American Academy of Physical Medicine and Rehabilitation

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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

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

Background

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

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

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

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

IMPACT Act Requirements Supported by AAPM&R

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

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

I. Quality Measure Domains:

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

II. Resource Use and Other Measure Domains:

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

III. Assessment Categories:

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

IV. Data Elements for Each Standardized Assessment Category

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

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

  - 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 post-injury or illness. This requires data standardization across PAC settings in a series of important domains, as detailed above. Once achieved, quality measurement in the PAC arena needs to expand toward assessment of quality of life and long-term functional outcomes, such as those community-oriented factors described in the International Classification of Function (ICF), including the ability to live independently, return to work (where appropriate), community participation, social interaction, and other factors that indicate the true value of rehabilitative care.