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June 26, 2017

RAND Corporation
20 Park Plaza, 9th Floor
Suite 920
Boston, MA 02116
Attn: Noreen Khan, Mailstop: BN-1

Re: CMS Contract No. HHSM-500-2013-13014I
Development and Maintenance of Post-Acute Care Cross-Setting Standardized Patient Assessment Data: Data Element Specifications for Public Comment 2

Dear Ms. Khan,

On behalf of the more than 10,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments to the Request for Information - ***Development and Maintenance of Post-Acute Care Cross-Setting Standardized Patient Assessment Data: Data Element Specifications for Public Comment 2 prepared by the RAND Corporation*.**

Physical medicine and rehabilitation (PM&R) physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting edge as well as time-tested treatments to maximize function and quality of life. Many provisions in the proposed rule will impact physiatrists nationwide. We therefore, appreciate your consideration of the following comments.

Medical Conditions: Pain

The AAPM&R has previously provided input that the assessment of pain independent of its influence on function is irrelevant. This is particularly true in the Post-Acute Care (PAC) setting, where the goal is to improve the function of patients. Of the items proposed, AAPM&R can support the one that relates to participation in the therapies, and other activities. However, the other activities as presented is extremely broad, perhaps useful as a triage item. We encourage RAND and CMS to consider the effect of pain on more specific items, such as those

in the Academy's previous input would be a better guide. However, those on that list that are only relevant to those living community should be eliminated for the PAC setting. AAPM&R believes these measures have the potential to improve quality, while the others do not. In the sense of the request, all are probably valid, but we believe only those relating to function are feasible for use in PAC. The items of pain related to function could be useful to case mix.

Medication Reconciliation

Medical reconciliation is an important process that currently generates great interest within the health delivery system, including The Joint Commission (TJC) that accredits hospitals. Therefore, any processes required by CMS should be compatible with those of TJC. The elements proposed in the CMS/RAND document are likely to improve quality and have validity, but would add significant data burden, thus reducing their feasibility in PAC, and would not be useful in improving case mix.

- Potential for Improving Quality
    - Yes – Use of medical reconciliation will likely be helpful improving quality with transitions across levels of care
    - Assessing pain is an important issue and in the post-acute setting is more challenging. Standardizing the pain measurement scales across post-acute settings would be helpful and may improve quality in there is uniformity in assessing both needed for pain management as well as response to pain relief interventions.
- Validity
    - Yes
    - The measurements as described appear that they would be valid in identifying pain and response to pain treatment. However, there is growing concern about the overuse of opioid pain medications and further assessment to make sure that this did not increase the widespread use of opioids further would be beneficial.
- Feasibility for use in PAC
    - Burdensome – overall concern with potential for excessive time and personnel burden regarding collection, documentation and the review process
    - Overall concerns with the measurement as suggested is the time burning for training, performing assessments with most Scales asking for 3 repetitions of questions and documentation burden associated with utilizing the assessments. Again,

concerned that this would not increase the widespread use of opioids further.

- Utility for Describing Case Mix
  - Probably not useful in improving case mix
  - The pain scales on the surface appeared to be valid and measuring pain however the distinction between chronic and acute pain is not clear. The extent of acute and chronic pain and can vary especially in the different settings of PAC.

Care Preferences

AAPM&R supports the inclusion of Care Preferences because it is patient-centric and would reasonably incentivize the PAC providers to have goals of care conversations and give the patient the opportunity to articulate his/her goals and desires. These conversations should align physiatrists with the patient at an early stage of care so not to result in expending effort that the patient does not want. This could have an impact on end-of-life care.

The inpatient rehabilitation faciality (IRF) is the only level of PAC where a rehabilitation physician has a role mandated by CMS. It is our contention that a physiatrist adds value to the PAC process across the continuum. Physiatry consultation is now frequently requested by more medically sophisticated patients and families in other PAC settings. For example, skilled nursing facilities (SNFs) that promote the availability of physiatry consultation may compete more effectively for short-term rehabilitation patients than those who do not provide such consultations.

