# White Paper:
# Standardizing Rehab Outcome Measures

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Patients who are cared for by post-acute care (PAC) and long-term care (LTC) providers often transition between multiple sites of care, moving among their homes, hospitals, PAC and LTC settings when their health and functional status changes. With almost one in every five Medicare beneficiaries admitted to the hospital each year, approximately 40% are discharged to one of four PAC settings for additional nursing or therapy services. In 2008, almost half (47%) of this group entered into a skilled nursing facility.[1] Further, the National Clearinghouse for Long-Term Care Information estimates that 21 million people required LTC services in 2008.[2] These patients are particularly vulnerable and costly to the system, given their clinical complexity and the frequency with which they transition between settings. Currently, performance measurement across PAC and LTC settings is fragmented due to the heterogeneity of patient populations, as well as the varying performance measurement obligations and reporting mechanisms across settings.

This paper addresses the critical concept of standardizing rehabilitation outcome measures in the LTC setting. It provides the reader with background information to understand why the issue is so important to address. Current projects and programs in other healthcare settings will be presented in order to provide the reader with a context for contributing to the solution. Finally, this paper will provide information on what measures are currently available and what measures are needed.

**I. Current measure landscape**
- A. CMS quality initiative strategies
  - a. Table 1: Current CMS Pay-for-Reporting Mechanisms
  - b. Table 2: Components of CMS Pay-for-Performance
- B. Measure Application Partnership (MAP)
  - a. Table 3: Highest Leverage Areas for Performance Measurement

**II. The gap between where we are and where we need to be**
- A. Information we know
- B. Information we need
- C. Developing a quality measure for rehabilitation services in LTC

[1] Post Acute Care Payment Reform Demonstration Report to Congress Supplement – Interim Report. RTI International. CMS contract No. HHSM-500-2005-00029I. May 2011.
[2] Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program. CMS OEA_1-16_508. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/downloads/VBPRoadmap_OEA_1-16_508.pdf Accessed June 3, 2012.

## I. CURRENT MEASURE LANDSCAPE

Over the last ten years, the Centers for Medicare & Medicaid Services (CMS), with direction from Congress, has begun to transform itself from a passive payer of services into an active purchaser of higher quality, affordable care. Future efforts will certainly link payment to the quality and efficiency of care provided and will shift Medicare away from paying providers based solely on their volume of services.

This concept is known as Value-Based Purchasing (VBP) and it is grounded in the creation of appropriate incentives encouraging all healthcare providers to deliver higher quality care at lower total costs. The cornerstones of VBP are the development of a broad array of consensus-based **clinical measures**, **effective resource utilization measurement and** the **payment system redesign,** mentioned above.

While private payers have collected a variety of measures for many years, the largest healthcare provider in the nation – Medicare – has only just begun to implement requirements that would change the focus of payments from purely quantity to that of incentive payments for quality reporting and performance, efficiency and, eventually, value. The Deficit Reduction Act of 2005 (DRA), the Tax Relief and Health Care Act of 2006 (TRHCA), the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Patient Protection and Affordable Care Act of 2010 (PPACA) each included key provisions that required CMS to establish quality reporting mechanisms for all provider types and settings. Hospitals, physicians, home health (HH), skilled nursing facilities (SNFs) and End Stage Renal Dialysis (ESRD) facilities are priorities.

The roadmap for moving from identification of quality measures to pay for reporting includes the following components, although each component may not be necessary for every provider setting:
• Payment for quality performance
• Measures of physician and provider resource use
• Payment for value - promote efficiency in resource use while providing high quality care
• Alignment of financial incentives among providers
• Transparency and public reporting

### A. CMS Quality Initiative Strategies

CMS has a variety of Quality Initiative Strategies underway, and more information can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/index.html. They are all based on CMS' Three-Part Aim for improving U.S. healthcare. The Three-Part Aim comprises three objectives:

(1) Improving the individual experience of care
(2) Improving the health of populations
(3) Reducing the per capita cost of care for populations

This paper will focus on those strategies that will likely affect the SNF setting. The SNF setting lagged behind other settings in its creation, adoption and implementation of quality performance measures, and thus performance has not been significantly impacted yet. Table 1 illustrates that point.

