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BIBLIOGRAPHY
McKesson Clinical Evidence Classification

References cited in the clinical content are classified according to the type of evidence presented. The class ratings, I through V, are intended to provide a classification of the evidence but are not necessarily hierarchical. Classifications appear in parentheses at the end of each reference. References followed by an (NC) are not classified; examples include pre-published research or information from government, manufacturer, laboratory, or patient education websites.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Type of Evidence</th>
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<tbody>
<tr>
<td>Class I</td>
<td>Meta-analysis, technology assessment, or systematic review</td>
</tr>
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<td>Class II</td>
<td>Randomized controlled trial</td>
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<td>Class III</td>
<td>Observational or epidemiologic study</td>
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<tr>
<td>Class IV</td>
<td>Evidence-based guideline</td>
</tr>
<tr>
<td>Class V</td>
<td>Expert opinion, panel consensus, literature review, text or reference book, descriptive study, case report, or case series</td>
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Class I
Class I sources synthesize the results of multiple studies. When quantitative synthesis is possible, meta-analyses can provide a more accurate estimate of the effect or association size than individual smaller studies can. A Class I study that finds insufficient evidence to support or refute an intervention (due to a lack of appropriate primary research) is inconclusive. A potential weakness of Class I studies is that they may only assess published research, potentially leaving their findings vulnerable to publication bias.

Class II
A randomized controlled trial (RCT) is an experimental study design in which subjects are randomly assigned to an intervention or a control group. An RCT is the gold standard for testing cause and effect relationships. Intention-to-treat analysis should be performed to account for missing data points.

Class III
Observational or epidemiologic studies can suggest an association between events or findings. These associations cannot be used to establish causality. Cross-sectional, cohort, and case-control studies are all used to identify possible risk factors. Cross-sectional studies are also used to determine the prevalence of a condition. Cohort studies are used to study incidence, the natural history of a condition, prognosis after a specific exposure, and associated harms. Nonrandomized controlled trials are sometimes used when randomization is impossible or unethical.

Class IV
Evidence-based guidelines are systematically developed recommendations for clinical practice. Evidence-based guidelines identify the methodology used to gather the evidence on which the recommendations are based. Usually, a grading system for both the quality of the evidence and the strength of the recommendations is provided. Guidelines that are evidence-based may also contain consensus recommendations in areas where evidence is lacking, but these recommendations are clearly identified and appropriately graded.

Class V
Class V references may be the best information in the absence of other evidence. Expert opinion, panel consensus, literature reviews, and descriptive studies (case reports or case series) are subject to significant bias. A case series with comparison to historical controls can be plagued with missing data, and data extraction inconsistencies are common. The use of historical controls does not address how the diagnosis of disease or its treatment has evolved over time with newer technologies or medication. Text book information may be out of date by the time the book is published.
Comparative Effectiveness Research (CER)

Citations are designated with the CER label as part of the evidence classification if the article cited is one of the following:
1. A clinical trial or other clinical study that directly compares two or more health care interventions for the same clinical scenario.
2. A systematic review that compares two or more health care interventions by synthesizing the research from previous clinical studies.

Bibliography

INTERQUAL® LEVEL OF CARE CRITERIA: POST ACUTE BIBLIOGRAPHY


Bayer. Innovations in reducing preventable hospital admissions, readmissions, and emergency room use: AHIP Center for Policy and Research; 2010. (V)

Berry et al. Hospital utilization and characteristics of patients experiencing recurrent readmissions within children’s hospitals. JAMA 2011. 305(7):682-90. (III)


INTERQUAL® LEVEL OF CARE CRITERIA: POST ACUTE BIBLIOGRAPHY


Centers for Disease Control and Prevention (CDC). National Center for Chronic Disease Prevention and Health Promotion. Defining Overweight and Obesity; [cited Aug 22 2016 ]. (IV)

Centers for Medicare & Medicaid Services. Hospital Compare datasets. Bethesda, MD: Center for Medicare & Medicaid Services; 2016. (V)

Centers for Medicare & Medicaid Services. Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016; Final Rule.; 2015. (IV)


Centers for Medicare & Medicaid Services. Revisions to State Operations Manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.43, Discharge Planning Center for Clinical Standards and Quality/Survey & Certification Group. Baltimore: Department of Health and Human Services; 2013. (V)

INTERQUAL® LEVEL OF CARE CRITERIA: POST ACUTE BIBLIOGRAPHY


Chiang et al. Survival and long-term outcomes following bioprosthesis vs mechanical aortic valve replacement in patients aged 50 to 69 years. JAMA 2014. 312(13):1323-9. (III)

Chikwe et al. Survival and outcomes following bioprosthesis vs mechanical mitral valve replacement in patients aged 50 to 69 years. JAMA 2015. 313(14):1435-42. (III)


Cohen et al. Clinical practice guidelines for Clostridium difficile infection in adults: 2010 update by the society for healthcare epidemiology of America (SHEA) and the infectious diseases society of America (IDSA). Infect Control Hosp Epidemiol. 31(5):431-455. (IV)


Commission on Accreditation of Rehabilitation Facilities. 2010 Standards Manual and Interpretive Guidelines for Medical Rehabilitation, Tucson, Arizona, 2010. (V)


Crytzer et al. Physical activity, exercise, and health-related measures of fitness in adults with spina bifida: a review of the literature. PM R 2013. 5(12):1051-62. (III)


