NATIONAL QUALITY FORUM

Memo

January 24, 2018

To: Patient Experience and Function Standing Committee

From: NQF Staff

Re: Competing Measures Discussion

Actions

1. Review this memo prior to the January 31 in-person meeting
2. Read CMS memo prior to the January 31 in-person meeting
3. Listen to presentations from UDSMR and Encompass Health
4. Discuss, ask questions, and notify the developers of any additional data or information needed to make a decision about Best in Class during the Fall 2018 Cycle

Overview

During the Patient and Family Centered Care Phase 2 work (2015), the PFCC Committee considered two pairs of competing measures, one on self-care and one on mobility.

- Two instrument-based measures developed by UDSMR and based on the FIM tool: 2286 and 2321. Both measures were considered new at the time of evaluation, but are based on a tool that has been in use for many years.
    - 2286: Functional Change: Change in Self Care Score
    - 2321: Functional Change: Change in Mobility Score
- Two instrument-based measures developed by CMS and based on the CARE tool: 2633 and 2634. Both measures were submitted as new measures, and are based on a relatively new standardized assessment tool developed by CMS that includes all of the required data elements specified in the IMPACT Act.
    - 2633: IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients
    - 2634: IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients

History

The PFCC Committee was unable to come to consensus on Best in Class; their rationale, detailed below, was included in the final report for the project.

- Measures 2286 and 2321 have a long history of utilization nationally, and are utilized for all adult patients, not just the Medicare population. Significant costs (personnel re-training, software systems for capturing data) would accompany a switch to another measure, without clear added benefit to the institutions involved in rehabilitation.
- One measure in each set is "tried and true," and the other is emerging with a good possibility of becoming superior over time.

- One measure in each set is based on the FIM® and has a long history; staff across the country are trained and familiar with it; and it would be a major upheaval not to endorse this measure. The other measure in each set is based on the CARE tool and was developed using more contemporary science, is designed to cut across settings of post-acute care, and has had significant investment by CMS in its development and refinement.
- It is hard to say whether one is superior at this time. By not selecting a superior measure at this time, CMS and other payers will be able to employ both measures and continue to experience how they work in practice, perhaps building an evidence base for future selection of one superior measure.

The measures were sent to the CSAC, which was also unable to come to an agreement. At this time, the NQF Board of Directors made the final decision on the ratification of endorsement, and the Board elected to endorse both sets of measures with conditions. The Board memo detailing these conditions is included as an appendix to this memo.

HealthSouth (now Encompass Health) submitted an appeal on the CMS measures, based on a number of concerns, ranging from concerns regarding the actual measures as well as concerns with the NQF process and the implications of conditional endorsement status for the two competing measure sets. After discussion with UDSMR, CMS, and NQF, this appeal was withdrawn. However, Encompass Health members use both measures and they were able to gather information from their membership regarding experience using the measures.

Of note, these are just two sets of measures; these two developers own a number of other competing measures that were endorsed in Phase 3 of the Person and Family Centered Care work, but the Committee decided at that time to defer the competing measures discussion until more data was available (projected to be 2017; now 2018).

PEF Committee Charge

The discussion at the January 31 meeting is purely informational. No decisions will be made on Best in Class. The Committee will discuss and vote on Best in Class during the Fall 2018 cycle (in-person meeting to be scheduled in January, 2019).

Appendix A: NQF Board of Directors Memo

TO: The NQF Board of Directors

FR: Helen Burstin, Chief Scientific Officer

Marcia Wilson, Senior Vice President, Quality Measurement

RE: Ratification of Measures for the Person- and Family-Centered Care Phase 2 Project

DA: October 28, 2015

ACTION REQUESTED

The Board of Directors is asked to ratify the CSAC's recommendation to endorse four measures for the second phase of the Person- and Family-Centered Care (PFCC) project. It is recommended that the measures be endorsed with special update requirements for the following four measures from both measure stewards. (See Appendices A, B and C for additional measure level detail.)

- 2633: IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (CMS)
- 2634: IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (CMS)
- 2286: Functional Change: Change in Self Care Score (UDSMR)
- 2321: Functional Change: Change in Mobility Score (UDSMR)

BACKGROUND

Upon request for re-consideration of the above four measures, the CSAC recommends approval with the conditions stated below. The Board of Directors reviewed the recommendations of the CSAC and the rationale for non-approval of two of the measures. The Board provided greater policy context including the importance of the IMPACT Act enacted in 2014 and the need for aligned measures that can be used to assess care across settings. The Board therefore directed NQF staff to return the four competing IRF measures in question back to the CSAC for further consideration. (See Appendix B for a side by side comparison of the competing measures.). In addition, the Board expressed concerns regarding measures derived from proprietary versus non-proprietary instruments, and the desirability of having measures that help assess quality improvement from the patient's perspective as he/she moves among multiple sites of care

As was true at the June CSAC meeting, there were extensive public comments made during the Board meeting. The FIM tool proponents primarily focused on concerns around the sensitivity of the CARE tool measures, the burden of having to report on two sets of measures for the same setting and the concerns about having to use a new tool (CARE) after providers have built considerable infrastructure (e.g., staff training, software) to collect data with the FIM Instrument. The CARE tool proponents supported measures developed from the CARE tool because they recognize the importance of all providers moving to just one tool and they supported the CMS' decision to use the CARE tool across multiple settings. Additionally, proponents supported the use of a non-proprietary assessment tool generally.

CONSENSUS PROCESS TO DATE:

These four measures were recommended for endorsement by the Standing Committee after considerable public comment, member voting and additional information provided by measure developers. (Appendix C provides themes from the public comments.) The Standing Committee was unable to select a best-in-class for either set of competing measures (#2633 versus 2286 and #2634 versus 2321). The two UDSMR measures (#2286 and 2321) were recommended for endorsement with 71% of councils approving. The councils were unable to reach consensus for the two CMS measures (#2633 and 2634) with only 56% of councils approving the measures.

In their initial vote in June, the CSAC voted to recommend the two UDSMR measures, while the two CARE tool measures only received 56% approval (below the required 60% threshold for CSAC approval). Based on the rationale provided by CSAC members, the CMS IRF measures were not approved largely due to competing measure concerns.

In their reconsideration vote in September, **12 out of 13 CSAC members or 92% voted to Approve endorsement for the four measures with conditions for specific updates**

Update Requirements:

UDSMR	CMS
• Provide information about how the inclusion or exclusion of cognitive items impacts the overall assessment of the patient. • Provide updated measure level testing for reliability and validity given that all the measures are new. There is particular interest in measure performance/scientific acceptability across care settings beyond IRF. • Provide information about costs associated with use of the FIM Instrument, respective software and tools; and costs of ongoing training in order to accurately use the FIM Instrument.	• Provide information about how the inclusion or exclusion of cognitive items impacts the overall assessment of the patient. • Provide updated measure level testing for reliability and validity given that all the measures are new and will be implemented in 2016. • Provide data on comparison of the competing measure results to gain an understanding of which scale is more reliable, valid and feasible. • Provide a summary of qualitative data gathered during rule-making process including perceived benefits from the field for instruments that cut across settings.

