Final IRF QRP New and Modified Items – Effective Date: October 1, 2020

Identification Information

15A. Admit From _____

(01. Home (e.g. private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements); 02. Short-term General Hospital; 03. Skilled Nursing Facility (SNF); 04: Intermediate care; 06. Home under care of organized home health service organization; 50. Hospice (home); 51. Hospice (medical facility); 61. Swing Bed; 62. Another Inpatient Rehabilitation Facility; 63. Long-Term Care Hospital (LTCH); 64. Medicaid Nursing Facility; 65. Inpatient Psychiatric Facility; 66. Critical Access Hospital (CAH); 99. Not Listed

Discharge Information

44D. Patient's discharge destination/living setting, using codes below: _____
(answer only if 44C = 1; if 44C = 0, skip to item 46)

(01. Home (e.g. private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements); 02. Short-term General Hospital; 03. Skilled Nursing Facility (SNF); 04: Intermediate care; 06. Home under care of organized home health service organization; 50. Hospice (home); 51. Hospice (medical facility); 61. Swing Bed; 62. Another Inpatient Rehabilitation Facility; 63. Long-Term Care Hospital (LTCH); 64. Medicaid Nursing Facility; 65. Inpatient Psychiatric Facility; 66. Critical Access Hospital (CAH); 99. Not Listed

ADMISSION

Section A	**Administrative Information**

A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?	
↓	**Check all that apply**
☐	**A.** No, not of Hispanic, Latino/a, or Spanish origin
☐	**B.** Yes, Mexican, Mexican American, Chicano/a
☐	**C.** Yes, Puerto Rican
☐	**D.** Yes, Cuban
☐	**E.** Yes, another Hispanic, Latino, or Spanish origin
☐	**X.** Patient unable to respond

A1010. Race
What is your race?

↓	**Check all that apply**
☐	**A.** White
☐	**B.** Black or African American
☐	**C.** American Indian or Alaska Native
☐	**D.** Asian Indian
☐	**E.** Chinese
☐	**F.** Filipino
☐	**G.** Japanese
☐	**H.** Korean
☐	**I.** Vietnamese
☐	**J.** Other Asian
☐	**K.** Native Hawaiian
☐	**L.** Guamanian or Chamorro
☐	**M.** Samoan
☐	**N.** Other Pacific Islander
☐	**X.** Patient unable to respond

A1110. Language

Enter Code ☐

A. What is your preferred language?

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. **No**
1. **Yes**
9. **Unable to determine**

A1250. Transportation
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

↓	**Check all that apply**
☐	**A. Yes**, it has kept me from medical appointments or from getting my medications
☐	**B. Yes**, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	**C. No**
☐	**X. Patient unable to respond**

Section B	Hearing, Speech, and Vision

B0200. Hearing	
Enter Code ☐	**Ability to hear** (with hearing aid or hearing appliances if normally used) 0. **Adequate** – no difficulty in normal conversation, social interaction, listening to TV 1. **Minimal difficulty** – difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. **Moderate difficulty** – speaker has to increase volume and speak distinctly 3. **Highly impaired** – absence of useful hearing

B1000. Vision	
Enter Code ☐	**Ability to see in adequate light** (with glasses or other visual appliances) 0. **Adequate** – sees fine detail, such as regular print in newspapers/books 1. **Impaired** – sees large print, but not regular print in newspapers/books 2. **Moderately impaired** – limited vision; not able to see newspaper headlines but can identify objects 3. **Highly impaired** – object identification in question, but eyes appear to follow objects 4. **Severely impaired** – no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1300. Health Literacy How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	
Enter Code ☐	0. **Never** 1. **Rarely** 2. **Sometimes** 3. **Often** 4. **Always** 8. **Patient unable to respond**

Section C	Cognitive Patterns

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment and reviewing medical record.

A. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the patient's baseline?

0. **No**
1. **Yes**

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Code in Boxes**

☐ **B. Inattention -** Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said?

☐ **C. Disorganized thinking -** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

☐ **D. Altered level of consciousness -** Did the patient have altered level of consciousness as indicated by any of the following criteria?

- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** - very difficult to arouse and keep aroused for the interview
- **comatose** - could not be aroused

Section D	Mood

D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

If yes in column 1, then ask the patient: "*About **how often** have you been bothered by this*?"

Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank)	**2. Symptom Frequency** 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	**1. Symptom Presence**	**2. Symptom Frequency**
		↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*		☐	☐
B. *Feeling down, depressed, or hopeless*		☐	☐
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.			
C. *Trouble falling or staying asleep, or sleeping too much*		☐	☐
D. *Feeling tired or having little energy*		☐	☐
E. *Poor appetite or overeating*		☐	☐
F. *Feeling bad about yourself – or that you are a failure or have let yourself or your family down*		☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*		☐	☐
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual*		☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*		☐	☐

D0160. Total Severity Score

Enter Score	
☐☐	**Add scores for all frequency responses in column 2**, Symptom Frequency. Total score must be between 02 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

D0700. Social Isolation How often do you feel lonely or isolated from those around you?	
Enter Code ☐	0. **Never** 1. **Rarely** 2. **Sometimes** 3. **Often** 4. **Always** 8. **Patient unable to respond**

Section J	**Health Conditions**

J0510. Pain Effect on Sleep	
Enter Code ☐	*Ask patient: "Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night****?"* 0. **Does not apply – I have not had any pain or hurting in the past 5 days** → *Skip to XXXX* 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**
J0520. Pain Interference with Therapy Activities	
Enter Code ☐	*Ask patient: "Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain****?"* 0. **Does not apply – I have not received rehabilitation therapy in the past 5 days** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**
J0530. Pain Interference with Day-to-Day Activities	
Enter Code ☐	*Ask patient: "Over the past 5 days,* ***how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain****?"* 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**

Section K	Swallowing/Nutritional Status

K0520. Nutritional Approaches Check all of the following nutritional approaches that apply on admission.	
	1. On Admission **Check all that apply** ↓
A. Parenteral/IV feeding	☐
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	☐
C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐
Z. None of the above	☐

Section N	Medications

N0415. High-Risk Drug Classes: Use and Indication		
1. Is taking Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes **2. Indication noted** If column 1 is checked, check if there is an indication noted for all medications in the drug class	**1. Is taking** **Check all that apply** ↓	**2. Indication noted** **Check all that apply** ↓
A. Antipsychotic	☐	☐
E. Anticoagulant	☐	☐
F. Antibiotic	☐	☐
H. Opioid	☐	☐
I. Antiplatelet	☐	☐
J. Hypoglycemic (including insulin)	☐	☐
Z. None of the above	☐	

Section O	Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs
Check all of the following treatments, procedures, and programs that apply on admission.

	a. On Admission Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	☐
A2. IV	☐
A3. Oral	☐
A10. Other	☐
B1. Radiation	☐
Respiratory Therapies	
C1. Oxygen Therapy	☐
C2. Continuous	☐
C3. Intermittent	☐
C4. High-concentration	☐
D1. Suctioning	☐
D2. Scheduled	☐
D3. As Needed	☐
E1. Tracheostomy Care	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G1. Non-invasive Mechanical Ventilator	☐
G2. BiPAP	☐
G3. CPAP	☐
Other	
H1. IV Medications	☐
H2. Vasoactive medications	☐
H3. Antibiotics	☐
H4. Anticoagulation	☐
H10. Other	☐
I1. Transfusions	☐
J1. Dialysis	☐

O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply on admission.	
J2. Hemodialysis **J3. Peritoneal dialysis**	☐ ☐
O1. IV Access	☐
O2. Peripheral **O3. Midline** **O4. Central** (e.g., PICC, tunneled, port)	☐ ☐ ☐
None of the Above	
Z1. None of the Above	☐

DISCHARGE

Section A	Administrative Information

A1250. Transportation
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

↓ **Check all that apply**	
☐	**A. Yes**, it has kept me from medical appointments or from getting my medications
☐	**B. Yes**, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	**C. No**
☐	**X. Patient unable to respond**

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
At the time of discharge to another provider, did your facility provide the patient's current reconciled medication list to the subsequent provider?

