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Summary of Feedback from the Technical Expert Panel (TEP) Regarding Cross-Setting Measures Aligned with the IMPACT Act of 2014

Report

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RTI INTERNATIONAL

SUMMARY OF FEEDBACK FROM THE TECHNICAL EXPERT PANEL (TEP) REGARDING CROSS-SETTING MEASURES ALIGNED WITH THE IMPACT ACT OF 2014

RTI International

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BACKGROUND

On October 6, 2014, President Obama signed the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act). The Act requires the development of cross-setting quality measures, including the following settings: Long-Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs). In order to implement the IMPACT Act, the Centers for Medicare & Medicaid Services (CMS) contracted with RTI International and Abt Associates to identify, develop, and maintain post-acute care cross-setting quality measures for the IRF, LTCH, SNF, and HHA settings. As part of the quality measure development work, RTI, in partnership with Abt Associates, convened a technical expert panel (TEP) via webinar on February 3, 2015. Additional feedback on specific issues raised during the TEP meeting was sought from TEP members via email following the webinar.

The purpose of the TEP meeting was to gather input on three cross-setting measures identified as potential measures to meet the requirements of the IMPACT Act. A specific focus of this TEP was to ensure that the measures accurately address concerns from stakeholders from different care settings. The TEP consisted of clinicians, researchers, and administrators with expertise in pressure ulcers, falls, functional assessment, and quality measure development across SNF, IRF, LTCH and HHA settings. Three cross-setting quality measures were discussed:

1. National Quality Forum (NQF) #0678: Percentage of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)
2. An Application of NQF #0674: Percentage of Residents Experiencing One or More Falls with Major Injury (Long Stay)
3. An Application of Percentage of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631; under NQF review)

This report summarizes discussions amongst TEP members during the February 3, 2015 meeting as well as TEP member responses to specific questions emailed to TEP members after the meeting. Appendix A of the report shows the slides presented during the TEP webinar.

THE MEASURE DEVELOPMENT TEAMS

The RTI cross-setting measure development team is multidisciplinary and includes individuals with knowledge and expertise in the areas of quality measure development, post-acute care, epidemiology, statistics, public health, and health care policy. The RTI post-acute care measure development is led by a team of four measure development experts: Karen Reilly, ScD; Samruddhi Thaker, MBBS, MHA, PhD; Laura Smith, PhD; and Anne Deutsch, RN, PhD, CRRN. The Abt Associates measure development team includes Terry Moore, BSN, MPH; Sara Galantowicz, MPH; Jen Pettis, BS, RN, WCC; and Nicole Keane, MSN, RN.

THE TECHNICAL EXPERT PANEL (TEP)

The TEP, convened after an open call for nominations, was composed of a diverse group of stakeholders with post-acute care expertise across settings of care. A list of all TEP members is provided in Table 1.

Table 1
Members of the TEP Regarding Cross-Setting Measures Aligned with the IMPACT Act of 2014