Appendix A: Additional Measure Level Detail for Four Candidate Consensus Standards

Measure	Steward	Committee Recommendation and Member Votes for Approval	Type of Measure	Measure* Setting of Care - Level of Analysis	Assessment tool Used	Standing Committee History/Considerations
2286: Functional Change: Change in Self Care Score (new)	UDSMR	Committee: Recommended % Councils Approving: 71% % CSAC Approving (original vote): 100%	Outcome	IRF – Facility	FIM® Instrument	Measure recommended at In-Person Meeting; while additional information not required, the Committee requested disparities data (data for race, age, payer); intra-class co-efficient at the facility level; and mean fit statistics.
2321: Functional Change: Change in Mobility Score (Uniform Data System for Medical Rehabilitation) (new)	UDSMR	Committee: Recommended % Councils Approving: 71% % CSAC Approving (original vote): 100%	Outcome	IRF – Facility	FIM® Instrument	Measure recommended at In-Person Meeting; while additional information not required, the Committee requested disparities data (data for race, age, payer); intra-class co-efficient at the facility level; and mean fit statistics.
2633: Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (new)	CMS	Committee: Recommended % Councils Approving: 57% % CSAC Approving (original vote): 56%	Outcome	IRF – Facility	CARE Item Set	Consensus Not Reached on Reliability and Validity at In-Person Meeting. Additional information was provided on reliability, validity and performance at the facility level and the Committee subsequently recommended the measure for endorsement.

Measure	Steward	Committee Recommendation and Member Votes for Approval	Type of Measure	Measure* Setting of Care - Level of Analysis	Assessment tool Used	Standing Committee History/Considerations
2634: Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation	CMS	Committee: Recommended % Councils Approving: 57% % CSAC Approving (original vote): 56%	Outcome	IRF– Facility	CARE Item Set	Measure recommended at In-Person Meeting. No additional information requested from the developer for clarification of NQF criteria.

*Note: While the assessment tools (or item sets) used to calculate these measures may be used in more than one setting, the Standing Committee evaluated and recommended endorsement based on the MEASURE submission form and information provided in the measure description, evidence, rationale, etc. As with the measures submitted for specific settings utilizing the CARE Item Set, UDSMR has been advised to prepare new measure submissions for settings of care beyond IRFs for the FIM tool.

Appendix B: Side By Side Comparisons of the Competing Measures

Measure Focus: Self-Care
Target Population: Inpatient Rehabilitation Facilities

	2633: IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	2286: Functional Change: Change in Self-Care Score
Steward	CMS	UDSMR
Brief Description	This measure estimates the risk-adjusted mean change in self-care score between admission and discharge for Inpatient Rehabilitation Facility (IRF) Medicare patients.	Change in rasch derived values of self-care function from admission to discharge among adult patients treated at an inpatient rehabilitation facility who were discharged alive. The timeframe for the measure is 12 months. The measure includes the following 8 items: Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory.
Measure Type	Outcome	Outcome
Measure Data Source/tool	Electronic Clinical Data Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI). CARE tool	Electronic/ FIM® Instrument
Reporting Level	Facility	Facility
Care Setting	Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility	Inpatient Rehab (per measure description); FIM used in broader settings: Home Health, Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing

	2633: IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	2286: Functional Change: Change in Self-Care Score
		Facility
Time Window	12 months	12 months
Numerator	This measure estimates the risk-adjusted change in self-care score between admission and discharge among Inpatient Rehabilitation Facility (IRF) Medicare patients age 21 or older. The change in self-care score is calculated as the difference between the discharge self-care score and the admission self-care score. The 7 self-care items are: GG 0130A. Eating GG 0130B. Oral hygiene GG 0130C. Toilet hygiene GG 0130D. Shower/bathe self GG 0130E. Upper body dressing GG 0130F. Lower body dressing GG 0130G. Putting on/taking off footwear	Average change in rasch derived self-care functional score from admission to discharge at the facility level, including items: Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, and Memory. Average is calculated as: (sum of change at the patient level for all items • Feeding, • Grooming, • Dressing Upper Body, • Dressing Lower Body, • Toileting, • Bowel, • Expression, • and Memory) / total number of patients).
Denominator	The denominator is Inpatient Rehabilitation Facility Medicare patients, age 21 and older, Medicare beneficiaries who have complete stays.	Facility adjusted expected change in rasch derived values, adjusted at the Case Mix Group level. 18 and older; alive at discharge

Measure Focus: Mobility
Target Population: Inpatient Rehabilitation Facilities

	2321 Functional Change: Change in Mobility Score	2634 Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients
Steward	UDSMR	CMS
Brief Description	Change in rasch derived values of mobility function from admission to discharge among adult inpatient rehabilitation facility patients aged 18 years and older who were discharged alive. The timeframe for the measure is 12 months. The measure includes the following 4 mobility FIM® items: Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.	This measure estimates the mean risk-adjusted mean change in mobility score between admission and discharge for Inpatient Rehabilitation Facility (IRF) Medicare patients.
Measure Type	Outcome	Outcome
Measure Data Source/tool	Electronic Clinical Data : Electronic Health Record FIM® Instrument	Electronic Clinical Data Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI). CARE tool
Reporting Level	Facility	Facility
Care Setting	Inpatient Rehab (per measure description); FIM used in broader settings: Post Acute/Long Term Care Facility : Long Term Acute Care Hospital, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility	Post Acute/Long Term Care Facility : Inpatient Rehabilitation Facility
Time Window	12 months	12 months

	2321 Functional Change: Change in Mobility Score	2634 Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients
Numerator	Average change in rasch derived mobility functional score from admission to discharge at the facility level. Includes the following FIM items: • Transfer Bed/Chair/Wheelchair, • Transfer Toilet, • Locomotion and • Stairs.	This measure estimates the risk-adjusted change in mobility score between admission and discharge among Inpatient Rehabilitation Facility (IRF) patients age 21 and older. The change in mobility score is calculated as the difference between the discharge mobility score and the admission mobility score. The 15 mobility items are: GG 0170A. Roll left and right GG 0170B. Sit to lying GG 0170C. Lying to sitting on side of bed GG 0170D. Sit to stand GG 0170E. Chair/bed-to-chair transfer GG 0170F. Toilet transfer GG 0170G. Car transfer GG 0170I. Walk 10 feet GG 0170J. Walk 50 feet with 2 turns GG 0170K. Walk 150 feet GG 0170L. Walking 10 feet on uneven surfaces GG 1070M. 1 step GG 0170N. 4 steps GG 0170O. 12 steps GG 0170P. Pick up object
Denominator	Facility adjusted adjusted expected change in rasch derived values, adjusted at the Case Mix Group level. 18 and older; alive at discharge	Inpatient Rehabilitation Facility patients included in this measure are at least 21 years of age, Medicare beneficiaries, are not independent with all of the mobility activities at the time of admission, and have complete stays.