- Potential for Improving Quality
  - Yes
- Validity
  - Yes – valid in concept
- Feasibility for use in PAC
  - Yes
  - Not all aspects of care preferences have been thoroughly studied to be determined as feasible across the PAC settings. Would be beneficial to get details of feasibility studies prior to initiation.
- Utility for Describing Case Mix
  - No

- **Additional Comments**
    - Advanced care directive and physician's orders
        - these items would not improve quality, are valid, feasible for use in PAC although duplicative of current processes and do not aid in case mix.
    - Preference for involvement of family/friends in decisions
        - this is more an operational item rather than one to improve quality, is valid and feasible, and would not contribute to case mix.
    - Preference for Involvement in decision making
        - this is an inappropriate cross-cutting data item for PAC, as all patients in IRFs are there to improve their function, a process that requires the patient to fully understand their situation, and to participate in the selection and implementation of the strategies to improve their function.

The Patient-Reported Outcomes Measurement Information System (PROMIS®)

Development and use of certain PROMIS® elements to be used across post-acute care settings as part of implementing data standardization in accord with the IMPACT Act.

AAPM&R generally agrees the PROMIS® domains of sleep disturbance, fatigue, ability to participate in social roles and activities, and global health themselves are appropriate to collect for all patients because they impact quality of life and ability to participate with therapy and treatment. However, the questions within these PROMIS® domains are currently only suitable for an outpatient individual who lives at home and interacts with their community/society, and are not appropriate for data standardization across Post-Acute Care (PAC) settings, without significant adaptation and rigorous testing of validity and reliability. Further, many individuals in post-acute care settings have relatively short lengths of stay where focus is on acute pain control and regaining function quickly. Utilization of these PROMIS® elements would provide little potential for

improving quality of care as they do not lend themselves to be "actionable" by PAC providers.

Several AAPM&R reviewers stated that the number of questions – 72 – left them with the impression that this section is more research protocol than something that is useable in the field. We suggest narrowing the number of questions to the most valid and impactful would be important step.

Standardizing patient assessment data amongst Post-Acute Care (PAC) settings is important work that greatly impacts AAPM&R's members. To comprehensively state AAPM&R's support for data standardization, we developed *Recommendations on Post-Acute Care Data Standardization and Quality Measurement* that was approved by AAPM&R's Board of Directors in June 2016. This document is intended to show our support for moving towards standardizing data elements across PAC settings if reliable, feasible and risk adjusted methods are at the forefront of doing so. Attached at the end of this comment letter is AAPM&R's official stance on data standardization across PAC settings.

- Potential for Improving Quality
  - Yes, if list of questions and domains are narrowed
- Validity
  - Not certain
- Feasibility for use in PAC
  - Yes, with caveats from above
- Utility of Describing Case Mix
  - No

AAPM&R in earlier comments has emphasized and recommended a unified system of outcomes data across all PAC levels of care. This will be critically important for any subsequent research into outcomes across PAC settings and levels of care.

We appreciate the opportunity to comment on this proposed rule. The AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Paul Smedberg, Director of Advocacy & Government Affairs, AAPM&R. He may be reached at PSmedberg@aapmr.org or at (202)420-5907.

Sincerely,

Jennifer Zumsteg, M.D.
Chair, Health Policy & Legislation Committee
American Academy of Physical Medicine and Rehabilitation

Background Documents

- Prior AAPM&R Comment Letters – Sept 2016 & Dec 2016
- AAPM&R Recommendations on PAC Data Standardization and Quality Measurement – June 2016

September 12, 2016 AAPM&R Comment Letter

Barbara Hennessey, W7E
RAND Corporation
1200 South Hayes Street
Arlington, VA 22202

RE: Development and Maintenance of Post-Acute Care Cross-Setting Standardized Assessment Data - Call for Public Comments

Dear Ms. Hennessey:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAMP&R), we appreciate the opportunity to submit comments to the Call for Public Comments: Development and Maintenance of Post-Acute Care Cross-Setting Standardized Assessment Data. Physical Medicine and Rehabilitation (PM&R) physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and

disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

Physiatrists coordinate, supervise and provide medical rehabilitation services in a wide variety of settings including all of the post-acute care (PAC) settings impacted by these draft specifications. physical medicine and rehabilitation (PM&R) physicians are increasingly present across the post-acute care continuum and are not aligned with any one PAC setting and, as a result, can act as an impartial medical decision-maker to help direct patients to the most appropriate setting and intensity of rehabilitative care to meet the individual medical and functional needs of patients.

