American Academy of Physical Medicine and Rehabilitation

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June 22, 2017

Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1671-P
P.O. Box 8016
Baltimore, MD 21244-1850

Re: CMS 1671- P Medicare Program; Inpatient rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2018

Dear Administrator Verma:

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 proposed rule: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal year 2018 that was published in the Federal Register on May 3, 2017. 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.

IX . Proposed Refinements to the Presumptive Compliance Methodology ICD-10-CM Diagnosis Codes

E.1. Traumatic Brain Injury Code Exclusions on the ICG List

AAPM&R appreciates that CMS has proposed to remove some of the traumatic brain injury codes on the IGC list, thereby allowing them to count toward the presumptive compliance criteria. However, several ICD-10 codes for brain injury with unspecified duration of loss of consciousness remain on the list, which we disagree with. AAPM&R recommends removal of the following codes from the exclusion list:

- S06.2X Diffuse traumatic brain injury
- S06.309A Unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, initial encounter

- S06.309D Unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, subsequent encounter
- S06.309S Unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, sequela

AAPM&R members have informed us that admission to IRFs are being denied by CMS due to use of the above listed codes rather than ICD-10 codes with specified duration of loss of consciousness. In cases of traumatic brain injury, specificity of information such as duration of loss of consciousness may be impossible to know. Furthermore, this information is often irrelevant for the prognosis or clinical management of the patient in the IRF. For CMS to exclude these patients as non-compliant under the "60% rule" prevents access to the medically necessary rehabilitation care needed by traumatic brain injury patients. Denials of care due to lack of specificity of diagnosis codes can place undue pressure on the physician to use inaccurate or spurious diagnosis codes.

XII. Proposed Revisions and Updates to the IRF Quality Reporting Program (QRP)

B.1. Accounting for Social Risk Factors in the IRF QRP

AAPM&R believes that the scientific literature has provided many examples of sociodemographic factors that directly contribute to the development of disease and the
importance to risk-adjust for them, including the ASPE report. The AAPM&R strongly believes that measures should include sociodemographic factors such as socioeconomic status of the individual/family the resources available in the community in which the patient resides, and work status. The Academy does not believe that risk-adjusting for sociodemographic status holds providers to different standards. Risk-adjustment helps ensure that facilities are not financially penalized for serving vulnerable populations which can further reduce resource availability and worsen care disparities.

AAPM&R suggests that CMS consider the use confidential patient-reported data. Although we recognize that self-report poses possible risks related to sociodemographic differences in recall and reporting, we believe that it can be a valuable source of information, if kept confidential. Furthermore, we believe that self-report offers a reasonably valid estimate of differences in utilization of health care between socioeconomic groups. In addition, the Academy recommends including functional status (activities of daily living, instrumental activities of daily living, and mobility) as a risk-adjustment variable to accurately assess patients across settings. The scientific literature contains many examples of the impact of functional limitations on mortality. For

instance, use of a frailty adjustment factor would help adjust for variations in functional status of patients.

H. Proposed Removal of the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs From the IRF QRP
AAPM&R supports removal of this measure and appreciates CMS incorporating the potentially preventable readmission measure across all settings.

I. IRF QRP Quality Measures Under Consideration for Future Years
While AAPM&R appreciates the opportunity to comment on measures being proposed in FY 2020, it can be difficult when not all measure specifications are complete. We hope that CMS will provide more opportunity to comment on these again in the future. AAPM&R would also like to suggest that CMS continues to align new measures in every Post-Acute Care setting. During our review of the quality measures being proposed, we noticed that not all proposed measures cover every setting. We believe the measures make sense and could be implemented in every PAC setting.

- Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)
    - AAPM&R does not believe that pain experience alone should be a quality measure. As we stated above, 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. "Pain as the fifth vital sign" caused opioid prescribing to soar and rephrasing these measures could be a huge opportunity for change. AAPM&R suggests modifying this measure to reflect the proportion of patients for which moderate to severe pain interferes with or prevents important daily functional tasks.
- Percent of SNF Residents Who Newly Received an Antipsychotic Medication
    - AAPM&R does not believe this is an actual "quality" measure since there is no baseline and we urge CMS to either reconsider this measure or continue the development of it.

J.2.a. Proposed Standardized Patient Assessment Data by Category
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 were 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.

XIII. Request for Information on CMS Flexibilities and Efficiencies

Thank you for the opportunity to respond to the Request For Information (RFI) on CMS Flexibilities and Efficiencies included in the Inpatient Rehabilitation Facility (IRF) Prospective Payment System Proposed Rule for FY 2018. The American Academy of Physical Medicine and Rehabilitation is the premier physician society representing rehabilitation physicians who routinely practice in inpatient rehabilitation hospitals and units. AAPM&R is devoted to ensuring patient access to inpatient hospital rehabilitation under the Medicare program.