Appendix C: Themes from Public Comment

In addition to the two sets of competing measures, the CSAC also voted on eight additional measures. Out of these twelve measures, three were derived from the FIM® Instrument for use in an Inpatient Rehabilitation Facility and nine were derived from the CARE tool for use in different settings including Inpatient Rehabilitation Facility. There were a number of comments received during the Public Comment period on the June 9th CSAC call. Many of the comments covered issues that had previously been raised either by the Standing Committee during measure evaluation or during the Public Comment period, and can be summarized as follows:

1. **Sensitivity of the CARE tool:** The overarching concern from the provider community is that the CARE tool is not sensitive enough to assess improvement in patients, and with this lack of sensitivity at the patient level there was question about impact on the overall measure. The Standing Committee conducted a detailed review of data at both the scale/item level and subsequently at various facility levels for each of the measures, regardless of the assessment tool used. They did not perceive a concern with the sensitivity testing conducted at the CARE item set. CMS and their measure development contractors re-iterated substantial testing at both levels of analysis (item and facility) that indicated the ability to discriminate between facilities. Additional measures based on the CARE Item Set, but developed by the American Health Care Association (AHCA), were supported by data that demonstrated sensitivity at both the item and facility levels. The measure developers have provided detailed responses on this issue in the attached memos. CMS response is located at this link and AHCA response can be found at the following link.
2. **Measurement Burden**: As indicated above, having multiple measures with the same focus and designed for the same care settings is expected to cause substantial burden on facility staff; this was a consideration by the Standing Committee and is part of the rationale for inability to reach consensus regarding harmonization or determination of best in class measures. The discussion around burden of measurement centered around the collection of the following assessment tools/item sets:
    a. The FIM System® is a an outcomes management program for skilled nursing facilities, sub-acute facilities, long-term care hospitals, Veterans Administration programs, international rehabilitation hospitals, and other related venues of care. While the FIM® has been collected for some time, the measures submitted for this project (#2286, 2287 and 2321) are considered new for endorsement. It should also be noted that the measures submitted, while potentially applicable for additional settings, were only considered for IRFs. The measure submission forms, including measure titles, descriptions, rationale and evidence provided were specific to IRFs, thus the Committee was directed to only consider that setting.
    b. CARE Item Set: As a part of the Medicare Post-Acute Care Payment Reform Demonstration (PAC-PRD), a standardized patient assessment tool was developed for use at acute hospital discharge and at post-acute care admission and discharge. This tool was named the Continuity Assessment Record and Evaluation (CARE) Item Set. Data collected using the CARE Item Set served as a major source of information in the

demonstration. The CARE Item Set measures the health and functional status of Medicare beneficiaries at acute discharge, and measures changes in severity and other outcomes for Medicare post-acute care patients. The CARE Item Set is designed to standardize assessment of patients' medical, functional, cognitive, and social support status across acute and post-acute settings, including long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs). The goal was to standardize the items used in each of the existing assessment tools while posing minimal administrative burden to providers. Nine (9) measures were submitted to this project, and are based on data derived from use of the CARE tool.

3. **Measure Gaps**: The Standing Committee and public comments expressed the need and interest in measures that focus on patient stabilization, when improvement is not the goal of treatment; and also for measures more directly related to patient goals versus treatment goals.

History – Competing Functional Status Measures

Suzanne Theberge, MPH, Senior Project Manager, NQF

January 31, 2018

Agenda

- NQF Overview
- Presentation from UDSMR
- Presentation from Encompass Health (formerly HealthSouth)
- Committee Discussion and Q&A
  - *UDSMR*
  - *CMS*
  - *Encompass Health*

Today's Committee Charge

The NQF Board of Directors (BOD), in October 2015, endorsed four measures (two sets of competing measures) with special update requirements.

Today's presentations and discussion on these functional status measures is purely informational as a follow-up to the BOD's required updates:

- this not an endorsement discussion;
- there will be no votes or decisions made.

Objectives

- Committee to determine if there is additional information needed to make a decision on *Best in Class*
- Developers to submit additional testing data by August 2018
- Committee will review and consider *Best in Class* during the Fall 2018 Measure Evaluation Cycle

Patient and Family Centered Care Project, Phase 2 (2015)

Self-Care	Mobility
2633: Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (CMS)	*2634: Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients* (CMS)
2286: Functional Change: Change in Self Care Score (UDSMR)	*2321: Functional Change: Change in Mobility Score* (UDSMR)

History

- Two sets of instrument-based competing measures
  - *Presently in the Inpatient Rehabilitation Facility setting -- there will be more in the future in other care settings*
- Committee and CSAC could not come to consensus on *Best in Class*
- NQF Board of Directors ultimately endorsed both measures with conditions
- HealthSouth (now Encompass) submitted an appeal, but later withdrew it and approached NQF with a opportunity to share feedback data on the measures.

Board of Directors Conditions

CMS (2633, 2634)	UDSMR (2286, 2321)
• Provide information about how the inclusion or exclusion of cognitive items impacts the overall assessment of the patient. • Provide updated measure level testing for reliability and validity given that all the measures are new and will be implemented in 2016. • Provide data on comparison of the competing measure results to gain an understanding of which scale is more reliable, valid and feasible. • Provide a summary of qualitative data gathered during rule-making process including perceived benefits from the field for instruments that cut across settings.	• Provide information about how the inclusion or exclusion of cognitive items impacts the overall assessment of the patient. • Provide updated measure level testing for reliability and validity given that all the measures are new. There is particular interest in measure performance/scientific acceptability across care settings beyond IRF. • Provide information about costs associated with use of the FIM Instrument, respective software and tools; and costs of ongoing training in order to accurately use the FIM Instrument.

Competing Measures Sub-Criteria

- 5b. Competing Measures
  - *The measure is superior to competing measures (e.g. is a more valid or efficient way to measure);* ***OR*** *Multiple measures are justified.*

Questions

- How are legislative and/or regulatory requirements considered in *Best in Class*?
- Is one of the measures clearly superior?
- If not,
  - *Is there a need for multiple measures?*
  - *What would be the burden of having multiple measures?*
  - *Are there ways to harmonize?*

This memorandum provides an update on the implementation of the Centers for Medicare & Medicaid (CMS) Post-Acute Care (PAC) functional outcome and process quality measures, with a focus on the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633), and IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) as requested by the National Quality Forum (NQF). Specifically, this memo provides a review of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), an overview of the statutory adoption and implementation of the functional outcome and process quality measures, and next steps related to the NQF maintenance endorsement work. Appendix A of this memo delineates the specifications for measures #2633 and #2634.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)

H.R. 4994, the "The Improving Medicare Post-Acute Care Transformation Act of 2014" (The IMPACT Act of 2014) amended Title XVIII of the Social Security Act by adding Section 1899B "Standardized Post-Acute Care Assessment Data for Quality, Payment and Discharge Planning and for other Purposes." The IMPACT Act requires that the Secretary, among other activities, modify the patient/resident assessment instruments required for submission by Long-Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs) to include core, standardized clinical assessment data and data on quality measures and standardized patient assessment data elements. It requires that the assessment instruments for these PAC providers include standardized health assessment data on at least quality five measurement domains and at least five patient assessment categories. It also requires data submission on at least three other resource use and other domains. The specified application dates vary for each measure domain and according to the PAC provider. The implementation date for the standardized assessment data on the five categories is October 1, 2018 for SNFs, IRFs and LTCHs and January 1, 2019 for HHAs.