Name	Professional Role	Location
Sandra Bergquist-Beringer, RN, PhD, CWCN	Associate Professor, School of Nursing at the University of Kansas Medical Center	Kansas City, KS
Michelle Camicia, MSN, CRRN, CCM	Director, Kaiser Foundation Rehabilitation Center	Vallejo, CA
Jean de Leon, MD	Professor, UT Southwestern Medical Center's Department of Physical Medicine and Rehabilitation Medical Director, Wound Care & Hyperbaric Oxygen Therapy Clinic	Dallas, TX
Barbara Gage, PhD	Fellow, Brookings Institution Senior Vice President, Post-Acute Care Center for Research (PACCR) Research Faculty, University of Southern California	Washington, DC
Bruce Gans, MD	Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation National Medical Director, Rehabilitation for Select Medical Professor of Physical Medicine and Rehabilitation, Rutgers New Jersey Medical School Chairman, governing board of the American Medical Rehabilitation Providers Association	West Orange, New Jersey
Barbara Goodman, RN, BSN, MSN, CHCE, COS-C, HCS-D, CPHQ	Vice President for Regulatory/Clinical Support for LHC Group	Lafayette, LA
Trudy Mallinson, PhD, OTR./L, FAOTA, NZROT	Visiting Associate Professor, School of Medicine and Health Sciences at the George Washington University	Washington, DC
Cynthia Morton, MPA	Executive Vice President, National Association for the Support of Long-Term Care (NASL)	Washington, DC
Christopher Murtaugh, PhD	Associate Director, Visiting Nurse Service of New York (VNSNY) Center for Home Care Policy and Research Faculty, Department of Public Health, Weill Medical College of Cornell University and Department of Geriatrics and Palliative Medicine at the Icahn School of Medicine at Mount Sinai	New York, NY
Barbara Resnick, PhD, CRNP	Professor, Department of Organizational Systems and Adult Health, University of Maryland School of Nursing Co-director, Adult/Gerontological Nurse Practitioner Program and the Biology and Behavior Across the Lifespan Research Center of Excellence, Sonya Ziporkin Gershowitz Chair in Gerontology Clinician at Roland Park Place	Baltimore, MD
Mary Van de Kamp, MS/CCC-SLP	Senior Vice President of Quality and Care Management, Kindred Healthcare	Louisville, KY

TEP FEEDBACK REGARDING THE THREE CROSS-SETTING QUALITY MEASURES

This section presents a summary of the TEP meeting and post-meeting feedback regarding the three cross-setting measures. TEP member feedback was guided by a series of open-ended questions for each of the three cross-setting quality measures. The questions are delineated below, stratified by each measure topic, and TEP member input is listed under each measure topic.

TEP MEMBER FEEDBACK

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

During the webinar, RTI staff reviewed the quality measure, and TEP members were asked to respond to four general questions specific to the cross-setting pressure ulcer measure. The questions are listed below along with responses aggregated into general categories because the discussion did not strictly adhere to question order.

1. *What are the strengths and what challenges should CMS anticipate in implementing this measure across the four post-acute care settings?*

2. *What are the potential unintended consequences of implementing this cross-setting measure?*

3. *What are the major setting-specific strengths and weaknesses regarding the expansion of this measure to HHAs?*

4. *What are the strengths and weaknesses regarding continuing to use and further refine this measure for use in Nursing Homes (NHs)/SNFs, LTCHs, and IRFs)?*

TEP Feedback: Measure Strengths

- The TEP was appreciative of CMS's prior work on developing this measure.

- TEP members noted that this measure will be important as CMS moves towards site-neutral and bundled payments.

- TEP members shared that for HHAs, this will be a new quality measure, and providers are generally willing to participate in data collection and reporting.

TEP Feedback: Measure Challenges and Areas for Further Development

Risk Adjustment and Selection of Risk Factors

- TEP members encouraged CMS to consider modifying the risk adjustment model in the future to include additional risk factors. Risk factors that were discussed included the following:

    - Anemia.

    - Interpersonal Factors: Several TEP members stressed the importance of adjusting for interpersonal factors such as living alone, especially in the HHA setting. However, one TEP member suggested that these factors are not significantly associated with pressure

ulcer development; further, this member suggested that factors such as bowel incontinence and decline in function were strongly associated with the development of pressure ulcers.

- Patient/Resident and Caregiver Participation: A few TEP members suggested patient/resident willingness to be involved in care and caregiver willingness to participate in pressure ulcer prevention are important risk factors that should be included in the quality measure, especially in home health. One TEP member cautioned that CMS should be leery of including risk factors in measure specifications that may "bless bad care." The TEP member described how HHAs (or other types of facilities) can implement changes, such as increased nursing care, to address issues around caregiver willingness to perform pressure ulcer prevention activities. It is particularly important to consider the impact of the measure specifications when they are tied to policy and could eventually affect payment.