The RFI invites public comment regarding ideas for regulatory or sub-regulatory, policy, practice, and procedural changes to better accomplish flexibility and efficiency in Medicare, including reducing unnecessary burdens for clinicians, other providers, and patients and their families. These suggestions are intended to increase quality of care, lower costs, improve program integrity, and make the health care system more effective, simple and accessible. The RFI states that this is an important opportunity for providers and patients alike to offer regulatory relief suggestions that could significantly streamline the program and improve access to patient care while reducing provider burden with existing regulatory requirements.

AAPM&R has a number of suggestions that CMS should consider in the context of its regulatory relief agenda that would limit documentation burdens on rehabilitation physicians while enhancing access to patient care. Documentation burdens on physicians practicing in the IRF setting were dramatically increased in the wake of 2010 IRF regulations that sought to clarify coverage and documentation standards for inpatient rehabilitation hospitals and units. See 42 C.F.R. § 412.622. Physician "burn-out" is a growing problem in physiatry and the burdens of documenting medical necessity in the IRF setting to avoid denials of IRF claims present an excellent opportunity to streamline and simplify regulatory and sub-regulatory guidance.

For these reasons, AAPM&R requests that CMS seriously consider each of our regulatory relief proposals described below. We have also provided some history and background on the reasoning for these recommendations.

I. History and Background of IRF Coverage

When a person is injured, becomes seriously ill, or requires surgery, acute hospital care is often just the first step toward recovery and returning to a normal life. Patients frequently require a course of post-acute, hospital-based rehabilitation, where a physician with experience in rehabilitation coordinates the patient's medical care during an intensive rehabilitation program. IRFs strive to improve the functional status and quality of life of patients recovering from surgical procedures, strokes, spinal cord injuries, brain injuries, amputations, hip fractures, and many other conditions. Intensive inpatient hospital rehabilitation improves a person's health, functional skills, and ability to live independently and perform common daily activities such as walking, using a wheelchair, bathing, or eating.

Prior to 2010, the determination of Medicare coverage for IRF services focused on whether the services and location were reasonable and necessary and listed eight criteria that IRFs and CMS auditors could use as guideposts when assessing Medicare coverage. Medicare auditors frequently second-guessed physician judgments under the pre-2010 standards. Beginning in 2004, Medicare contractors began using the coverage criteria to second-guess significant numbers of physician decisions to admit patients to IRFs. Using non-physician clerical staff, Medicare auditors routinely asserted that patients "could have been treated in a less intensive setting, such as a skilled nursing facility." IRFs found themselves defending the care that they provided based on comparisons to an idealized SNF, which rarely, if ever, existed in practice. Physicians were on the front lines of these audits and appeals to defend their medical decisions, even though the IRF was the entity being denied payment for services rendered.

In 2010, CMS issued new coverage regulations for IRF services, and those regulations place greater emphasis on the physician's judgment with a major emphasis on documentation and process.[1] Under the 2010 rules, IRF coverage is determined "at the time of admission,"[2] based on a rehabilitation physician's reasonable expectations regarding the patient's need for intensive, multi-disciplinary therapy services under the supervision of the rehabilitation physician, and with the assistance of an interdisciplinary care team, in order to participate in and achieve significant benefit from those therapy services. The 2010 regulations emphasize the physician's judgment when admitting a patient to an IRF and, while they focus on documentation of medical necessity, they do not create black and white coverage rules that can be applied mechanically by auditors. Contractors are again overriding the decisions of admitting physicians based on the contractors' subjective assessments of the medical records. Thus, while the policy's coverage criteria changed to emphasize physician judgment in determining medical necessity, its application by Medicare auditors did not.

Each Medicare patient treated in an IRF must meet strict medical necessity coverage criteria. To be covered in an IRF, the patient must need an interdisciplinary approach to care and be stable enough at admission to participate in intensive rehabilitation. In addition, there must be a "reasonable expectation" that the patient will need multi-disciplinary therapy, and intensive rehabilitation, and supervision by a rehabilitation physician.[3]

The interdisciplinary approach to care is demonstrated by weekly meetings of the rehabilitation team, led by the rehabilitation physician.[4] The requirement for multi-disciplinary therapy must include physical or occupational therapy.[5] Intensive rehabilitation is defined as three hours per day, five days per week (or 15 hours per week).[6] This weekly standard is commonly referred to as the "three-hour rule." The therapy must be reasonably likely to result in measurable, practical improvement to the patient's functional capacity or adaptation to impairments.[7] The rehabilitation physician must see the patient at

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[1] 74 Fed. Reg. 39,762 (Aug. 7, 2009) (final rule); 42 C.F.R. § 412.600 *et seq.*
[2] 42 C.F.R. § 412.622(a)(3); Medicare Benefits Policy Manual (MBPM), ch. 1, § 110.2.
[3] 42 C.F.R. § 412.622(a)(3), (a)(5).
[4] *Id.* § 412.622(a)(5).
[5] *Id.* § 412.622(a)(3)(i).
[6] *Id.* § 412.622(a)(3)(ii).
[7] *Id.*

least three times per week.[8] Other post-acute care providers are not required to provide many of these critical services, nor do so with the same frequency, intensity, or professional staffing as IRFs.