The law further specifies that the data [elements] "… be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes…"

Overall, the intent of the IMPACT Act is to enable electronically exchangeable assessment data, cross-setting quality comparison, and comparable data for the evaluation and recommendation of a payment system in which reimbursement would be based on patient characteristics rather than the setting. Additionally, the law requires that the data on measures be publically reported and that the Secretary provide the PAC providers with confidential feedback reports, the opportunity to correct their data and preview reports prior to public reporting.

In our effort to support the requirements, obligations, and intent of the IMPACT Act, and its call for the modifications of the PAC assessment instruments to include standardized and interoperable data, we selected for program adoption, patient assessment data applying guiding principles. Such principles included overall clinical relevance, ability to support clinical decisions, care planning and interoperable exchange to facilitate care coordination during transitions in care, as well as the ability to capture medical complexity and risk factors that can inform both payment and quality. Additional principles we applied included that the data elements hold strong scientific reliability and validity, be meaningful to inform longitudinal analysis by providers, and that general consensus agreement exist for the usability of the data and the ability to collect such data once and have it support multiple uses. Further, to inform data

elements for program adoption, we took into account technical and clinical subject matter expert review, public comment, and consensus input in which such principles were applied. We also took into account the consensus work and empirical findings from the Post-Acute Care Payment Reform Demonstration (PAC PRD).

Statutory Rule Adoptions: Update on the Function Quality Measures and Standardized Patient Assessment Data Elements

Function Process Measure to meet the intent of the IMPACT Act of 2014: An Update

The IMPACT Act requires the Secretary specify a quality measure in satisfaction of the domain *functional status, cognitive function, and changes in function and cognitive function*. In order to meet the intent of the IMPACT Act, CMS adopted a process measure entitled, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). This process measure is calculated using standardized patient assessment data elements from the Section GG: Functional Abilities and Goals section of each PAC assessment instrument [i.e., the Minimum Data Set (MDS), Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI), Long-Term Care Hospital CARE Data Set (LCDS), and Outcome and Assessment Information Set (OASIS)]. This measure is currently collected and reported in the SNF, IRF, and LTCH QRPs. The measure collection for the HH QRP begins in 2019. For more information on the adoptions of the function process measure, please see the following links:

- IRF PPS Final Rule FR 80:
  https://www.gpo.gov/fdsys/pkg/FR-2015-08-06/pdf/2015-18973.pdf
- SNF PPS Final Rule FR 80:
  https://www.gpo.gov/fdsys/pkg/FR-2015-08-04/pdf/2015-18950.pdf
- LTCH PPS Final Rule FR 80:
  https://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf
- HH PPS Final Rule FR 82:
  https://www.gpo.gov/fdsys/pkg/FR-2017-11-07/pdf/2017-23935.pdf

Functional Outcome Measures: Updates and Links Provided

IRF QRP:

CMS finalized the functional outcome measures for the IRF QRP in the FY 2016 IRF PPS Final Rule (80 FR 47111 through 47117). These measures are: (1) IRF Functional Outcome Measure: Change in Self-Care for Medical Rehabilitation Patients (NQF #2633); (2) IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation (NQF #2634); (3) IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635); and (4) IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636). These measures were endorsed by the NQF Person and Family Centered Care Panel in 2015. The outcome function measures are currently collected by all IRFs with the IRF-PAI Section GG: Functional Abilities and Goals quality section. Confidential feedback reports on the measures performance have just been made available to IRF providers through the Certification and Survey Provider Enhanced Reports (CASPER) system in late 2017. We intend to publically report the measures in 2018. For more information on the measure adoptions for the IRF QRP from the IRF PPS FY2016 Final Rule FR 80, please see https://www.gpo.gov/fdsys/pkg/FR-2015-08-06/pdf/2015-18973.pdf.

Of note, NQF is seeking updates on measures #2633 and #2634 on specific conditions for a periodic performance update. CMS has provided updates for these conditions in the *Next Steps* section of this memo.

LTCH QRP:

CMS finalized two functional outcome measures entitled, the Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF#2632), and the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF#2631) in the FY 2015 IPPS/LTCH PPS Final Rule (79 FR 50286)[1]. Data collection for these measures began in 2016. These measures are currently collected by all LTCHs by the LCDS Section GG: Functional Abilities and Goals quality section. Confidential feedback reports on the measures performance have been made available to LTCH providers through the CASPER system. We intend to publically report the measures in 2018. For more information on the measure adoptions for the LTCH QRP from the FY 2015 IPPS/LTCH PPS final rule, please see https://www.gpo.gov/fdsys/pkg/FR-2016-08-22/pdf/2016-18476.pdf.

SNF QRP:

In the FY 2018 SNF PPS proposed rule (82 FR 21047 through 21057) CMS adopted for use in the SNF QRP four functional outcome measures. These measures are: (1) the Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633); (2) the Application of the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634); (3) the Application of the IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635); and (4) Application of the IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636). CMS finalized the analogous, standardized functional outcome measures for the IRF QRP in the FY 2016 IRF PPS final rule (80 FR 47111 through 47117). The outcome measures will be collected by SNFs beginning in 2018 by the MDS Section GG: Functional Abilities and Goals quality section. Confidential feedback reports on the measures performance have been made available to SNF providers through the CASPER system. We intend to publically report the measures. For more information on the measure adoptions for the SNF QRP from the SNF PPS Final Rule FR 82, please see https://www.gpo.gov/fdsys/pkg/FR-2015-08-06/pdf/2015-18973.pdf.

Adoption of the Standardized Patient Assessment Data Elements

Section 1899B(b)(1) of the IMPACT Act requires PAC providers to report standardized patient assessment data requires the submission of standardized patient assessment data in satisfaction of at least five health assessment categories including the category of functional status, such as mobility and self-care. CMS finalized that the standardized patient assessment data elements in the Section GG: Functional Abilities and Goals section of each PAC assessment instrument met the definition of standardized patient assessment data for this category. These self-care and mobility items are also used to calculate the quality measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631). For more

[1] The Change in Mobility Among Long-Term Care Hospital Patients Requiring Ventilator Support (NQF#2632) satisfies Section 1206(c) of Division B of Public Law 113–67, the Pathway to SGR Reform Act of 2013, which amends section 1886(m)(5)(D) of the Act to add a new clause (iv) requiring the Secretary to establish by no later than October 1, 2015, ''a functional status quality measure for change in mobility among inpatients requiring ventilator support.''

information on the adoptions of these standardized patient assessment data elements, please see the following links:

- IRF PPS Final Rule FR 82:
  https://www.gpo.gov/fdsys/pkg/FR-2017-08-03/pdf/2017-16291.pdf
- LTCH PPS Final Rule FR 82:
  https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf
- SNF PPS Final Rule FR 82:
  https://www.gpo.gov/fdsys/pkg/FR-2017-08-04/pdf/2017-16256.pdf
- HH PPS Final Rule FR 82:
  https://www.gpo.gov/fdsys/pkg/FR-2017-11-07/pdf/2017-23935.pdf

Quality Measures Implementation and Public Reporting Timelines

Below is a graph that details when collection for each functional outcome or process measure commenced [or is scheduled], when provider feedback reports are planned for dissemination, and when public reporting of all measure outcomes are intended to be displayed on a public-facing website for each PAC setting.

