AAPM&R Recommendations on Post-Acute Care Data Standardization and Quality Measurement

Background
Medicare spending on post-acute care provided by home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals accounted for approximately 10 percent of total Medicare spending in 2013, totaling $59 billion. The Medicare Payment Advisory Commission (MedPAC) has noted several long-standing problems with the payment systems for post-acute care (PAC) and has suggested refinements that are intended to encourage the delivery of appropriate care in the right setting for a particular patient's condition. Several recent federal laws have affected, or will affect, payments to one or more post-acute care providers, including physicians who provide services in these settings. These federal laws include the Patient Protection and Affordable Care Act of 2010 (ACA), the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). However, new legislation is also being considered by lawmakers that may accelerate payment reform of post-acute care, possibly including value-based purchasing.

AAPM&R Position on Post-Acute Care Data Standardization and Quality Measurement
Data standardization across PAC settings is critical to compare and contrast care episodes in the various PAC settings. Not only will data standardization help facilitate appropriate payment reforms, it is also important to the development of appropriate quality measures that reflect the setting in which rehabilitation care is being provided. AAPM&R supports outcome measures in post-acute care environments that accurately assess patients' functional status, whether the treatment is improving, maintaining, or slowing deterioration of function. AAPM&R cautions, however, that the data collected may be affected by educational level and the professional expertise of the evaluator that will need to be factored into conclusions based on the data.

AAPM&R continues to advocate for post-acute care quality measures that are based on sound evidence with fully developed risk-adjusters. The following are requirements extracted directly from the IMPACT Act on data standardization and quality measurement across post-acute care settings in three areas, from high level domains to standardized assessment categories with specific data elements within each. AAPM&R supports these requirements. ***However, AAPM&R continues to stress to lawmakers and interested stakeholders that risk adjustment is necessary for comparison purposes and needs to be further studied for reliability.***

IMPACT Act Requirements Supported by AAPM&R
The IMPACT Act of 2014 requires The Secretary to implement specified clinical assessment categories using standardized (uniform) data elements to be nested within the assessment instruments currently required for submission by LTCH, IRF, SNF, and HHA providers. The Act further requires that CMS develop and implement quality measures from five quality measure domains using standardized assessment data. In addition, the Act requires the development and reporting of measures pertaining to resource use, hospitalization, and discharge to the community. These domains and categories are listed below.

Through the use of standardized quality measures and standardized data, the intent of the Act, among other obligations, is to enable interoperability and access to longitudinal information for such providers to facilitate coordinated care, improved outcomes, and overall quality comparisons. AAPM&R supports the following measure domains, assessment categories and data elements as specified in the IMPACT Act.

    I.   ***Quality Measure Domains:***
- *Skin integrity and changes in skin integrity;*
- *Functional status, cognitive function, and changes in function and cognitive function;*
- *Medication reconciliation;*
- *Incidence of major falls;*
- *Transfer of health information and care preferences when an individual transitions*

II. Resource Use and Other Measure Domains:
- *Resource use measures, including total estimated Medicare spending per beneficiary;*
- *Discharge to community; and*
- *All-condition risk-adjusted potentially preventable hospital readmissions rates.*

III. Assessment Categories:
- *Functional status*
- *Cognitive function and mental status*
- *Special services, treatments, and interventions*
- *Medical conditions and co-morbidities*
- *Impairments*
- *Other categories required by the Secretary*

IV. Data Elements for Each Standardized Assessment Category

In order to compare outcomes across post-acute care settings, specific data elements must be identified and collected for each of the standardized assessment categories. AAPM&R recommends collection of the following data elements in each assessment category.

- Functional Status
  - Self-Care
    - Data elements of self-care should include eating; showering/bathing; upper body dressing; lower body dressing; toileting and medication management. Depending on the patient's goals, there may be a need to evaluate more complex abilities (Instrumental Activities of Daily Living) such as cooking, laundry, shopping, driving, money management, and using a telephone and computer.
  - Mobility
    - Data elements of mobility should include measurement of a patient's unique capacity for mobility, whatever form it takes. Data collected should include bed mobility, the ability to transfer from bed to chair, come from sitting to standing and to complete a car transfer. If a patient is expected to be able to ambulate, data collected should include: distance able to ambulate on level surfaces indoors; go up and down 1 step (curb); 4 steps; 12 steps; and ambulate on uneven surfaces and the use of an assistive device. If a patient is expected to primarily use a wheelchair, data should include safe wheelchair use (e.g. locking the wheelchair before transfer), the distance rolled, the ability to navigate more complex environments (such as turns or uneven surfaces) and the ability to go up and down a ramp.
- Cognitive and behavioral function
  - General Mental status including alertness and orientation
  - Evaluation of memory, attention, concentration
  - Evaluation of mood, agitation and pain
- Communication function
  - Ability to understand and express verbal and written information
- Special services, treatments and interventions provided such as
  - Pulmonary treatment/ventilator
  - Dialysis
  - Chemotherapy and other intravenous medications
  - Enteral nutrition
  - Use of assistive devices (DME, orthotics/prosthetics, communication devices)
- Medical conditions and co-morbidities such as
  - Diabetes
  - Pressure Ulcers

- o   Post-surgical or complex wound care
- o   Respiratory failure, tracheostomy
- o   Heart failure, cardiac monitoring
- Impairments
  - o   Bowel and Bladder function and level of patient independence
  - o   Swallowing function
  - o   Visual impairment
  - o   Hearing impairment
- Environmental factors
  - o   Community and family support
  - o   Access to community for basic needs
  - o   Access to transportation
  - o   Independent living status, with or without long term services and supports
  - o   Ability to return to work

Future Quality Measurement of PAC Services

It is important for PAC settings to move from the current emphasis on process measures and toward a series of outcome-related measures to compare and contrast between PAC settings and to assess short-and long-term patient status post-injury or illness. This requires data standardization across PAC settings in a series of important domains, as detailed above. Once achieved, quality measurement in the PAC arena needs to expand toward assessment of quality of life and long-term functional outcomes, such as those community-oriented factors described in the International Classification of Function (ICF), including the ability to live independently, return to work (where appropriate), community participation, social interaction, and other factors that indicate the true value of rehabilitative care.