The IRF coverage requirements established in 2010 were accompanied by significant documentation requirements. Since 2010, the medical necessity of IRF care must be demonstrated by the following documents in the patient's medical record: a preadmission screening, a post-admission physician evaluation, and an individualized overall plan of care.[9] The preadmission screening must be completed within 48 hours of admission and is the basis for the decision to admit the patient to the IRF.[10] The preadmission screening assesses the patient's functional deficits, comorbidities, expected treatments, and anticipated discharge destination.[11]

The post-admission physician evaluation is conducted by a rehabilitation physician within 24 hours of the patient's admission to the IRF.[12] It documents the patient's status on admission in comparison to the preadmission screening and is the basis for the individualized overall plan of care.[13] The individualized overall plan of care must be developed by the rehabilitation physician within four days of admission.[14] In addition, CMS requires that each patient's medical record contain physician admission orders, and the IRF-PAI, a document that records a wide variety of patient data, focusing on functional and cognitive impairments.[15]

The 2010 IRF regulations did not deliver the clarity that physicians and IRFs hoped for and expected. IRFs throughout the country have seen Medicare contractors, especially Recovery Audit Contractors (RACs), again overriding the medical decisions of the admitting physicians, often asserting that the patients did not qualify for care in a rehabilitation hospital because the patient did not need physician supervision of the rehabilitation program. Contractors have also begun reverting to the "less intensive setting" rationale for denying

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[8] *Id.* § 412.622(a)(3)(iv).
[9] 42 C.F.R. § 412.622(a)(4).
[10] *Id.* § 412.622(a)(4)(i).
[11] *Id.*; MBPM, ch. 1, § 110.1.1.
[12] 42 C.F.R. § 412.622(a)(4)(ii).
[13] *Id.*
[14] *Id.* § 412.622(a)(4)(iii).
[15] MBPM, ch. 1, §§ 110.1.4, 110.1.5.

coverage, asserting that patients could have been treated in a SNF. Contractors also frequently deny claims when physicians or other rehabilitation professionals inadvertently do not meet one of the many technical IRF documentation requirements. This last category of denial is known in the IRF field as a "technical denial" because all payment is denied due to technical documentation issues, even if the care was reasonable and necessary.

These denials force the treating physician to review voluminous medical records on patients who have long since left the IRF. Physicians must assist in preparation of written appeals and participate in oral hearings before Administrative Law Judges in order to overturn claims denials. Medicare contractor audits often include multiple claims at a time, which increases this burden exponentially. The extensive amount of time spent on these activities is time taken away from direct patient care.

II. Modifications to IRF Regulations and Coverage Rules

A. Eliminate "Technical" IRF Denials

1. Proposal: Include an affirmative statement in the IRF regulation at 42 C.F.R. § 412.622 governing IRF coverage and contractor audits that clarifies that isolated technical deficiencies in documentation shall not constitute the sole basis for denial of a claim.

2. This proposal is consistent with verbal assurances made by CMS officials before the 2010 IRF regulations were implemented and would create a much more equitable standard of review as applied by Medicare contractors. It would also alleviate one of the most frustrating aspects for IRFs of providing services to Medicare beneficiaries and limit many Medicare denials that are challenged by providers and wind up in the backlog at the Office of Medicare Hearings and Appeals (OMHA).

B. Permit Documentation Deadlines to Be Extended When Falling on a Weekend or Federal Holiday

1. Proposal: Permit documentation that is required to be signed by a physician or other rehabilitation professional within a certain timeframe to be completed by noon of the next business day if the original deadline falls on a weekend or Federal holiday.

2. This provides more reasonable documentation deadlines that would result in fewer denials for minor documentation errors. The proposal would improve the ability of physicians to direct their rehabilitation teams and provide greater flexibility of IRFs to assign staff to meet patient needs.

C. Clarify the Rehabilitation Physician's Role With Respect to Managing Both Medical and Rehabilitation Needs

1. **Proposal**: Recognize that the rehabilitation physician's role is both to maintain a patient's medical stability while participating in an intensive therapy program and facilitate the patient's best participation in and progress from that therapy.