Setting	Quality Measure	Data Collection Start	Provider Feedback Report	Public Reporting
LTCH	NQF #2631 NQF #2632	2016 2016	2017 2017	2018 2020
IRF	NQF #2631 NQF #2633-36	2016 2016	2017 2017	2018 2020
SNF	NQF #2631 NQF #2633-36	2016 2018	2017 2019	2018 2020
HH	NQF #2631	2019	2020	2021

Training Opportunities: A focus on training for the IRF QRP

As with all measure development and implementation, CMS provides training and guidance prior to implementation of the measure to promote consistency in the interpretation of the measure. Training includes in-person and online webinars, Open Door Forums (ODFs), as well as YouTube videos that focus on specific aspects of coding and collection. Listed below are YouTube videos that demonstrate training, specifically on the coding of Section GG: Functional Abilities and Goals. In addition, the IRF Quality Reporting Help Desk is available for questions about quality measure calculation, data submission deadlines, and data items in the Quality Indicator section of the IRF-PAI (IRF.questions@cms.hhs.gov).

- IRF May 2016 Training:

https://www.youtube.com/watch?v=sQKBHGGKrHk

- IRF August 2016 Training: https://www.youtube.com/watch?v=C_TS6SHo24Q&list=PLaV7m2-zFKphDDJggYmxBqZ6XSAZFvGYL&index=9
- IRF August 2017 - Refresher webinar: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/August_2017_IRF_QRP-Refresher_Webinar.pdf
- IRF December 2017 – Section GG Web-based Training Module:

  https://www.cms.gov/medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/gg-training/

Next Steps: Responses to the NQF Committee Requests

As discussed with NQF, CMS intends to submit applications for endorsement maintenance for our functional outcome measures in August, 2018. At the time of the measure maintenance submissions, we will have access to one year of data for the IRF functional outcome measures. With this data, CMS intends to submit a comprehensive update addressing the NQF Committee's requests.

- For the NQF Committee request to be able to provide information about how the inclusion or exclusion of cognitive items impacts the overall assessment of the patient, CMS will update our literature review and provide a memo to address this topic.
- For the NQF Committee Request to provide updated measure level testing for reliability and validity given that all the measures are new and will be implemented in 2016, CMS will update the facility-level (measure) analyses as part of our NQF application using one year of data.
- For the NQF Committee Request to provide data on comparison of the competing measure results to gain an understanding of which scale is more reliable, valid, and feasible, CMS will conduct the several analyses to address this request, including Item/scale-level analysis (e.g., Rasch analysis, factor analysis, Inter-class correlation), Facility-level (measure) reliability analyses.
- For the NQF Committee Request to provide a summary of qualitative data gathered during rule-making process including perceived benefits from the field for instruments that cut across settings, CMS has provided links to our finalized rules in this memo. It should be noted that all public comments received on the proposal and adoption of the functional status quality measures in IRF PPS Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016 (CMS-1624-P) can be accessed at https://www.regulations.gov/docketBrowser?rpp=25&so=DESC&sb=commentDueDate&po=0&dct=PS&D=CMS-2015-0053. In closing, CMS will be available to speak to the nuances of the IMPACT Act and next steps for our work after August, 2018.

Appendix A:
OVERVIEW OF THE FUNCTIONAL OUTCOME MEASURES:
NQF #2633 AND NQF #2634

Overview of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)

This quality measure estimates the risk-adjusted mean change in self-care score between admission and discharge among IRF patients. The change in self-care score is calculated as the difference between the discharge self-care score and the admission self-care score, and the target population is the number of IRF Medicare patient stays, except those that meet the exclusion criteria. For this quality measure, the following functional activities are assessed and rated at the time of admission and discharge:

Self-Care Items

- **GG0130A, 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.
- **GG0130B, 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.]
- **GG0130C, Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.
- **GG0130E, Shower/bathe self:** The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
- **GG0130F, Upper body dressing:** The ability to put on and remove shirt or pajama top; includes buttoning, if applicable.
- **GG0130G, Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
- **GG0130H, Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility.

Self-Care Rating Scale: Codes and Code Definitions

06. Independent – Patient completes the activity by him/herself with no assistance from a helper.
05. Setup or clean-up 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. Helper lifts or holds patient's 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 the activity was not attempted, code reason:
07. Patient refused

09. Not applicable
88. Not attempted due to **medical condition or safety concerns**

We note that the items used to calculate this functional outcome measure, Change in Self-Care, are also used to calculate other adopted quality measures in the Inpatient Rehabilitation Facility Quality Reporting Program, including:

- Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function - IRF-PAI (NQF #2631)
- IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients - IRF-PAI (NQF #2635)

Overview of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)

This quality measure estimates the risk-adjusted mean change in mobility score between admission and discharge among IRF patients. The change in mobility score is calculated as the difference between the discharge mobility score and the admission mobility score, and the target population is the number of IRF Medicare patient stays, except those that meet the exclusion criteria. For this quality measure, the following functional activities are assessed and rated at the time of admission and at discharge:

Mobility Items

- **GG017A, Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back.
- **GG0170B, Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
- **GG0170C, 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.
- **GG0170D, Sit to stand:** The ability to safely come to a standing position from a sitting in a chair or on the side of the bed.
- **GG0170E, Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
- **GG0170F, Toilet transfer:** The ability to safely get on and off a toilet or commode.
- **GG0170G, Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
- **GG0170I, Walk 10 feet:** Once standing, the ability to walk at least 10 feet in room, corridor or similar space.
- **GG0170J, Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
- **GG0170K, Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
- **GG0170L, Walking 10 feet on uneven surfaces:** The ability to walk at least 10 feet on uneven or sloping surfaces, such as grass or gravel.
- **GG0170M, 1 step (curb):** The ability to step over a curb or up and down one step.
- **GG0170N, 4 steps:** The ability to go up and down four steps with or without a rail.
- **GG0170O, 12 steps:** The ability to go up and down 12 steps with or without a rail.

- **GG0170P, Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

Mobility Rating Scale: Codes and Code Definitions

06. Independent – Patient completes the activity by him/herself with no assistance from a helper.
05. Setup or clean-up 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. Helper lifts or holds 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 reason:
07. Patient refused
09. Not applicable
88. Not attempted due to **medical condition or safety concerns**

We note that the items used to calculate this functional outcome measure, Change in Mobility, are also used to calculate other adopted quality measures in the Inpatient Rehabilitation Facility Quality Reporting Program, including:

- Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function - IRF-PAI (NQF #2631)
- IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients - IRF-PAI (NQF #2636)

2016-2017 Updates for UDSMR Functional Measures: Measure #2286 Functional Change: Change in Self-Care & Measure #2321Functional Change: Change in Mobility

Paulette Niewczyk, MPH, PhD
Director of Research
UDSMR, University at Buffalo, Amherst, NY

UDSMR: Who We Are

- Not-for-profit organization, established in 1987, affiliated with the University at Buffalo, SUNY
- Developed several instruments for use in the rehabilitation industry to measure patient functional outcomes
- Maintains the world's largest database for medical rehabilitation outcomes; roughly 75% of all US inpatient rehabilitation facilities submit patient level data to include in benchmarking reports including the Veterans Administration in addition to several TBI, SCI and burns model systems.