Enter Code	
☐	0. **No** – Current reconciled medication list not provided to the subsequent provider 1. **Yes** – Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	**Check all that apply** ↓
A. Electronic Health Record	☐
B. Health Information Exchange Organization	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

A2123. Provision of Current Reconciled Medication List to Patient at Discharge
At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver?

Enter Code	
☐	0. **No** – Current reconciled medication list not provided to the patient, family and/or caregiver 1. **Yes** – Current reconciled medication list provided to the patient, family and/or caregiver

A2124. Route of Current Reconciled Medication List Transmission to Patient Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver.	
Route of Transmission	**Check all that apply** ↓
A. Electronic Health Record (e.g., electronic access to patient portal)	☐
B. Health Information Exchange Organization	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

Section B	**Hearing, Speech, and Vision**

B1300. Health Literacy How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	
Enter Code ☐	0. **Never** 1. **Rarely** 2. **Sometimes** 3. **Often** 4. **Always** 8. **Patient unable to respond**

Section C	**Cognitive Patterns**

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? (3-day assessment period) Attempt to conduct interview with all patients.	
Enter Code ☐	0. **No** (patient is rarely/never understood) → *Skip to XXXX* 1. **Yes** → *Continue to C0200, Repetition of Three Words*

Brief Interview for Mental Status (BIMS)	
C0200. Repetition of Three Words	
Enter Code ☐	Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue and bed****. Now tell me the three words."* **Number of words repeated after first attempt** 3. **Three** 2. **Two** 1. **One** 0. **None** After the patient's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.
C0300. Temporal Orientation (orientation to year, month, and day)	
Enter Code ☐	Ask patient: *"Please tell me what year it is right now."* **A. Able to report correct year** 3. **Correct** 2. **Missed by 1 year** 1. **Missed by 2 - 5 years** 0. **Missed by > 5 years** or no answer
Enter Code ☐	Ask patient: *"What month are we in right now?"* **B. Able to report correct month** 2. **Accurate within 5 days** 1. **Missed by 6 days to 1 month** 0. **Missed by > 1 month** or no answer
Enter Code ☐	Ask patient: *"What day of the week is today?"* **C. Able to report correct day of the week** 1. **Correct** 0. **Incorrect** or no answer

C0400. Recall	
Enter Code ☐	Ask patient: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. **A. Able to recall "sock"** 2. **Yes, no cue required** 1. **Yes, after cueing** ("something to wear") 0. **No** - could not recall
Enter Code ☐	**B. Able to recall "blue"** 2. **Yes, no cue required** 1. **Yes, after cueing** ("a color") 0. **No** - could not recall
Enter Code ☐	**C. Able to recall "bed"** 2. **Yes, no cue required** 1. **Yes, after cueing** ("a piece of furniture") 0. **No** - could not recall
C0500. BIMS Summary Score	
Enter Score ☐☐	**Add scores** for questions C0200-C0400 and fill in total score (00-15) **Enter 99 if the patient was unable to complete the interview**

C1310. Signs and Symptoms of Delirium (from CAM©)		
Code **after completing** Brief Interview for Mental Status and reviewing medical record.		
A. Acute Onset Mental Status Change		
Enter Code ☐	**Is there evidence of an acute change in mental status** from the patient's baseline? **0. No** **1. Yes**	
Coding: **0. Behavior not present** **1. Behavior continuously present, does not fluctuate** **2. Behavior present, fluctuates** (comes and goes, changes in severity)	↓ **Enter Code in Boxes**	
	☐	**B. Inattention -** Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said?
	☐	**C. Disorganized thinking -** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	☐	**D. Altered level of consciousness -** Did the patient have altered level of consciousness as indicated by any of the following criteria? ▪ **vigilant** - startled easily to any sound or touch ▪ **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch ▪ **stuporous** - very difficult to arouse and keep aroused for the interview ▪ **comatose** - could not be aroused
Confusion Assessment Method. © 1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Used with permission.		