Focus on Outcome Instead of Process Measures

- One TEP member said that the measure seemed too focused on outcomes instead of processes associated with prevention of pressure ulcers. This member shared the importance of using process-based measures to promote use of best practices for pressure ulcer prevention. The TEP member suggested that CMS may want to consider pairing this outcome measure with process measures in the future.

- One TEP member was concerned that this measure may not encourage patient-centered care because it holds facilities accountable for negative outcomes among patients who refuse care.

Documentation of Pressure Ulcers

- TEP members shared that although staff education regarding the proper staging and documentation of pressure ulcers occurs in all settings, there is room for improvement. Additionally, training varies across settings.

  - Some providers find it difficult to identify the stage of pressure ulcers from existing documentation even with standardized items. For example, it is difficult to monitor skin that is breaking down and healing.

- TEP members noted that in order to accurately stage a pressure ulcer, staff often need to wait until a wound care nurse is available to conduct the assessment. However, TEP members shared that the ability to immediately engage a wound care nurse is difficult in smaller facilities because they often share a wound care expert across multiple facilities, and the expert may not be on site.

  - In HHAs, staff nurses often stage pressure ulcers when a wound care nurse is unavailable.

- TEP members felt that these gaps and training for all post-acute care settings should be addressed as part of the implementation of a cross-setting quality measure.

Missing Data and Exclusions from Public Reporting

- The TEP expressed concerns about excluding patients or residents because of missing data for the new or worsened pressure ulcer items, and suggested that those with missing pressure ulcer data may actually be at higher risk of pressure ulcers. One TEP member asked for more

information about the percentage of patients or residents that were excluded and the potential for analysis of those who were excluded to see if there was bias in those excluded. RTI shared that there is not a significant correlation between facility-level missing data rates and facility-level performance on the quality measure.

  - TEP members were concerned that HHAs may have higher rates of missing data than the other settings. When HHA patients have an unplanned hospital admission, the discharge Outcome and Information Assessment Set (OASIS) pressure ulcer items are not completed (resulting in missing data).

- TEP members noted the exclusion of providers who have fewer than 20 patients/residents in their sample. RTI shared that if a provider has a sample size smaller than 20 patients/residents, data are not publicly reported; these providers are still required to submit data for measure calculation.

  - TEP members shared that HHAs may have higher rates of "small sample sizes" because there is not an even distribution of agencies across states (e.g., there are a lot of small "mom and pop" HHAs clustered in certain states).

Varying Assessment Periods Aacross Settings

- Each setting has different time windows for the admission or initial assessment. In SNFs, the initial assessment of pressure ulcers can be conducted as late as the 8th day of the stay, whereas LTCHs and IRFs have a 3-day admission assessment window, but typically conduct the assessment as close to admission as possible. In HHAs, providers have 5 days to complete the assessment, so pressure ulcers that develop during the first 5 days could be counted as present on admission.

  - One TEP member recommended that CMS standardize the admission observation period.

  - The TEP stressed that education regarding what is captured; why, when, and how is critical in all settings in order to ensure a standardized approach to conducting the initial assessment as early in the stay as possible across all settings.

Attribution Related to Transfers

- TEP members asked for more information about cases in which a patient or resident is transferred and then returns to the original site of care. During an LTCH or IRF stay, if a patient leaves the IRF or LTCH and returns to the original facility within 3 days of the transfer, the IRF or LTCH is held responsible for any pressure ulcers that develop or worsen during the time away from the facility.

  - The TEP was concerned about the incentives that may be created by the example described above. In this case, LTCHs or IRFs may avoid sending patients to acute care facilities in the future, even when it would be the most clinically appropriate level of care. The TEP member also noted that this example may potentially complicate business relationships between post-acute care facilities and acute care facilities.

