4, Severely Impaired**, if the patient has no vision, sees only light, colors, or shapes, or does not appear to follow objects with eyes.

B1000: Coding Tips



- Some patients have never learned to read or are unable to read English. In such cases, ask the patient to read numbers, such as dates or page numbers, or to name items in small pictures. Be sure to display this information in two sizes (equivalent to regular and large print).

B1000: Coding Tips (cont.)



- If the patient is unable to communicate or follow your directions for testing vision, observe the patient's eye movements to see if their eyes seem to follow movement and objects.
- Though these are gross measurements of visual acuity, they may assist you in assessing whether or not the patient has any visual ability. For patients who appear to follow movement and objects, **Code 3, Highly impaired.**



Summary



- New SDOH data elements in Sections A, B, and D were added to the IRF-PAI and LCDS to conform to the 2011 Health and Human Services Data Standards.
- In addition, there are a few non-SDOH data elements that were added, and another data element was revised to achieve standardization.

Submitting Questions

- If you have questions about this presentation, please submit them to PACTraining@Econometricalnc.com by June 3, 2022.
- Select questions will be answered in a Q&A session during the June 2022 virtual live event.