**Table 1. Current CMS Pay for Reporting (P4R) Mechanisms**

| Healthcare Setting | Quality Program(s) | Mandatory Reporting | Payment Incentive/Penalty |
|---|---|---|---|
| **Inpatient (Acute Care Hospitals)** | IQR, HAC, Readmissions & VBP | Yes | Yes<br>P4R and P4P in 2013 |
| **Long Term Care Hospitals (LTCH)** | Beginning 2014 | Yes<br>Beginning Q4 2012 | Yes<br>P4R Penalty 2% |
| **Inpatient Rehabilitation Facilities (IRF)** | Beginning 2014 | Yes<br>Beginning Q4 2012 | Yes<br>P4R Penalty 2% |
| **Skilled Nursing Facilities (SNF)** | MDS 3.0 | Yes | No |
| **Hospice** | Beginning 2014 | Yes<br>Beginning Q4 2012 | Yes<br>P4R Penalty 2% |
| **Home Health** | OASIS, HH CAHPS | Yes | Yes<br>P4R Penalty 2% |
| **Outpatient** | PQRS | Yes<br>2013 data will inform 2015 penalty | Yes P4R Incentive 0.5% until 2014<br>Penalty 1.5% in 2015 |

SNFs can gain insight into what may be in store for them by watching activities in other provider settings as they move from Pay for Reporting to Pay for Performance. Table 2 provides information on current projects underway in each area of the CMS roadmap.

**Table 2. Components of CMS Pay for Performance (P4P) Roadmap[2]**

| I. Payment for Quality Performance | | | |
|---|---|---|---|
| **Project** | **Size** | **Ongoing?** | **Result** |
| Premier Hospital Quality Incentive Demonstration: The demonstration, which began in 2003, is measuring and providing bonus incentives for improving quality of care as measured by more than 30 evidence-based clinical quality measures in five clinical areas: acute myocardial infarction, pneumonia, heart failure, CABG and hip and knee replacement. | 250 hospitals 38 states | No. Project ended after six years. | Overall quality raised by an average of 18.6% across the 30 measures; received incentive payments of > $60 million from CMS for performance, improvement and attainment of quality goals; 18 hospitals moved from the bottom to the top 20% of hospitals in one or more clinical areas.[3] |

[3] CMS/Premier Hospital Quality Demonstration White paper; Nov 2012

| II. Measures of Physician and Provider Resource Use | | | |
|---|---|---|---|
| **Project** | **Size** | **Ongoing?** | **Action** |
| MIPPA required Medicare to implement a program to provide confidential reporting to physicians on their resource use. The Affordable Care Act (ACA) of 2010 extended and enhanced the program, and it is now referred to as *The Physician Feedback Program*. The next step is the development and implementation of a Value-based Payment Modifier. | Phase I: 310 providers in 12 MSAs received reports. Phase II: In early 2012, physicians practicing in IA, KS, MO, & NE received reports about care and costs during CY 2010. | Yes | Under the physician fee schedule, Medicare will begin using differential payment to physicians, or groups of physicians, based upon the quality of care furnished compared with cost. This will affect payment to some physicians beginning in 2015, and will be extended to most or all physicians by 2017. |
| **III. Payment for Value** | | | |
| **Project** | **Size** | **Ongoing?** | **Action** |
| In 2008, CMS implemented a policy to stop paying for reasonably preventable Hospital Acquired Conditions (HACs) – e.g. conditions acquired during a hospitalization. Conditions include high cost, high volume, or both, or those that reasonably could have been prevented through application of evidence–based guidelines. | All Medicare inpatient hospitals | Yes | Beginning in FY 2014, hospitals in the lowest quartile for medical errors or serious infections will be paid 99% of what they otherwise would have been paid. |
| Readmissions: CMS is implementing readmissions measures in several settings to encourage providers to improve sustainability of health outcomes. The ACA established a Readmissions Reduction Program effective for discharges beginning on October 1, 2012. The measure tracks patients who are re-hospitalized within 30 calendar days of their discharge from a particular setting. The program uses a NQF methodology and establishes a three-year period of discharge data to determine the excess readmission ratio from. For specific conditions, 'planned' readmissions are excluded from the measure. | All Medicare inpatient hospitals, inpatient rehab hospitals and home health agencies | Yes | Hospitals are currently measured on heart attack, heart failure and pneumonia. Acute exacerbation of COPD and elective THA/TKA will be added for FY 2015. For IRF, an all-cause unplanned readmission measure will be reported beginning FY 2014. For HHAs, an all-cause unplanned readmission measure will be reported beginning FY 2014, as well as emergency department use without readmission during the first 30 days of a HH episode. |