  - To promote high-quality care, it is important to perform a skin assessment when the patient leaves a facility and immediately upon return. TEP members were concerned that holding facilities responsible for the care that happens during stay interruptions of 3

calendar days or less may discourage providers from conducting assessments when the patient leaves and returns.

- TEP members recommended that CMS consider implementing two sets of specifications: one for planned discharge and one for unplanned discharge. They suggested that in the case of unplanned discharge, CMS should consider specifications that initiate a new stay if the resident returns within 3 days.

- The TEP expressed concern that patients or residents who are transferred to a hospital and stay there for more than 3 days are medically different from other patients, because the transfer to acute care indicates a significant change in medical status. Some TEP members suggested that CMS consider excluding these patients or residents from the measure. One TEP member pointed out that there are possible litigation issues associated with transfers and related attribution, particularly for an HHA. A HHA may not even know that a patient went to the hospital and returned home.

Other Comments

- One TEP member shared that HHAs sometimes provide services in assisted living facilities (ALFs). The pressure ulcer measure is not currently specified to capture people who live in ALFs.

- One TEP member noted that there are no OASIS questions which capture worsening of pressure ulcers; however, OASIS item M1309 captures worsening in pressure ulcer status since the start of care (SOC) or resumption of care (ROC).

Post-Meeting Responses Specific to Percentage of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) Measure (NQF #0678)

TEP members were asked to provide additional feedback via email to specific issues (presented in bold below) about the pressure ulcer measure following the meeting. Eight of 11 TEP members provided input. The following is a synopsis of their responses.

Using the Minimum Data Set (MDS) 3.0, SNF providers can conduct the initial assessment of pressure ulcers as late as the 8th day of the stay, whereas LTCHs and IRFs (using the LCDS and IRF-PAI) have a 3-day assessment time frame starting at the time of admission, and are encouraged to complete the assessment as close to admission as possible. These different coding instructions leave room for differences in the way pressure ulcers are coded on the initial assessment.

Are these assessment time frame differences a significant concern if data were being compared across types of providers?

TEP member responses were mixed. The majority of responses (3) perceived the differences to be acceptable as is. One TEP member indicated that this was an area of concern and would make it difficult to compare different providers.

In order to standardize collection of pressure ulcer status within HHAs, the following pressure ulcer items will need to be added at transfer to an inpatient facility (TIF): 1.[M1306, Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as Unstageable?], 2.[M1308, Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable (a-c, Stages II-

IV, only)], and 3.[M1309, Worsening in Pressure Ulcer Status since SOC/ROC (a-c, Stages II-IV only)].

Proposed procedures for standardizing the collection of pressure ulcer status within HHA were met with mixed reception. One TEP member said that the plan for standardization was reasonable, while another TEP member said that current HHA staffing would not allow for reliable assessment of pressure ulcer stage.

Is coding of these items based on the most recent clinical information available in the medical record that is no more than 7 days prior to the assessment date (i.e., date of assessment plus 6 previous days) an appropriate option?

Most TEP members (4) perceived that coding pressure ulcers based on the most recent clinical information available in the medical record that is no more than 7 days prior to the assessment date would be appropriate. However, TEP members requested additional discussion and thought about how to capture this data and who or what entity should capture it. One TEP member disagreed by stating that using 7-day-old data would be inappropriate because pressure ulcers can develop very quickly.

If a patient is transferred to an inpatient facility on June 15th, for example, the assessor should consider available information regarding pressure ulcers from June 9th through June 15th. An "unknown" option would be provided for M1306 that, if chosen, would initiate a skip pattern for the remaining items and would result in no useable pressure ulcer data on the TIF assessment.

TEP members (2) commented that this approach to capturing information upon TIF was necessary if it were exactly the same information as collected upon admission (e.g.,IRFs and HHAs). TEP members indicated some items are more challenging to obtain in the home setting because staff are not in the home at the time of transfer, and there may have been many days since the items were completed at admission. This is exacerbated if the patient does not return to home health care with the opportunity to reassess.