Measure #2286
Functional Change: Change in Self-Care

Measure #2286 Functional Change: Change in Self-Care

- Measures physical and cognitive aspects of a patient's ability to manage daily self care
- ***8 items- 6 motor and 2 cognitive***: feeding, grooming, upper-body dressing, lower-body dressing, toileting, bowel control, expression and memory
- 7-level rating scale; clinicians rate patient's lowest actual observed score over a 24-hour period
- ***Endorsed by NQF on 11/4/2015;*** PFCC Committee: 71% voted to endorse, CSAC Committee: 100% voted to endorse

Reliability

- ***Cronbach's alpha= .83 indicating a reliable measure***
- N=488,942, missing=0
- Number of items=8
- Inter-item correlation ranged from .79 (expression and memory) to .21 (memory and dressing lower), ***all items were significantly correlated (p<.001)***

Facility Level Reliability Analysis

- An intra-class correlation coefficient (ICC) using the split-half method was used to assess the score level reliability across facilities.
- A random sample of 30 facilities were included from a total of 920 facilities from the most recent complete data file (patients discharged from 10/1/2016 to 9/30/2017, n= 488,942).
- ***ICC= .92, p <.001, demonstrating very high consistency among facilities for the measure***
- Rasch-converted average range in scores for the measure by facility was 9.2 to 21.2

Construct Validity

- Factor analysis using principal component analysis resulted in 2 components identified in the measure, cumulatively accounting for 63.8% of the total explained variance
- Component 1 included: eating (.68), grooming (.72), dressing upper (.77), dressing lower (.68), toileting (.71), and bowel (.59), eigenvalue=3.78, contributing ***47.3% of the explained variance***
- Component 2 included: expression (.61) and memory (.63), eigenvalue=1.32**,** contributing ***16.5% of the explained variance***

Predictive Validity

Regression models were used to determine the predictive ability of the self-care measure items on patient outcomes.

The self-care measure was a significant predictor of:

- ***Patient discharge to the community***, chi-square=50178.4, (df=8), p<.001. R_2 =.15, ***all items were retained in the model and were statistically significant*** (p<.001)
- ***Patient length of stay (LOS)***, adjusted R_2 =.15, p<.001
- ***Patient discharge functional status*** (total functional gain from admission to discharge), adjusted R_2=.44, p<.001

Impact of Cognitive Items

Stepwise regression models were performed to determine the contribution of each item within the measure on the outcomes.

- ***Predicting likelihood of patient discharge to the community***: ***expression and memory*** were retained and statistically significant (p<.001) in the model
- ***Predicting LOS: expression was retained*** and statistically significant (p<.001), memory was not retained in the model
- ***Predicting patient discharge functional status: expression and memory were retained*** and statistically significant (p<.001) in the model. It is noteworthy that ***expression was the first item retained in the model, with a contributing adjusted R_2 = .23.***

Measure #2321
Functional Change: Change in Mobility

Measure #2321 Functional Change: Change in Mobility

- Measures patient's mobility, ability to ambulate and need for assistance with transfers
- ***4 items***: bed/chair transfer, toilet transfer, locomotion, stairs
- 7-level rating scale; clinicians rate patient's lowest actual observed score over a 24-hour period
- ***Endorsed by NQF on 11/4/2015;*** PFCC Committee: 94% voted to endorse, CSAC Committee: 100% voted to endorse

Reliability

- ***Cronbach's alpha= .78 indicating a reliable measure***
- N=488,942, missing=0
- Number of items=4
- Inter-item correlation ranged from .76 (transfer bed/chair and transfer toilet) to .37 (transfer toilet and walking***), all items were significantly correlated (p <.001)***

Facility Level Reliability Analysis

- ICC using the split-half method was used to assess the score level reliability across facilities
- A random sample of 30 facilities were included from a total of 920 facilities from the most recent complete data file (patients discharged from 10/1/2016 to 9/30/2017, n= 488,942)
- ***ICC was 0.951, p <.001, demonstrating very high consistency among facilities for the measure***
- Rasch-converted average range in scores for the measure by facility was 17.1 to 35.6

Construct Validity

- Factor analysis using principal component analysis resulted in 1 component identified in the measure, cumulatively ***accounting for 61.1% of the total explained variance***
- Component 1 included items: transfer bed/chair (.86), transfer toilet (.84), walking (.69), and stairs (.73), eigenvalue=2.44

Predictive Validity

- Regression models were used to determine the predictive ability of the mobility measure items on patient outcomes.

The mobility measure was a significant predictor of:

- ***Patient discharge to the community,*** chi-square=46078.9, (df=4), p<.001. R_2 =.14, all items were retained and statistically significant (p<.001) in the model
- ***Patient LOS,*** adjusted R_2 =.15, p<.001
- ***Patient discharge functional status,*** adjusted R_2=.27, p<.001

Utility in Multiple PAC Settings

Use in Skilled Nursing Facilities and Long-Term Acute Care Facilities

- **The measures have been endorsed by NQF for use in SNF and LTAC settings** (Functional Change: Change in Self-Care for SNF measure #2769 and Change in Mobility for SNF measure #2774 endorsed 10/25/2016; Functional Change: Change in Self-Care for LTAC measure #2777 and Change in Mobility for LTAC measure #2778 endorsed 10/25/2016)
- **A cross-walk for the Self-Care Measure:**

  NQF #2286 (IRF) = NQF #2769 (SNF) = NQF #2777 (LTAC)
- **A cross-walk for the Mobility Measure:**

  NQF #2321 (IRF) = NQF #2774 (SNF) = NQF #2778 (LTAC)

Facility Level Reliability Analysis: SNF Venue

- ICC using the split-half method was used to assess the score level reliability across SNFs, a random sample of 25 facilities were included
- ***Self-care measure: ICC = 0.87, p <.001, demonstrating high consistency among facilities for the measure;*** the Rasch-converted average range in scores by facility was 11.1 to 27.1
- ***Mobility measure: ICC = 0.75, p <.001, demonstrating consistency among facilities for the measure;*** the Rasch-converted average range in scores by facility was 14.0 to 28.9

Facility Level Reliability Analysis: LTAC Venue

- ICC using the split-half method was used to assess the score level reliability across LTAC facilities, a random sample of 39 facilities were included
- ***Self-care measure: ICC = 0.95, p <.001, demonstrating very high consistency among facilities for the measure;*** the Rasch-converted average range in scores by facility was 11.1 to 20.9
- ***Mobility measure: ICC = 0.94, p <.001, demonstrating very high consistency among facilities for the measure;*** the Rasch-converted average range in scores by facility was 8.8 to 25.6