General Concerns in the Call for Public Comments:

Standardizing patient assessment data amongst Post-Acute Care (PAC) settings is important work that greatly impacts AAPM&R's members. In an effort to comprehensively state AAPM&R's support for data standardization, we developed **Recommendations on Post-Acute Care Data Standardization and Quality Measurement** that was approved by AAPM&R's Board of Directors in June 2016. This document is intended to show our support for moving towards standardizing data elements across PAC settings as long as reliable, feasible and risk adjusted methods are at the forefront of doing so. Attached at the end of this comment letter is AAPM&R's official stance on data standardization across PAC settings.

In response to your specific comment request, AAPM&R appreciates the opportunity to comment. However**,** the summary document given for review does not allow itself to critical analysis, especially in the context of dealing with different PAC settings. There was not enough data presented on the assessment instruments. For these reasons, **AAPM&R has the following concerns based upon the information that was provided:**

1) The document does not speak to how these instruments will be standardized in each of the PAC settings. Timing is extremely important when using a number of these assessments. While we found the data assessment instruments to be reliable, we cannot speak to the validity if they are not executed the same way in each setting. **AAPM&R recommends that if using assessment instruments across settings, there should be clear instructions on exactly how to use them and when.**

2) Another concern with the information provided, was the uncertainty of how one assessment item impacts another. For example, the data element, *Expression of Ideas and Wants* was tested and when combined with the data

element, *Understanding Verbal Content,* the *Expression of Ideas and Wants* data has been shown to be reliable. If one of these data elements is used on its own, its validity will come into question. What if Expression of Ideas and Wants, is not used with Understanding Verbal Content? **In this request for comments, CMS is asking for comments on each data element as if it stands alone; however, the evidence presented is not consistent across the data elements as stand-alone items. There needs to be a level of certainty that that the data elements are both reliable and valid on their own before AAPM&R can support this data element.**

In addition to the general comments above, AAPM&R has the following comments in each category:

Cognitive Function and Mental Status

Brief Interview for Mental Status

- AAPM&R agrees this is a reliable data element and feasible to implement across PAC settings.

Expression of Ideas and Wants

- While AAPM&R agrees this data element has good reliability, we have concerns with the feasibility of implementation. Expression is extremely variable which could cause problems in different settings. For example, brain injury patients can be more assertive than other patients and may score well in this area; however, this does not always indicate a positive clinical situation.

Ability to Understand Others: Understanding Verbal Content

- AAPM&R knows this is an important item, however we have major concerns with validity. As we stated previously, since this item is tied to *Expression of Ideas and Wants*, it may not be valid on its own. Another concern is that this assessment could have huge variations moment to moment depending on when a patient is assessed. This element would be stronger if it took into account other variables that impact a person's ability to understand, such as if the patient has slept, what medications they are on and when the assessment is taking place.

Confusion Assessment Method

- AAPM&R has some concern with this data element. Its low kappa value indicates it needs further testing across the settings. Once testing is complete and the data element is found valid, then we believe it would be useful and feasible to use across settings.

Behavioral Signs and Symptoms

- This data element was extremely difficult to assess with limited information. While it is important for care planning and clinical decision making, AAPM&R is concerned with the lack of inter-rater reliability.
  •**AAPM&R also strongly urges treatment refusal be added as a data element.** This is a disruptive behavioral response not directed towards others and can provide insight into how individuals react to treatment recommendations.

Patient Health Questionnaire

- AAPM&R likes the approach of using PHQ-2 as a gateway to PHQ-9. It will help reduce data burden on physicians and patients. We also believe it would be feasible across all settings when using this approach.