To address some of these challenges, particularly with the OASIS assessment instrument, one TEP member recommended using "d" item plus the Readmission OASIS to track patients who have admission to discharge OASIS, interrupted by an inpatient stay. For example, if TIF indicated no pressure ulcer on transfer/no added number, and the readmission OASIS indicated no pressure ulcer/no added number, the patient remains in the sample cohort. However, if "d" indicates an added number and the readmission OASIS revealed the same number, the patient would remain in the cohort but be counted as having 1+ pressure ulcer. Furthermore, if "d" indicated no pressure ulcer but the readmission OASIS indicated a pressure ulcer, the patient would not receive a 1+ count of pressure ulcers unless the patient developed another pressure ulcer.

Another TEP member recommended adding an "unknown" category, including skip logic if data were not available.

Another comment pertaining to the OASIS assessment instrument stated that the "look-back" period focuses on looking back to the last SOC/ROC *or* last OASIS. The commenter stated that there are too many different rules on look back and recommended aligning home health with last SOC/ROC or OASIS.

The Abt Associates team is proposing to use the initial assessment coding of OASIS item M1850: Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast as the mobility covariate for the pressure ulcer measure. Inability to transfer one's

self would be indicated by any of the following codes entered in item M1850: 2: Able to bear weight and pivot during the transfer process, but unable to transfer self, 3: Unable to transfer self and is unable to bear weight or pivot when transferred by another person, 4: Bedfast, unable to transfer but is able to turn and position self in bed, or 5: Bedfast, unable to transfer and is unable to turn and position self.

All TEP members (4) agreed that the OASIS item is a reasonable proxy of the impaired mobility items. However, one TEP member wanted clarity on whether it would be from SOC or from the most recent SOC/ROC.

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

During the webinar, RTI reviewed this quality measure, and TEP members were asked to respond to five questions about the cross-setting falls measure. The questions are listed below, along with responses aggregated into general categories (the discussion did not strictly track with the questions).

1. *What are the unique challenges in defining falls and falls with major injury, by setting and across settings?*

2. *How should the measure account for unwitnessed falls in patients served by home health agencies?*

3. *Is it feasible to collect the data on incidence of major falls using standardized items as specified?*

4. *What are the unique challenges with the implementation of standardized items, by setting and across settings?*

5. *What are your concerns about potential negative unintended consequences of this measure?*

Reporting Falls Across Settings

- One TEP member felt that, because of differences between the LTCH and HHA settings, it is difficult to specify a falls measure that is applicable across settings (e.g., the recall period varies by setting).

- Two TEP members felt that risk adjustment would be important, particularly for cognitive status.

- Two TEP members thought that a process measure would be more important for the falls domain than for an outcome measure. One member stated that process measures are especially important in falls prevention because processes such as education and training can influence outcomes.

Capturing Falls in the Home Setting

- Several TEP members questioned how a major fall could be identified in the home setting where a person is receiving HH services (e.g., using claims or adding items to the OASIS).

- One TEP member asked if there were plans to capture falls data more explicitly in home settings. The measure developer for HHAs (Abt Associates) responded that it was seeking

feedback about adding items to the OASIS assessment instrument in order to capture falls and falls with major injury.

- One TEP member asked about prior assessments in the home setting. On the OASIS assessment instrument, assessments are typically from SOC or ROC through transfer or discharge. If a patient receiving HH services had a fall and was hospitalized, a new assessment would be created. The measure developer for HHAs (Abt Associates) responded that OASIS M1910 tracks process, but there are challenges related to collecting information initially, tracking who is at risk for falls (e.g., M1033, adding an item). Another TEP member reported that OASIS item M1910 would capture this, including a high falls risk group (using M1910 item response category #2). The measure developer (Abt Associates) responded that the existing item in OASIS calculates risk and includes item #M2310 (went to hospital for injury by fall).