Conclusions: Summary & Application

The UDSMR Self-Care and Mobility Functional Measures

- ***High reliability and construct, content and predictive validity***
- ***Meet the defined requirements of the IMPACT Act with the inclusion of cognitive functional items***
- ***Ability to assess disparities***; differences in outcomes, based on sociodemographic variability controlling for other factors
- ***May be used in multiple PAC venues for a true 'apples to apples' quality comparison***; ability to track patient outcomes over time for those treated in multiple PAC venues for the same treatment episode (ex. admitted to LTAC from acute hospital, to SNF after LTAC stay, from SNF to IRF, from IRF to home)

Utility

- ***Intended for use among all adult (ages 18+) patients*** (all impairments/conditions, low and high functioning, independent of reimbursement/payment source)
- Items, rating scales and assessment rules are the same for all PAC settings, ***the measures are standardized and interoperable***
- ***All items within both measures are assessed by provider*** (not self-reported) ***based on observed performance*** (actual ability not estimated/assumed capability)
- ***All items are applicable for all patients; N/A-type rating options are not included,*** reducing the extent of missing data and increasing the accuracy of patient outcomes assessment

Accessibility

- Both measures are embedded in the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), mandated for use among IRFs by CMS since 2002 for payment reimbursement; the measures are ***publicly available and free of charge*** (there would be no charge for national reporting of measures if CMS elects to make available)
- Facilities that subscribe to UDSMR ***do not pay for the use of instruments or measures;*** subscription is for specialized services including: clinical training, national benchmarks and facility-level outcomes reporting, report interpretation, coding assistance, performance improvement guidance
- Subscription costs vary based on facility type (ex. single facility or multiple facilities within a corporation) and facility-level service needs

Questions?

Thank you!

Encompass Health

Implementer Presentation: Feedback on Competing Measures

Andrew Baird, JD

Director, Government Relations

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Director, Quality

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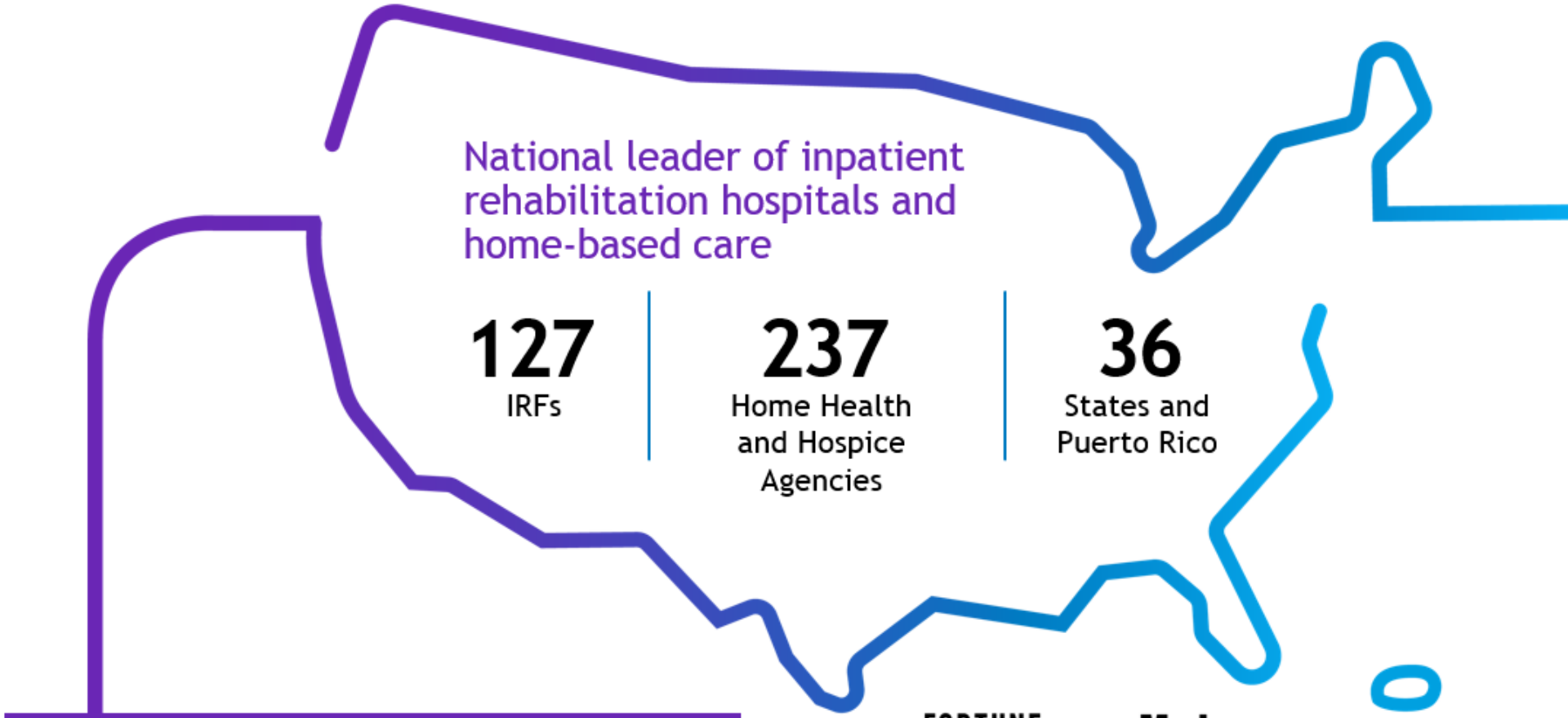
Vice President, Therapy Operations

Encompass Health



National leader of inpatient rehabilitation hospitals and home-based care

127
IRFs

237
Home Health and Hospice Agencies

36
States and Puerto Rico

Committed to delivering high-quality, cost-effective care across the post-acute continuum