| III. Payment for Value (continued) | | | |
|---|---|---|---|
| **Project** | **Size** | **Ongoing?** | **Action** |
| CMS is currently developing a VBP plan for physician services.<br>The Physician Group Practice (PGP) demonstration project, which ran from 2005 to 2010, resulted in financial rewards for physician groups that improved quality of care and lowered expenditures for 3 chronic conditions by coordinating their patients' Part A and Part B health care services, especially for beneficiaries with a chronic illness or multiple co-morbidities, and those near the end of life. By the end of the demonstration, all 10 groups achieved benchmark performance on 30 of 32 measures, and 4 earned incentive payments. | 10 physician groups in the original 5 year study | Yes | CMS has engaged the groups in a 2 year Transition Demonstration that began on 1/1/2011. |
| A Home Health Pay-for-Performance demonstration was implemented on January 1, 2008 in AL, CA, CT, GA, IL, MA and TN to determine the impact of incentive payments to HHAs for improving the quality of care of Medicare beneficiaries who receive home health services. | Participating agencies represent >30% of all Medicare certified HHAs | No | Completed end of 2009. Report[4] found only modest incremental improvements in quality in the second year of demonstration. Cost-savings were calculated in only 3 regions. |
| The Nursing Home Pay-for-Performance demonstration project offers financial incentives to nursing homes that perform the best or improve the most in the level of care that they provide. The demonstration includes beneficiaries who are on a Part A stay, as well as those with Part B coverage only. The project began on July 1, 2009, and CMS anticipates that potentially avoidable hospitalizations may be reduced as a result of improvements in quality of care. Each year of the demonstration, CMS will assess each participating nursing home's quality performance based on four domains:<br>1. Staffing (staffing levels and turnover rates)<br>2. Hospitalizations (rate of potentially avoidable hospitalizations)<br>3. MDS outcomes (select outcomes from already available resident MDS assessments)<br>4. Survey deficiencies (from state survey inspections) | 3 states: AZ, NY, WI<br>Number of Participants: 182 | Yes | The demonstration was projected to last three years. A Final Report will be submitted to CMS once analysis of the data has been completed. |

[4] Evaluation of the Medicare HH Pay-for-Performance Demonstration Final Report. Volume 1: Agency Characteristics, Costs, and Quality Measure Performance among Treatment, Control, and Non-Participant Groups. University of Colorado Anschutz Medical Campus; Division of Health Care Policy and Research. February 2012. Accessed June 11, 2012.