2. Most Medicare contractors focus exclusively on a patient's medical stability without accounting for how participation in an intense therapy program—that likely far exceeds the patient's typical level of physical exertion—may impact the patient's medical recovery and stability. This creates tension between the requirement that the patient be medically stable for transfer to an IRF and the requirement for ongoing medical management from a physician. This regulatory relief proposal seeks to clarify these dual roles and require contractors to consider the interplay between medical condition and therapy intensity.

3. This regulatory ambiguity is a common reason for denial of IRF services through post-payment review, services that have already been provided and paid for by Medicare.

Clarification of the regulations in this regard would significantly reduce regulatory burdens on physicians who are most often called upon to defend claims denied for these reasons.

D. <u>Allow for Physician Extenders to Act Under Rehabilitation Physician Supervision for Purposes of Meeting Certain Coverage Criteria</u>

1. **<u>Proposal</u>:** Allow physician extenders (i.e., physician assistants and nurse practitioners) who are acting under the supervision of the rehabilitation physician to fulfill certain requirements, with documented concurrence by the physician.

2. This proposal will provide additional capacity for physicians practicing in the IRF setting to comply with the onerous documentation standards, enhancing the ability of these physicians to comply with relevant deadlines and reducing the likelihood of IRF denials.

3. Certain reasonable limitations could be put in place to ensure the integrity of the intensity of care provided in an IRF (e.g., limiting the number of physician face-to-face visits that may be carried out by the physician extender or requiring the rehabilitation physician to review and sign the preadmission screening).

4. Expanding the authority to use physician extenders in this context is consistent with the expanding use of physician extenders across the health care system and would ease the documentation burdens on IRF physicians.

E. <u>Clarify the Intensity of Therapy Requirements</u>

1. Make the 3-Hour Rule More Flexible by Allowing IRFs to Count Recreational Therapy Toward Satisfaction of the Intensity of Therapy Requirement.

a. **Proposal:** Recreational therapy—and perhaps other skilled therapies—should be counted as one of the skilled therapy modalities allowed under calculation of the 3-hour rule when these services are prescribed by the treating physician and the rehabilitation team as part of the patient's plan of care, are considered active treatment, and are provided by a qualified recreational therapist.

b. IRF regulations promulgated in 2010 unnecessarily restricted the types of therapies that can be counted toward the 3-hour rule (otherwise known as the "intensity of therapy requirement"). Recreational therapy is often used in the IRF to assist patients with reintegration into the community after a hospitalization and rehabilitation stay and can help reduce unnecessary re-admission. Recreational therapy services are skilled treatment, not diversionary activities. Recreational therapists are an important component of a multi-disciplinary rehabilitation team. Recognizing that recreational therapy can be counted toward the 3-hour rule would reinstate CMS' treatment of this therapy prior to 2010. The modification would permit physicians practicing in IRFs to better manage their rehabilitation therapy teams and provide the appropriate mix of services required by IRF patients.

2. Clarify Policies for Group and Concurrent Therapy

a. Group Therapy

i. **Proposal:** Clarify that group therapy shall be permitted to count towards the "3-hour rule" calculation when determined to be medically appropriate by the rehabilitation physician and therapy team, as long as individualized therapy constitutes the preponderance of therapy provided (i.e., 51% or more).

ii. This proposal clarifies and codifies current CMS policy but would protect against further changes that restrict access to the use of group therapy as an adjunct to individual, one-on-one therapy in IRFs. Group therapy often motivates patients to try harder and can in some cases be more beneficial than one-on-one therapy. This policy would preserve access to group therapy at the discretion of the rehabilitation physician and clarify that it is an accepted skilled therapy modality in IRFs.

b. Concurrent Therapy

i. **Proposal**: Clarify that concurrent therapy, wherein a single therapist works independently with more than one individual patient simultaneously (e.g., moving between two patients), shall be considered equivalent to one-on-one individualized therapy.

ii. Concurrent therapy generally occurs where a therapist sets one patient to completing a set of exercises and works with a second patient while the first patient completes his/her tasks, moving between the two patients but without overlapping the care provided individually to each.

iii. Further regulatory clarification of group and concurrent therapy will give physicians the direction they need to prescribe concurrent therapy based on the needs of the individual patient, without exposing IRFs to claims denials.

The AAPM&R strongly believes that the regulatory relief proposals contained in this comment letter constitute, on balance, very minor regulatory and sub-regulatory changes. But their impact could be very significant for physiatrists practicing in inpatient rehabilitation hospitals and units. Please note that the AAPM&R will also submit a separate letter in response to the CMS Request for Information on Regulatory Relief suggestions.

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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 Carolyn Winter-Rosenberg, Manager of Reimbursement and Regulatory Affairs in the AAPM&R Division of Health Policy and Practice Services. She may be reached at cwinterrosenberg@aapmr.org or at (847)737-6024.

Sincerely,

Annie Purcell, DO
Chair
Reimbursement and Policy Review 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.