Davis et al. AARC clinical practice guideline: blood gas analysis and hemoximetry: 2013. Respir Care 2013. 58(10):1694-703. (IV)


Diabetes care in the hospital, nursing home, and skilled nursing facility. Diabetes Care 2015. 38 Suppl:S80-5. (IV)


Doughty, Dorothy. Management of Recalcitrant Wounds. Advance for Nurses 2003; 3(9);18-20. (V)


Engrav et al. 12-Year within-wound study of the effectiveness of custom pressure garment therapy. Burns 2010. 36(7):975-83. (III)


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INTERQUAL® LEVEL OF CARE CRITERIA: POST ACUTE BIBLIOGRAPHY


Global Initiative for Chronic Obstructive Lung Disease. Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease; 2014. (IV)


Global Initiative for Chronic Obstructive Lung Disease. Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease; 2016. (IV)


Hines et al. Preventing heart failure readmissions: is your organization prepared? Nurs Econ 2010. 28(2):74-85. (V)


Inglis et al. Structured telephone support or telemonitoring programmes for patients with chronic heart failure. Cochrane Database Syst Rev 2010. 8:CD007228. (I)


INTERQUAL® LEVEL OF CARE CRITERIA: POST ACUTE BIBLIOGRAPHY


MacIntyre et al. Evidence-based guidelines for weaning and discontinuing ventilatory support: a collective task force facilitated by the American College of Chest Physicians; the American Association for Respiratory Care; and the American College of Critical Care Medicine. Chest 2001. 120(6 Suppl):375S-395S. (IV)


Mancia et al. 2013 ESH/ESC Guidelines for the management of arterial hypertension: the Task Force for the management of arterial hypertension of the European Society of Hypertension (ESH) and of the European Society of Cardiology (ESC). J Hypertens 2013. 31(7):1281-357. (IV)


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<tbody>
<tr>
<td>Medicare program; inpatient rehabilitation facility prospective payment system for federal fiscal year 2012; changes in size and square footage of inpatient rehabilitation units and inpatient psychiatric units. Final rule. Fed Regist 2011. 76(151):47836-915. (V)</td>
</tr>
<tr>
<td>Mukherjee. Improving adherence to medications--can we make this horse drink? Am Heart J 2008. 155(4):589-590. (V)</td>
</tr>
</tbody>
</table>
INTERQUAL* LEVEL OF CARE CRITERIA: POST ACUTE BIBLIOGRAPHY


National Transitions of Care Coalition Medication Reconciliation Elements: National Transitions of Care Coalition; 2010. (V)


NICE, National Collaborating Centre for Chronic Conditions. Tuberculosis. Clinical diagnosis and management of tuberculosis, and measures for its prevention and control 2006 (revised 2016 Jan). Clinical guideline; no. 117 (64) (IV)


INTERQUAL® LEVEL OF CARE CRITERIA: POST ACUTE BIBLIOGRAPHY


Patel et al. Hypotension during hospitalization for acute heart failure is independently associated with 30-day mortality: findings from ASCEND-HF. Circ Heart Fail 2014. 7(6):918-25. (III)


Pederson et al. Depressive symptoms are associated with higher rates of readmission or mortality after medical hospitalization: A systematic review and meta-analysis. J Hosp Med 2016. 11(5):373-80. (I)


Qaseem et al. Pharmacologic treatment of hypertension in adults aged 60 years or older to higher versus lower blood pressure targets: A clinical practice guideline from the american college of physicians and the american academy of family physicians. Annals of Internal Medicine 2017. (IV)


**INTERQUAL® LEVEL OF CARE CRITERIA: POST ACUTE BIBLIOGRAPHY**


Sharma et al. Outpatient follow-up visit and 30-day emergency department visit and readmission in patients hospitalized for chronic obstructive pulmonary disease. Arch Intern Med 2010. 170(18):1664-70. (III)


Stelfox et al. A North American survey of respiratory therapist and physician tracheostomy decannulation practices. Respir Care 2009. 54(12):1658-64. (V)


Texas Medical Foundation (TMF), Health Quality Institute. Long-term Acute Care Program for Evaluating Payment Patterns; Long-Term Acute Care Q4FY15 Report, Nationwide Top 20 MS-DRGs for All Discharges. Accessed Sep 19 2016. (I)
INTERQUAL® LEVEL OF CARE CRITERIA: POST ACUTE BIBLIOGRAPHY


Thomas et al. AACVPR/ACCF/AHA 2010 Update: Performance Measures on Cardiac Rehabilitation for Referral to Cardiac Rehabilitation/Secondary Prevention Services Endorsed by the American College of Chest Physicians, the American College of Sports Medicine, the American Physical Therapy Association, the Canadian Association of Cardiac Rehabilitation, the Clinical Exercise Physiology Association, the European Association for Cardiovascular Prevention and Rehabilitation, the Inter-American Heart Foundation, the National Association of Clinical Nurse Specialists, the Preventive Cardiovascular Nurses Association, and the Society of Thoracic Surgeons. J Am Coll Cardiol 2010. 56(14):1159-67. (IV)


Weissman et al. Are there predicting factors for burn patients that transfer to a rehabilitation center upon completion of acute care? Burns 2012. 38(7):992-7. (V)


INTERQUAL® LEVEL OF CARE CRITERIA: POST ACUTE BIBLIOGRAPHY

American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. Circulation 2016. 134 (IV)

Yazdanpanah et al. Literature review on the management of diabetic foot ulcer. World J Diabetes 2015. 6(1):37-53. (V)