| IV. Alignment of Financial Incentives Among Providers | | | |
|---|---|---|---|
| **Project** | **Size** | **Ongoing?** | **Action** |
| The Medicare Hospital Gain-Sharing Demonstration began October 1, 2008 and ran through September 30, 2008. The project allowed hospitals to provide gain-sharing payments to physicians. These payments represented a share of the savings incurred as a result of collaborative efforts to improve overall quality and efficiency during the IP stay and immediately post-discharge. | 2 hospital sites: NY and WV | No | Both sites distributed bonus payments to physicians who maintained acceptable quality of care performance. Savings were related to lowering length of stay through use of electronic health records, more efficient use of consults, improved communication, surgical cost reductions, reductions in infection, complications and readmissions, and streamlining care through implementation of protocols. |
| The Acute Care Episode (ACE) demonstration, which began January 1, 2009, tests the use of a bundled payment for both hospital and physician services for a select set of inpatient episodes. The first project includes cardiac and/or orthopedic procedures. | 5 hospitals: CO, NM, OK, TX | Yes | The program will continue for 3 years. Quality will be reported through process & outcome measures. |
| The Post- Acute Care (PAC) payment reform demonstration examined the relative costliness and outcomes of patients admitted to different types of PAC providers. A single, standardized assessment data set was used: the continuity Assessment Record and Evaluation (CARE). It is expected the project results will be used to generate recommendations for potential payment alternatives to help assure that post acute care patients are treated in the clinically most appropriate setting. The demonstration lasted from 2008 to 2011. | 140 providers, 11 market areas, and 39,205 assessments | No | Initial report submitted to Congress in 2011. Second report in November 2012 recommended development of two motor functional status quality metrics, self-care and mobility. These quality metrics would be used across acute and post-acute care providers including IRFs, LTCHs, SNFs and HHAs. The quality metric would use items from the CARE item set. |
| **V. Transparency and Public Reporting** | | | |
| **Project** | **Size** | **Ongoing?** | **Action** |
| Nursing Home Compare website: Beneficiaries can compare 19 quality measures, information on the number of nursing staff hours per resident, survey deficiency information and information regarding ownership. CMS began assigning quality ratings (from a low of 1 star to a high of 5 stars) to Nursing Homes in December of 2008. | All Medicare certified NHs included | Yes | In 2009, they released a list of 52 poorly performing facilities – i.e,. facilities on Special Focus Review. Other initiatives: a pilot demonstrating a comprehensive system of criminal and other background checks for prospective new hires in nursing homes and strengthened surveillance of infection control and nutrition. In July of 2012, MDS 3.0 expanded measures were posted for both short-stay and long-stay patients. |

| V. Transparency and Public Reporting (continued) | | | |
|---|---|---|---|
| **Project** | **Size** | **Ongoing?** | **Action** |
| For hospitals, CMS posts quality information about selected inpatient hospital stays provided to Medicare patients, such as how often Medicare patients were admitted to the hospital for certain conditions and what Medicare pays for those services. Patient survey results are also publicly reported. | All Medicare inpatient hospitals included | Yes | 26 quality measures, such as readmission rates, healthcare-associated infections, mortality rates and utilization of medical imaging, are now supplemented by 10 measures of patient care experience, such as level of provider communication, pain control, cleanliness of facility, and whether patients would recommend the hospital to others. |
| Available to physicians and therapists in private practice, the Physician Quality Reporting System consists of over 200 endorsed measures of quality care. Participation in the PQRS has been voluntary since its inception in 2007, and participating providers have received up to a 2% bonus on annual Medicare charges for meeting reporting requirements. | Current estimates are that 20% of eligible providers participate | Yes | CMS' Physician Compare website provides information on which physicians and group practices participate in CMS quality reporting programs. In the future, information on performance in quality programs will be reported, as will quality of care ratings for group practices. |

### B. Measure Application Partnership (MAP)

Another group to watch is the Measure Applications Partnership (MAP). It is a public-private partnership convened by the National Quality Forum (NQF) with statutory authority from the ACA. The ACA directed the Department of Health and Human Services HHS to contract with the NQF to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses[5] MAP is responsible for providing input to the HHS on selecting performance measures for public reporting and performance-based payment programs, and for other purposes. Five workgroups make up the MAP structure in order to ensure appropriate representation for providers, specific care setting and patient populations. These workgroups include a Hospital Workgroup, Clinician Workgroup, PAC/LTC Workgroup, Dual Eligible Workgroup and the Ad Hoc Safety Workgroup. More than 60 organizations representing major stakeholder groups, 40 individual experts and 9 federal agencies are represented throughout the workgroups.