- Another discussion point focused on emergency care in the home setting and that the reasons for visits to the emergency department are often unknown. Data collected at transfer or discharge to acute care (or even at the physician's office) are potentially less reliable than data from the acute care setting. The measure developer for LTCHs, SNFs, and IRFs (RTI International) suggested that the reliability of information from the emergency department regarding information on transfer or discharge from a post-acute care setting may not be optimal.

- One TEP member underscored the importance of this quality measure for all settings including reporting all falls (i.e., no injury, injury, and major injury—a never event). This individual expressed that a person who has a fall with major injury should have had more supervision (in institutional settings). In the home setting, a fall with major injury may mean that the person needs care in an institutional setting. There may be reliability challenges related to item J1900's response A ("No injury"). When an HH nurse speaks with a family member, he/she should discuss whether an injury has occurred. Within the OASIS, there may not be a perfect way to measure falls. Adding J1900 items may help.

Timing of Assessment for Falls in HH

- One TEP member suggested that in the home setting, falls assessment should be done either at transfer or discharge to capture what happened while the person was enrolled in HH care. At discharge, assessment would cover the time since admission; at transfer, assessment would cover the time since the most recent ROC assessment.

Unintended Consequences of failing to Risk Adjust for Cognitive Impairment

- TEP members agreed that risk adjustment is an important measure and that falls with major injury are a never event. However, a simple count of the number of falls will not help decrease the number of falls. TEP members suggested that risk adjustment was important/ needed for this measure. They recommended a risk adjustment for cognitive impairment (e.g., minimize disincentives for providers to accept people with cognitive impairments).

Standardized Look-Back Period Across Provider Settings

- One TEP member asked if the time horizon was different for the various instruments in different settings. The measure developer for LTCHs, SNFs, and IRFs (RTI International) affirmed that this look-back period does need to be taken into account.

- CMS commented that "Falls with Major Injury" is a category specified in the IMPACT Act, an important topic area. In institutional settings, falls with major injury are considered a never event. The goal is to implement a process to assess quality across settings. The measure would help improve long-term outcomes and improveimprove efforts to reduce falls without reducing function and mobility.

An Application of the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631; under NQF review)

During the webinar, RTI reviewed this new quality measure and TEP members were asked to respond to five general questions specific to the cross-setting function measure. The questions are listed below along with responses presented as themes, because the discussion did not strictly track with the questions.

1. *Is it feasible to collect the function data for this measure as specified?*
2. *Should additional items (e.g., dressing) be added?*
3. *What are the potential challenges unique to each type of provider (LTCHs, IRFs, HHAs, and SNFs)?*
4. *How should an 'incomplete stay/episode' be defined for each type of provider?*
5. *If this measure were implemented, what might be some potential negative unintended consequences?*

RTI staff began the discussion by giving an overview of the cross-setting function quality measure, including the importance of a cross-setting function quality measure for patients receiving care from LTCHs, IRFs, SNFs, and HHAs. Many post-acute care patients receive rehabilitation treatment and clinicians set function goals. Development of a cross-setting *outcome* measure was considered, but the heterogeneous populations treated in LTCHs, IRFs, SNFs, and HHAs present a challenge for risk adjusting such a measure. Provider-specific functional outcome measures for IRFs and LTCHs have been developed and are undergoing review by the NQF. The function measure under consideration for cross-setting use is a process measure.

Items

The items used for this process measure are from the functional status section of the CARE Item Set.[1] The items have been tested as cross-setting standardized items. The CARE function items build upon prior research and incorporate lessons learned from clinicians treating patients and residents treated in all post-acute care settings (LTCHs, IRFs, SNFs, and HHAs), and target a wide range of patient/resident functioning. Reliability and validity testing of the CARE items was conducted, including: inter-rater reliability with paired clinicians, video reliability (using "standardized" patients who have been videotaped), internal consistency, Rasch analysis, and exploratory factor analysis. In addition, patient specific comparisons were made using CARE function scores and current setting-specific assessment data (IRF-PAI, MDS, and OASIS).