Medical Conditions: Pain

Pain Presence and Pain Severity

- **AAPM&R strongly urges these data elements be removed and replaced with an element that focuses on how pain impacts an individual's level of function, such as question 9 of the Brief Pain Assessment (BPI):** Mark the box beside the number (0-10) that describes how, during the past 24 hours, pain has interfered with your**:**
  - general activity
  - mood
  - walking ability
  - normal work (outside the home and housework)
  - relations with other people
  - sleep
  - enjoyment of life

  Solely asking about the presence of pain does not provide enough information to help an individual's overall quality of life improve. Pain levels may never change, even when the function/ability of the patient does. Therefore, *the focus on pain should be on how pain limits function*. As you know, opioid abuse is on the rise and the more focus that is solely on pain and not its relationship to function, the more risk of over prescribing and overuse of narcotics. The importance of both *Pain Presence and Pain Severity* must be assessed by their relationship to function.

Impairments of Hearing and Vision

Ability to Hear and Ability to See in Adequate Light

- AAPM&R agrees both data elements are important and would improve quality. As we stated in our general comments, these should be collected at a standard time among the various settings.

Special Services, Treatments and Interventions

General Comments:

AAPM&R agrees that all of the data elements in this category are feasible to collect in the different PAC settings and that they are valid. Due to the nature of these data elements, every positive score will create a larger burden of care, will be tougher to treat and will use more resources. However, we do have concern that these are difficult to assess and monitor quality improvement. For example, if someone requires oxygen during their length of stay and treatment, you cannot improve in that area.

Below are our comments on some of the data elements in this category:

Hemodialysis

- AAPM&R is unsure why peritoneal dialysis was left out and believes that it should be included in this data element.

Central Line Management

- There was no mention of peripherally inserted central catheters (PIC Line) and AAPM&R believes they should be included here.

Oxygen (intermittent or continuous)

- In line with our comments in the pain category, **AAPM&R urges that the focus on pain should be in relation to function.** *A better question to ask is, does oxygen requirement/use/supplementation limit the patient's functional ability?*

BiPAP/CPAP

- **AAPM&R suggests these data elements need be separated** because they deal with two very different types of patients.

Invasive Mechanical Ventilator: Weaning Status

- **AAPM&R would like further clarification of what "weaning" means when used with this data element**, since it is not clear in the document provided.

We appreciate the opportunity to comment on this request for information. AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Beth Radtke, Manager of Quality and Research Initiatives in the AAPM&R Division of Health Policy and Practice Services. She may be reached at bradtke@aapmr.org or at (847)737-6088.

Sincerely,

Thiru Annaswamy, MD
Chair, Evidence Based Practice Committee
American Academy of Physical Medicine and Rehabilitation

December 13, 2016 AAPM&R Comment Letter

December 13, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1645–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Project Title: Quality measures to satisfy the Improving Medicare Post- Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions.

Contract names are Development and Maintenance of Symptom Management Measures (contract number HHSM-500-2013-13015I; Task Order HHSM-500-T0001) and Outcome and Assessment Information Set (OASIS) Quality Measure Development and Maintenance Project (contract number HHSM -500-2013-13001I, Task Order HHSM-500T0002)

American Academy of
Physical Medicine and Rehabilitation

Dear Mr. Slavitt:

The American Academy of Physical Medicine and Rehabilitation (AAMP&R), the society that represents more than 9,000 physiatrists, appreciates the opportunity to submit comments on the draft specifications for the functional status quality measures for skilled nursing facilities. Physical medicine and rehabilitation (PM&R) physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

AAPM&R appreciates that CMS is seeking input on the development of cross-setting quality measures for use in post-acute care settings such as Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, and Home Health Agencies. We recognize our comment letter was submitted past the deadline but want to offer some comments and recommendations for your consideration. Our comments below recognize that the purpose of this project is to develop, maintain, re-evaluate, and implement measures reflective of quality care for PAC settings to support CMS quality missions, including the Long-Term Care Hospital Quality Reporting Program (LTCH QRP), the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP), the Nursing Home (NH)/Skilled Nursing Facility Quality Reporting Program (SNF QRP), and the Home Health Quality Reporting Program (HH QRP) and will address the domains required by the IMPACT Act, which mandates specification of cross-setting quality, resource use, and other measures for post-acute care providers.