In February 2013, the MAP issued a report to CMS with its recommendations on measures currently under consideration by the Department of Health and Human Services for use in federal programs. After reviewing over 500 measures for use in twenty federal programs, the report identified priority measure gaps and proposed solutions to fill those gaps.[6]

For PAC and LTC providers, the MAP reiterated the need to align performance measurement across PAC/LTC settings, as well as with other acute settings, such as hospitals. MAP suggested robust risk adjustment methodologies to address the variability of patients across these settings. Admission, readmission and transition of care measures were named as examples of measures that MAP recommended should be standardized across settings, and yet also allow for customization due to the

[5] U.S. Government Printing Office (GPO), *Patient Protection and Affordable Care Act (ACA), PL 111-148 Sec. 3014,* Washington, DC: GPO; 2010, p.260. Available at www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. In National Quality Forum Final Report: Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement. February 2012.
[6] National Quality Forum. MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS; Final Report; February 2013. ISBN 978-1-933875-47-7.

unique needs of the PAC/LTC population. The MAP identified six areas they believe to be the "highest-leverage" areas for measurement, and further defined these with a set of 13 measure concepts[7] illustrated in Table 3).

**Table 3.**

| Highest Leverage Areas for Performance Measurement | Core Measure Concepts |
|---|---|
| **I. Function** | 1. Functional and cognitive status assessment<br>2. Mental health |
| **II. Goal Attainment** | 3. Establishment of patient/family/caregiver goals<br>4. Advanced care planning and treatment |
| **III. Patient Engagement** | 5. Experience of care<br>6. Shared decision-making |
| **IV. Care Coordination** | 7. Transition planning |
| **V. Safety** | 8. Falls<br>9. Pressure ulcers<br>10. Adverse drug events |
| **VI. Cost / Access** | 11. Inappropriate medicine use<br>12. Infection rates<br>13. Avoidable admissions |

## II. THE GAP BETWEEN WHERE WE ARE AND WHERE WE NEED TO BE

The Balanced Budget Act of 1997 created a major shift in who provided rehabilitation services for a large percentage of Medicare certified facilities. In an effort to minimize costs in the new prospective payment system, many nursing facilities began to contract their therapy services. Rehabilitation contracting companies, while originally seen as a risky business model, soon flourished as they partnered with nursing facilities to understand the nuances of the payment system and promote the value of rehabilitation for both the short and long-term patient populations.

One of the benefits nursing homes experienced from subcontracting rehabilitation was they did not have to spend time and resources to manage an aspect of care they may not have fully understood. However, an unintended side effect was no longer having access to specific rehabilitation data. The opposite was also true; rehabilitation companies did not always concern themselves with operational data about nursing home performance or cost. Each organization had its own metrics and its own definitions of a successful operation.

As more contract rehabilitation companies entered the market in the 1990s, nursing homes had options to choose from when selecting a rehabilitation partner. In the early years, a few of the biggest differentiators between companies were:

- Price – i.e. cost to the nursing home
- Availability of therapists
- Customer service
- Programs

Since all rehabilitation companies offered the same core service of PT, OT and SLP, they had to find new ways to set themselves apart from the rest of the marketplace. Therefore many began developing

[7] National Quality Forum Final Report: Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement. February 2012.

sophisticated systems to measure not just their operational performance results, but also their clinical performance results. This information has historically been heavily guarded.

As Medicare and other payers have moved toward transparency in reporting clinical performance measures, the long-term care rehabilitation industry has moved a little slower. The biggest challenge is often trying to consolidate the information in a manner that is useful to the provider. Nursing homes have a multitude of costs, and depending on whether the provider of these services is a direct employee or a contractor, it may be extremely difficult to gather the information necessary to analyze it in a way that assists providers in changing their performance and efficiency. For example, a nursing home that utilizes contract staff and pays an invoice each month probably does not allocate cost to human resources, benefits, program development and/or equipment. However, a nursing home that has its own in-house therapy staff does incur those costs. Therefore as an industry, it is very difficult to compare one facility to another unless you know they have like characteristics. CMS encountered this in 2005, when a Technical Expert Panel for the Nursing Home Value-Based Purchasing program was assembled to discuss measures. Nursing hours per patient were proposed, as were therapy hours per patient. Unfortunately, the latter was abandoned because CMS realized nursing homes cannot report this information easily, especially in rural areas. In 2012, CMS began reporting therapy staff hours per resident per day, but only for physical therapy, rather than for all therapy disciplines. Furthermore, the number is calculated from survey and certification reports and divided across total patient days, instead of using a denominator of only therapy patient days. The result is a number that is difficult to interpret and use in a meaningful way for consumers or providers. The majority of publicly available reports only include cost data related to nursing, plant management and supplies.