[1] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html

The function process quality measure under consideration contains only selected self-care and mobility items. Function data would be collected at admission and discharge. In addition, at least one discharge goal would be reported on the admission assessment. If the patient or resident does not perform an activity, the reason that the activity was not attempted could be coded, such as medical or safety concerns, or the person refused. This measure is not risk adjusted because it reports the percent of patients/residents with 1) a complete admission and discharge functional assessment and, 2) a discharge goal for one or more functional items. The completion of the assessments and discharge goal would not be affected by the individual's medical and functional complexity.

Patient with Incomplete Stays

When a patient has an incomplete stay (e.g., patient is discharged to acute care, leaves an institutional setting against medical advice, or dies), assessment of patient/resident functioning might not be feasible. Therefore, discharge data are not required for patients who have an incomplete stay.

Denominator and Numerator

Denominator

Patients or residents for whom assessment data are currently required using the assessment instruments; that is, the OASIS for home care, IRF-PAI for IRFs, MDS for SNFs, and Long-Term Care Hospital CARE Data Set (LCDS) for LTCHs.

Numerator

1. Patients or residents with complete stays/episodes: the number of records with complete admission functional assessment data AND at least one self-care or mobility goal AND complete discharge functional assessment data.

2. Patients or residents with incomplete stays/episodes: the number of records with complete admission functional assessment data AND at least one self-care or mobility goal.

Items Included in the Quality Measure

Self-Care Items

Eating: *The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.*

Oral hygiene: *The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]*

Toileting hygiene: *The ability to maintain perineal hygiene; ability to adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.*

Mobility Items

Sit to lying: *The ability to move from sitting on side of bed to lying flat on the bed.*

Lying to sitting on side of bed: *The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.*

Sit to stand: *The ability to safely come to a standing position from sitting in a chair or on the side of the bed.*

Chair/bed-to-chair transfer: *The ability to safely transfer to and from a chair (or wheelchair).*

Toilet transfer: *The ability to safely get on and off a toilet or commode.*

For patients who are walking, complete the following items:

Walk 50 feet with two turns: *Once standing, the ability to walk 50 feet and make two turns.*

Walk 150 feet: *Once standing, the ability to walk at least 150 feet in a corridor or similar space.*

For patients who use a wheelchair, complete the following items:

Wheel 50 feet with two turns: *Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.*

Indicate the type of wheelchair/scooter used.

1. *Manual*
2. *Motorized*

Wheel 150 feet: *Once seated, the ability to wheel at least 150 feet in a corridor or similar space.*

Indicate the type of wheelchair/scooter used.

1. *Manual*
2. *Motorized*

Self-Care and Mobility Rating Scale: Codes and Code Definitions

06. Independent*—Patient completes the activity by himself/herself with no assistance from a helper.*

05. Setup or cleanup assistance*—Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.*

04. Supervision or touching assistance*—Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.*

03. Partial/moderate assistance*—Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.*

02. Substantial/maximal assistance*—Helper does MORE THAN HALF the effort of the activity. Helper lifts, holds or supports trunk or limbs and provides more than half the effort.*

01. Dependent*—Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.*

If activity was not attempted, code:

07. Patient refused

09. Not applicable

88. Not attempted due to medical condition or safety concerns

Comments from TEP members

Panel members began the discussion with several suggestions for provider training related to this measure.

- Panel members' suggestions included these recommendations for the content of provider education:
    - Increase provider understanding of both patient motivation and capacity to complete functional tasks.
    - Decrease provider/caregiver fear, allowing patients to attempt functional tasks toward discharge goal attainment.
    - Improve training for clinicians to assess functional activities for patients or residents who are cognitively impaired through demonstration or verbal cues to better achieve discharge goal(s).
- Panel members also had suggestions about training that would improve the reliability for the functional status data collected for this process measure. These suggestions included:
    - Educating providers about the differences between the CARE functional status rating scales and the provider's existing functional rating scale to avoid confusion in data collection.
    - Training providers when to score an item (e.g., daytime toilet transfer versus nighttime) due to patient's time-of-day variability in performance of functional activities.