FORTUNE 100 BEST COMPANIES TO WORK FOR 2017

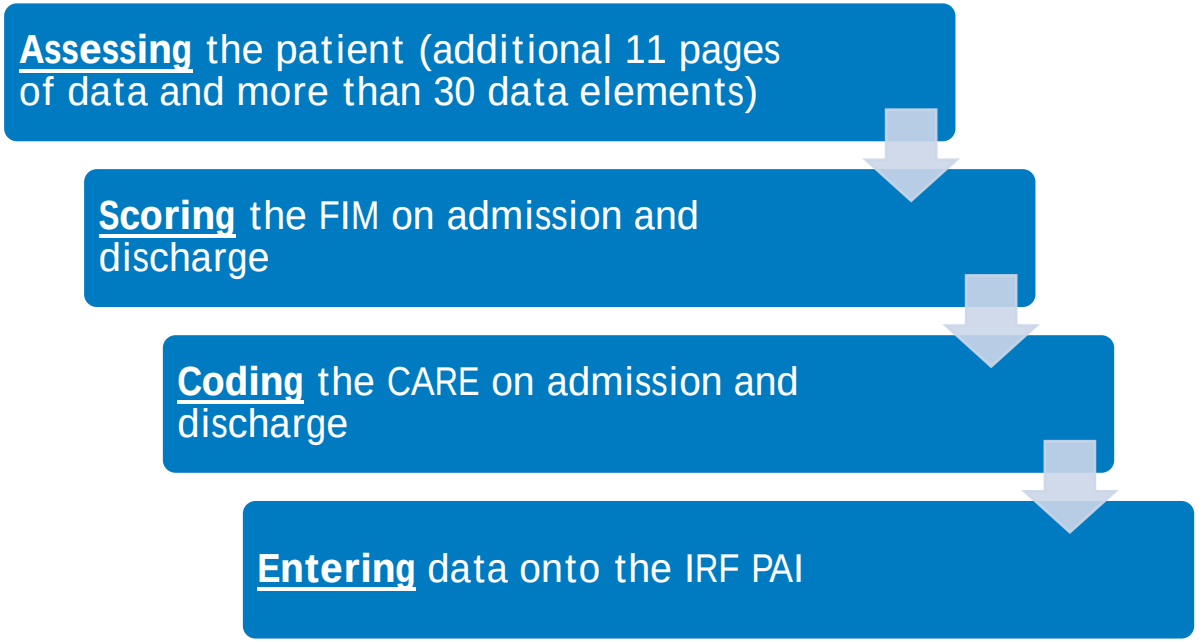
Modern Healthcare BEST PLACES TO WORK 2017

Rebranding and Name Change Initiative

- **Both business segments — inpatient rehabilitation and home health and hospice — will transition to the Encompass Health branding by the end of 2019.**
  - Rebranding and name change reinforce the Company's existing strategy and position as an integrated provider of inpatient and home-based care.
  - Effective as of January 1, 2018, HealthSouth Corporation will change its name to Encompass Health Corporation, with a corresponding ticker symbol change from "HLS" to "EHC."
  - Rollout will be deliberately sequenced across the Company's hospitals and agencies; overlap markets will be prioritized.

WORKFLOW

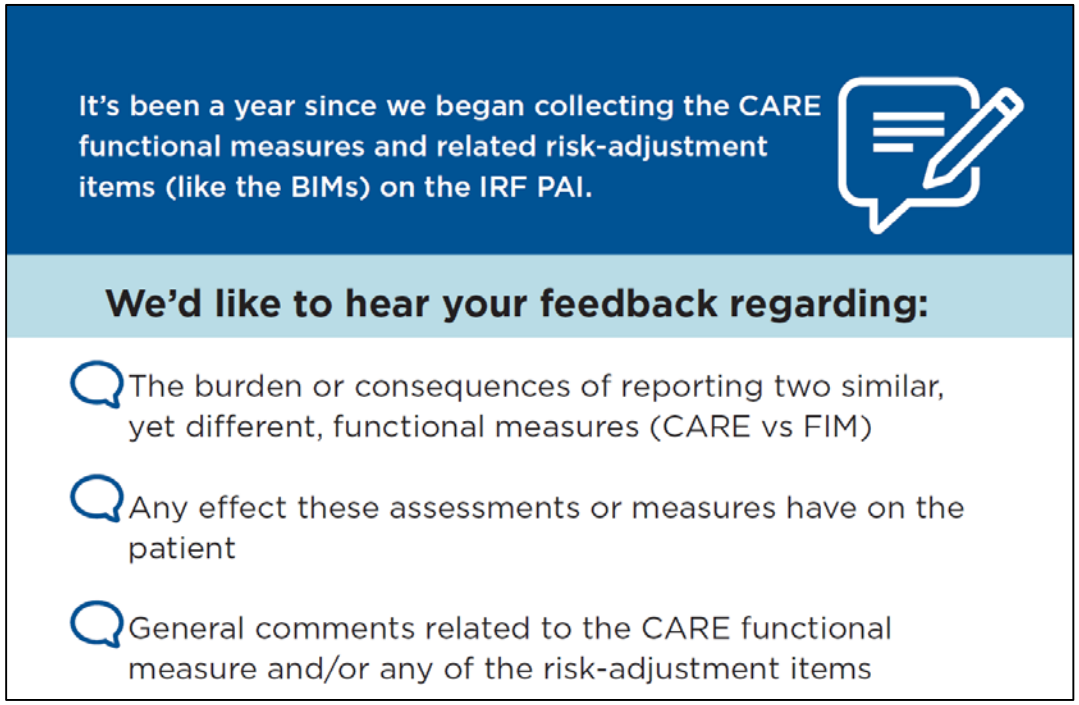
A 40-person Encompass Health workgroup spent approximately one year redefining the process workflow and updating the electronic medical record to minimize the impacts on patients and clinicians. Completing the functional items includes the following discrete steps:



Encompass Health opted to have clinicians focus on assessments and quality documentation and have separate coordinators that score and code final CARE and FIM measures based on documentation. *Clinical frontline staff were trained to assess the CARE items, not trained on coding the CARE items.*

FEEDBACK

- **Collected feedback from 35 hospital Directors of Therapy Operations (DTO) on feedback cards on-site at national DTO meeting. These individuals oversee clinicians who ASSESS the functional items.**
- **Collected feedback electronically from over 110 Patient Assessment Standards Coordinators (PASCs). These are the individuals in the hospitals that SCORE and CODE the functional items based on the assessments.**



BURDEN

Impact on Patient

- **Delayed initiation of treatment** as more time spent on assessment.
- **Patients feel they are being ignored**; perceive care providers' attention focused on collecting measures and documenting data instead of treatment.
- **Patients can be intolerant or become too fatigued** to complete all of the tasks in the required time period.

Impact on Staff

- **Increased time**;
  - to assess duplicative measures
  - assign scoring/coding and documenting in medical record and IRF PAI
  - audit record for completeness and accuracy
  - re-work any items that were missed or inaccurate
- **Frustration** caused by assessing redundant measures creates re-work, additional audits, and decreases job satisfaction
- *Paralysis by analysis* – In effort to collect required data clinicians may sacrifice clinical judgement. Staff also unsure why data is being collected, how they score, or how to improve.

Impact on Organization

- **Increased time/costs** associated with increased onboarding education and training on an ongoing basis
- **Complete overhaul** to electronic medical record to account for additional functional measure
- **Increased costs** resulting from added staff requirements
- **Increased turnover** as a result of staff frustration

ACCURACY

Confusion for staff between the two measures reduces accuracy

- Different Functional Elements Assessed
  - examples: footwear vs. lower body dressing; oral hygiene vs. hygiene
- Different Scale of measurement (6 point vs. 7 point scale)
- Different Rules
  - Reasons for not scoring an element
  - Devices used by patients

Most usual performance vs. highest burden of care

- Paints a different picture of a patient, despite the redundancy in measurement

Lack of interrater scoring confidence

- No competency program for scoring both elements simultaneously

Increased data collection and confusion between measures increases opportunity for staff to make mistakes and errors.

The biggest issue with collecting two measures, in addition to the *increased burden* and *reduced accuracy*, is that the additional work has not contributed to improved quality of care or outcomes