THE OFFICIAL JOURNAL OF
ACRM
AMERICAN CONGRESS OF REHABILITATION MEDICINE

Archives of Physical Medicine and Rehabilitation

Editors' Selections From This Issue: Volume 99 / Number 6 / June 2018

REHABCAST

The audio hub for rehabilitation medicine produced by the *Archives of Physical Medicine and Rehabilitation*, the field's top journal. Hosted by Dr. Ford Vox, each episode features in-depth interviews with scientists publishing in the journal and news briefs relevant to all rehabilitation clinicians. Our growing collection of podcasts, is available at http://www.archives-pmr.org/content/podcast_collection.

MEASUREMENT TOOL

See ***Measurement Characteristics and Clinical Utility of the Pediatric Evaluation of Disability Inventory in Children with Cerebral Palsy,*** by Brew et al on page 1251. Measurement Tools, from the Rehabilitation Measures Database, are designed to facilitate the selection of outcome measures by clinicians. Previously published Tools are available at http://www.archives-pmr.org/content/measurementtools.

COGNITIVE REHABILITATION TRAINING

Based on the *ACRM Cognitive Rehabilitation Manual: Translating Evidence-Based Recommendations into Practice*, this introductory training teaches evidence-based interventions for impairments of executive functions, memory, attention, hemispatial neglect, and social communication. Go to http://www.cognitiverehabilitation.org/ for details.

ACRM 2018

The ACRM Annual Conference is comprised of the main **CORE Conference** and the **Pre-Conference** delivering a total of SIX jam-packed days of evidence-based educational content. Call for Late Breaking Posters happening now. For details and to register go to http://bit.ly/2yIOpiC.

Evolving Models of Rehabilitation-Related Patient Safety and Quality: PIECES

In the introduction to this special issue, Dr. Bruce Gans describes the PIECES conceptual framework: Prevent avoidable harm; Improve health; Enhance Function; Consider the patient experience; Efficiently use resources; and Sustain the benefits. The framework has recently been adopted by the Commission on Accreditation of Rehabilitation Facilities (CARF International) as a teaching construct, and the six domains are a useful model to apply to safety and quality program activities in rehabilitation settings. The studies in this issue address most of these "PIECES". ■ SEE THE FULL ARTICLE AT PAGE 1033

Measuring Inpatient Rehabilitation Facility Quality of Care: Discharge Self-Care Functional Status Quality Measure

Pardasaney and colleagues describe the calculation and psychometric properties of the discharge self-care functional status quality measure implemented in the Centers for Medicare & Medicaid Services' (CMS) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program. A total of 4769 patient stays were included in the study. For each patient, the authors calculated an expected discharge self-care score. The performance score of each IRF equaled the percentage of patient stays where the observed discharge self-care score met or exceeded the expected score. About 54% of IRFs had scores significantly different from the percentage of stays that met or exceeded the expected discharge self-care score. The authors conclude that the discharge self-care quality measure showed strong discriminatory ability and reliability, representing an important initial step in evaluation of IRF self-care outcomes. A wide range in performance scores suggested a gap in quality of care across IRFs. ■ SEE THE FULL ARTICLE AT PAGE 1035

Effect of Rehabilitation Intensity on Mortality Risk After Stroke

Hsieh and colleagues examined the relationship between rehabilitation intensity and poststroke mortality in patients (N=6737) hospitalized for a first-ever mild to moderate stroke. The intensity of rehabilitation therapy within 90 days after stroke was categorized into low, medium, or high based on the distribution of the number of rehabilitation sessions. Patients in the high-intensity group were younger but had a higher burden of comorbidities and greater stroke severity. During follow-up, the high-intensity group was associated with a significantly lower adjusted risk of mortality than the low-intensity group, whereas the medium-intensity group carried a similar risk of mortality compared with the low-intensity group. Stroke severity did not modify this association. The authors conclude that among patients with mild to moderate stroke severity, high-intensity rehabilitation therapy within the first 90 days was associated with a lower mortality risk than low-intensity therapy. Efforts to promote high-intensity rehabilitation therapy for this group of patients with stroke should be encouraged. ■ SEE THE FULL ARTICLE AT PAGE 1042

Evaluating Hospital Readmission Rates after Discharge from Inpatient Rehabilitation

Coots Daras and colleagues examined facility-level rates of all-cause, unplanned hospital readmissions for 30 days after discharge from inpatient rehabilitation facilities (IRFs). The study included Medicare fee-for-service beneficiaries (N=567,850 patient-stays). The national observed hospital readmission rate by 30 days postdischarge from IRFs was 13.1%. The mean unadjusted readmission rate for IRFs was 12.4%±3.5%, and the mean risk-standardized readmission rate was 13.1%±0.8%. Nearly three-quarters of IRFs (73.4%) had readmission rates that were significantly different from the mean. Readmission rates reflect the quality domain of discharge planning and coordination across the care continuum. The authors conclude that the results of this study demonstrate the ability to assess 30-day, all-cause hospital readmission rates postdischarge from IRFs and the ability to discriminate between IRFs with higher- and lower-than-average hospital readmission rates. ■ SEE THE FULL ARTICLE AT PAGE 1049

Geographic Region and Profit Status Drive Variation in Hospital Readmission Outcomes among Inpatient Rehabilitation Facilities in the United States

Coots Daras and colleagues examined whether inpatient rehabilitation facilities' (IRFs') all-cause 30-day postdischarge hospital readmission rates vary by organizational characteristics and geographic regions. The authors studied 1166 IRFs, estimated facility-level observed and risk-standardized readmission rates, and then examined variation by several organizational characteristics (facility type, profit status, teaching status, proportion of low-income patients, size) and geographic factors (rural/urban, census division, state). IRFs' mean risk-standardized hospital readmission rate was 13.00%±0.77%. After controlling for organizational characteristics and practice patterns, the authors found substantial variation in readmission rates: for-profit IRFs had significantly higher readmission rates than did not-for-profit IRFs (P<.001). They also found geographic variation: IRFs in the South Atlantic and South-Central census regions had the highest hospital readmission rates while IRFs in New England had the lowest rates. The authors conclude that these findings point to variation in quality of care as measured by risk-standardized hospital readmission rates after IRF discharge. ■ SEE THE FULL ARTICLE AT PAGE 1060