In general, AAPM&R believes the 11 measure specifications listed in the 'Areas of Focus' which collect data on the types of information received or provided at patient/resident transitions between healthcare providers is a relatively good list. We do, however, want to provide some comments and suggestions for your consideration as you evaluate quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an Individual Transitions.

Areas of Focus – Comments
***1.* Completeness of the list for the transfer of information between providers during transitions.**

The list of 11 items identifies important elements necessary for smooth transitions of care.

*a. **An additional category** should be psychosocial information that is relevant to the goals of the admissions.*

b. We do not see any elements that could be eliminated, but believe that there should be formats designed to make aggregating all of this information from charts easier than it would be at present.

2. Examples of the specific types of information and items to be collected within each of the types under information items.

a. Function

i. The functional information should include both activities of daily living and mobility items.

1. For both the information should include caregiver requirements.

2. A triage approach would be helpful to avoid collecting information not necessary for those with minimal problems.

3. However, the transfer information should include some quantification of degree of functional loss in those with significant problems.

4. It is important to include whether ambulation is by wheelchair or walking.

b. Medication

i. Preadmission medications and dosages should be at all transitions, but most importantly in the one of discharge to the community.

ii. Medications and dosages in the setting prior to the transition should be available to the next setting.

c. Patient preferences

i. Patient and family preferences for treatment facilities and level of post discharge care should be available at each level of care.

3. Suitability of the list (used also in Question 5) for gathering data about important information provided to the patient/family/caregiver at discharge or transfer.

a. *The items are suitable for both transfer and discharge. We have no additional suggestions for additions or subtractions*.

4. Admission and Discharge measure exclusions

a. Information related to function would be less important if the transfer was back to acute care because of a medical emergency.

b. Otherwise, we cannot think of admission or discharge circumstances where the information items could be excluded.

5. If the draft measure specifications capture the common routes of information transmission and are these routes clearly stated in a way that is understandable to providers in all PAC settings.

a. Not all settings have experience in collecting all of this information. There will need to be training and procedural manuals to help facilities collect this information.

6. Feasibility of data collection for these items.

a. Not all settings have experience in collecting all of this information. There will need to be training and procedural manuals to help facilities collect this information.

b. Even in facilities that already collect most of this information will have a challenge in aggregating from the various parts of their charts.
i. Methods perhaps related to the electronic health record may need to be developed to make the data burden reasonable.

7. Potential impact and any unintended consequences of the measures.
a. Positive impact on patient care through routinely having necessary information to provide thorough care of patients.

b. Negative impact of increased staff time to collect information in a comprehensive report.

c. Negative impact of possible delays in discharge pending aggregation of all of the necessary information.

AAPM&R also wants to take this opportunity to highlight the effect of physiatrist leadership across post-acute care settings has on patient outcomes. AAPM&R strongly believes that physiatrists are optimally suited by way of the unique combination of medical and functional knowledge and expertise to achieve the highest functional outcome for patients at the least financial cost to our society across post-acute care settings.

We appreciate the opportunity to comment on the project *'Quality measures to satisfy the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) domain of: Transfer of Health Information and Care Preferences When an*

Individual Transitions'. The AAPM&R looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Paul C. Smedberg, Director of Government Affairs & Advocacy at PSmedberg@aapmr.org or at (202)-420-5907.

Sincerely,
Jennifer Zumsteg, M.D.

Chair, Health Policy & Legislation Committee
American Academy of Physical Medicine and Rehabilitation

Data Standardization Document – June 2016

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*

Adopted by AAPM&R Board of Governors June 2016

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

- 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 postinjury 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.

Adopted by AAPM&R Board of Governors June 2016