The same is true when trying to compare clinical performance measures. The reporting systems currently in place for nursing homes are largely focused on “medical” information, such as severity of condition. The information is collected from the Minimum Data Set (MDS) 3.0, and therefore the change in condition is due to the composite of care provided to the resident. There is no direct provider-type cause and effect relationship that can be measured, and while rehabilitation is an integral part of the “composite of care,” there is no way to differentiate how much of the improvement (or decline) was a direct effect of the intensity (or lack) of rehabilitation provided.

As a result of the increase in Rehab RUG utilization over the last ten years, providers are facing increased scrutiny from Medicare Administrative Contractors and Program Safeguard Contractors. CMS has begun to question the value of intense rehabilitation in the nursing home setting. The rehabilitation industry is struggling with how to justify this increase in higher rehab RUGs to entities that are primarily interested in the burden of cost it has imposed on the health care system. While each therapy discipline utilizes standardized clinical performance tools specific to their own professional literature, and some rehabilitation companies have their own proprietary tools, there is not one tool or measure that all providers have accepted as “the” measure of quality rehabilitative care in the skilled nursing and long-term care setting. The result is an absence of industry-accepted metrics, and therefore, the industry must find ways to overcome these present and future challenges, detailed below.

**1. Rehabilitation services in nursing facilities are interdisciplinary.** This interdisciplinary aspect is integral to both the regulatory and payment context of care. Conditions of participation, survey guidelines and OBRA requirements all focus on building and promoting a care plan that is holistic and meets all the needs of a patient. A facility must utilize all departments to achieve this goal. Medicare Part A payment in nursing facilities is bundled, such that providers receive one per diem rate for nursing, therapy and ancillary services. Medicare Part B payment remains fee-for-service, but regardless of payer type, the efficiency of care and the durability of its outcomes are closely linked to the medical, psychosocial, and nutritional aspects of care.

**2. Patient characteristics in nursing facilities are diverse.** No two patients who utilize the skilled nursing facility benefit are alike. In fact, most of them have a diverse set of rehabilitation, nursing and psychosocial needs. Many patients who receive rehabilitation services are long-term residents. These patients present an entirely different set of impairments, and may require a different model of care. Therefore, finding one, two or even three clinical performance measures that represent such a diverse population is extremely difficult.

**3. Lack of a defined clinical performance benchmark.** What is a "good clinical outcome" of rehabilitation in the skilled nursing facility setting? Ask ten different people and you will get ten different answers. Most people will agree on a few things: it depends on the patient, their primary condition and comorbidities and their prior level of function. Another critical issue to tackle is how to measure the "outcome of rehabilitation" regardless of how many and what type of therapy disciplines received. Discharge to community and transitions of care are two such measures that have been used as a proxy, but so far, no one has the answer.

**4. No "universal" rehabilitation measure exists for this setting.** The inpatient rehabilitation facility utilizes the FIM™ to measure a patient's motor and cognitive score at admission to the facility and again at discharge. This proprietary measure has been in place since 1996, and quickly became one of the most widely accepted functional assessment measures in the rehabilitation community. While it is considered a strong measure of progress for inpatient rehabilitation, it has not found applicability in other rehabilitation settings. Other post-acute care settings cannot point to one measure that is universally accepted by those who practice within their setting, as well as by those who pay for their services.

In an attempt to fill the gap, professional associations have developed clinical performance measures:

- The American Speech-Language Pathology and Hearing Association developed NOMS™, but this system is not used consistently across all therapists who work in the skilled nursing setting
- The American Physical Therapy Association is developing OPTIMA™, but this system is primarily applicable to community-based patients and clients
- The professional literature for OT, PT and SLPs has an extensive list of standardized clinical outcome tools available to use, such as the Katz ADL scale, the Berg Balance Test and the Western Aphasia Battery. While important for clinical practice, most of these tools are intended to measure improvements in certain aspects of function, such as self-care, balance and aphasia respectively.