Section D	Mood

D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

If yes in column 1, then ask the patient: "*About **how often** have you been bothered by this*?"

Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank)	**2. Symptom Frequency** 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	**1. Symptom Presence**	**2. Symptom Frequency**
		↓ Enter Score in Boxes ↓	
A. *Little interest or pleasure in doing things*		☐	☐
B. *Feeling down, depressed, or hopeless*		☐	☐
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.			
C. *Trouble falling or staying asleep, or sleeping too much*		☐	☐
D. *Feeling tired or having little energy*		☐	☐
E. *Poor appetite or overeating*		☐	☐
F. *Feeling bad about yourself – or that you are a failure or have let yourself or your family down*		☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*		☐	☐
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual*		☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*		☐	☐

D0160. Total Severity Score

Enter Score ☐☐	**Add scores for all frequency responses in column 2**, Symptom Frequency. Total score must be between 02 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

D0700. Social Isolation How often do you feel lonely or isolated from those around you?	
Enter Code ☐	0. **Never** 1. **Rarely** 2. **Sometimes** 3. **Often** 4. **Always** 8. **Patient unable to respond**

Section J	**Health Conditions**

J0510. Pain Effect on Sleep	
Enter Code ☐	*Ask patient: "Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night****?"* 0. **Does not apply – I have not had any pain or hurting in the past 5 days** → *Skip to XXXX* 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**
J0520. Pain Interference with Therapy Activities	
Enter Code ☐	*Ask patient: "Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain****?"* 0. **Does not apply – I have not received rehabilitation therapy in the past 5 days** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**
J0530. Pain Interference with Day-to-Day Activities	
Enter Code ☐	*Ask patient: "Over the past 5 days,* ***how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain****?"* 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**

Section K	Swallowing/Nutritional Status

K0520. Nutritional Approaches		
4. Last 7 Days Check all of the nutritional approaches that were received in the last 7 days **5. At Discharge** Check all of the nutritional approaches that were being received at discharge	**4.** **Last 7 Days** **Check all that apply** ↓	**5.** **At Discharge** **Check all that apply** ↓
A. Parenteral/IV feeding	☐	☐
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	☐	☐
C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. None of the above	☐	☐

Section N	Medications

N0415. High-Risk Drug Classes: Use and Indication		
1. Is taking Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes **2. Indication noted** If column 1 is checked, check if there is an indication noted for all medications in the drug class	**1.** **Is taking** **Check all that apply** ↓	**2.** **Indication noted** **Check all that apply** ↓
A. Antipsychotic	☐	☐
E. Anticoagulant	☐	☐
F. Antibiotic	☐	☐
H. Opioid	☐	☐
I. Antiplatelet	☐	☐
J. Hypoglycemic (including insulin)	☐	☐
Z. None of the above	☐	

Section O	Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs
Check all of the following treatments, procedures, and programs that apply at discharge.

	c. At Discharge Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	☐
A2. IV	☐
A3. Oral	☐
A10. Other	☐
B1. Radiation	☐
Respiratory Therapies	
C1. Oxygen Therapy	☐
C2. Continuous	☐
C3. Intermittent	☐
C4. High-concentration	☐
D1. Suctioning	☐
D2. Scheduled	☐
D3. As Needed	☐
E1. Tracheostomy Care	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G1. Non-invasive Mechanical Ventilator	☐
G2. BiPAP	☐
G3. CPAP	☐
Other	
H1. IV Medications	☐
H2. Vasoactive medications	☐
H3. Antibiotics	☐
H4. Anticoagulation	☐
H10. Other	☐
I1. Transfusions	☐
J1. Dialysis	☐

O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply at discharge.	
J2. Hemodialysis **J3. Peritoneal dialysis**	☐ ☐
O1. IV Access	☐
O2. Peripheral **O3. Midline** **O4. Central** (e.g., PICC, tunneled, port)	☐ ☐ ☐
None of the Above	
Z1. None of the Above	☐