Data Collection

- Several TEP members commented that the IMPACT Act addressed reducing redundancy by replacing similar items, which would allow for greater data collection efficiency.

Recommended Addition of Items to the Quality Process Measure

- Several TEP members identified dressing and bathing items as important patient data to capture in this process measure. However, one panel member commented that these activities may not be feasible to assess in LTCH settings if a patient is not taking off and putting on clothing (at the present time, gowns are used).

- Swallowing was identified as an important area of function to be considered across settings.

Post-Meeting Responses specific to Functional Status Measure

TEP members were asked to provide additional feedback via email to specific issues (presented in bold below) about the functional status measure following the meeting. Seven of 11 TEP members provided input. The following points are a synopsis of their responses.

1. **How should an "incomplete stay" be defined for HHA and SNF patients?**

   For SNF patients TEP members recommended the use of the same criteria as used for LTCH and IRF patients.

   - Three panel members felt that the definition of "incomplete stays" should generally be the same, with some variation for the HHAs.

   - One TEP member stated that HH "incomplete" assessments could include: a transfer resulting in no discharge visit or when a patient refuses the last clinician visit so that the discharge data are based upon the last qualified clinician's notes (i.e., when patient was last seen).

   - Three TEP members recommended a consistent definition of incomplete stays across provider type that would also include patient discharges to hospice, and due to death.

   - Three TEP members felt that a transfer to hospice should be considered *a complete* stay because it captures important patient information. One panel member used the same rationale for death as counting as *a complete stay*.

   Functional data would be required for this measure at admission and discharge. Should ROC or recertification assessments be considered "admission" assessment and, thus, functional data would be required?

   - Most panelists agreed that ROC should include functional status data collection, since the patient's status has often changed. All but one panel member believed functional status data collection was not necessary for recertification assessments.

2. **This measure requires the collection of standardized assessment functional assessment data. We discussed several self-care and mobility items during the TEP meeting. Do you think that additional items such as upper body dressing, lower body dressing and taking on/removing footwear be included in this function measure? If so, for which type of providers should it be included? IRFs, SNFs, LTCHS, HHAs? Please provide a rationale for your responses.**

   - Several TEP members supported adding functional status items for all types of providers.

- One TEP member noted the importance of assessing patients on these additional functional status items because providers that are not assisting patients to do these activities (either through retraining, adaptive equipment, or compensatory strategies) are not offering the best quality of care.

3. **Do you think that items relating to cognitive function should be included in measure? If so, what aspects of cognitive function would you suggest for each type of provider – IRFs, LTCHS, SNFs and HHAs? For example, orientation questions (asking patient about current year and month), screening for delirium, reporting whether the patient is comatose.**

    - TEP members indicated that a standardized, evidence-based cognitive assessment would be beneficial for patients/residents, but were divided on the assessment items. The recommendations varied from screening (e.g., nonresponsive or noncommunicative) to a full instrument (e.g., BIMS or Minicog™).

    - An HHA panel member suggested that if patients have severe cognitive issues, they should be excluded from the measure and added that HHA currently screens patients for cognitive issues.

    - One TEP member stated that cognition should not be included as part of a cross-cutting functional quality measured, but should be assessed as part of a separate quality measure.

4. **If this measure were implemented, what might be some potential negative unintended consequences?**

    - One panel member indicated that some staff may create "workaround" coding of a patient's status to exclude patients from being included in the count.

    - One TEP member felt there may be little variability in the measure, because all providers will indicated their patients have at least one functional goal.

    - One member felt that function is complex and that the patient's/resident's status may only be temporary.