Many rehabilitation companies have developed their own clinical performance measurement tools, but these are usually proprietary and come with their own specific definitions and applications. Therefore, therapists must learn the definitions to use with each employer's tools, which may or may not be consistent with the professional associations and/or measurement tools they used in other settings.

What is the bottom line? There is a lot of information being gathered, analyzed and disseminated by a lot of different organizations, but none of it is standardized. Without standardization, none of it can be used to compare one company's or one organization's clinical performance to another.

## A. Information We Know

There are some operational and clinical measures currently available in the public domain. However, the user must be aware this information is strictly historical and based upon cost reports, claims data and MDS reporting. They are not intended to represent a "gold standard" or best practice benchmark to be achieved.

Examples are:

| OPERATIONAL | | | |
|---|---|---|---|
| **Average Payer Mix** | LarsonAllen*, AHCA* MedPAC | **Intensive Rehab Rugs** | LarsonAllen*, AHCA* MedPAC, CMS |
| **Utilization Of Rehab** | LarsonAllen*, AHCA* MedPAC, CMS | **RUGs Utilization (All)** | LarsonAllen*, AHCA* MedPAC, CMS |
| **Hours Per Resident Day^** | LarsonAllen*, AHCA* NH Compare | **Average Skilled Med A Length of Stay** | LarsonAllen*, AHCA* MedPAC, CMS |
| **Financial and Cost Data** | LarsonAllen*, AHCA* | | |

| CLINICAL | |
|---|---|
| **% of patients on a Pain Medicine Regimen on admission reporting a decrease in pain intensity or frequency^** | NH Compare website |
| **% of residents whose need for Help With Daily Activities has increased^** | NH Compare website |
| **% of patients who self-report Moderate To Severe Pain^** | NH Compare website |
| **Section G ADL scores^** | NH Compare website, AHCA* |
| **Discharge to Community^** | MedPAC, ANHQ/AHCA* |
| **Rehospitalization Rate** | MedPAC, ANHQ/AHCA* |
| **Nursing Facility Patient Characteristics** | AHCA* |

***Current information available to organization members only; Historical information may be available publicly***
***^Information is not specific to rehabilitation patients only***

## B. Information We Need

We are entering a unique time as we witness our industry and our professions being significantly threatened by increasing regulations and payment cuts. In an effort to remain a viable and affordable part of the health care system, nursing facility and rehabilitation provider groups are more incentivized to share information and partner together to solve this challenge.

Rehabilitation providers must find a valid method of measuring the value of rehabilitation services in the long-term care setting. This method must be:

- Statistically valid
- Universally accepted by all three therapy disciplines
- Universally accepted by all rehabilitation provider companies
- Not overly burdensome
- Acceptable to CMS, the National Quality Forum and other payer stakeholders

### C. Developing a Quality Measure for Rehabilitation Services In LTC

The American Health Care Association (AHCA) and the National Association for the Support of Long Term Care (NASL) were jointly engaged in a pilot study to validate several proprietary tools against the same functional mobility and self-care items included in the CMS Post-Acute Care Payment Reform Demonstration (PAC-PRD). This monumental effort was intended to meet the challenges described above. The project was heavily influenced by NASL's previous work with The Moran Group, as well as CMS' PAC-PRD (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/index.html), whose findings point to several functional measures of mobility and self-care that were reliable sources of outcomes data, as well as useful predictors of resource use.

Next steps include reaching out to additional therapy companies for data, and engaging companies in an effort to create a national database for outcomes. The final product is anticipated to be the development of a proposed Quality Measure(s) related to a patient's functional status in the nursing home setting. This would be an important and exciting first step in directly measuring the value and benefit of rehabilitation services in this setting.

That is why Optima Healthcare Solutions (Optima) has embarked on a focused strategy to provide a system that helps to answer some of these tough questions. Optima has been an active member of the NASL Quality Workgroup since July 2011, and is poised to be an active participant in this ongoing process with rehabilitation providers as the need for clinical performance and quality outcomes systems becomes just as important as financial operational data systems.

**Note:** Optima will publish an Outcomes roadmap outlining development phases and targeted release goals in the coming weeks.