January 12, 2015

Measure Application Partnership
National Quality Forum
1030 15th Street NW
Suite 800
Washington DC 20005

Re: Pre-Rule Making Report for Post-Acute and Long-term Care Performance Measurement Programs

On behalf of the Association of Rehabilitation Nurses (ARN) – representing 5,700 rehabilitation nurses that work to enhance the quality of life for those affected by physical disability and/or chronic illness, we appreciate the opportunity to comment on the Pre-Rule Making Report for Post-Acute and Long-term Care Performance Measurement Programs.

ARN supports efforts to ensure people with physical disability and chronic illness have access to comprehensive, quality care in whichever care setting is most appropriate for them. Rehabilitation nurses take a holistic approach to meeting patients’ medical, vocational, educational, environmental, and spiritual needs. Rehabilitation nurses begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness. We continue to provide support and care, including patient and family education, which empowers these individuals when they return home, to work, or to school. Rehabilitation nurses often teach patients and their caregivers how to access systems and resources.

Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. We base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/skilled nursing facilities, inpatient rehabilitation facilities, long-term acute care facilities, comprehensive outpatient rehabilitation facilities, home health, and private practices, just to name a few.
**E0141-Patient Fall Rate**

ARN realizes that falls in a hospital and rehabilitation setting present significant risk for injury. All patients in rehabilitation are at risk of falling. In fact, studies indicate that the rate of falls for acute care is 3-6 falls per 1000 patient days versus the rate for inpatient rehabilitation hospitals (IRF) vary between 2.92 – 17.8 falls per 1000 patient days (Gilewski, Roberts, Hirata & Riggs, 2007; Mayo, Korner-Bitensky, Becker & Georges, 1989). Thus IRFs have a higher rate just because of the nature of the type of patient being admitted. Patients admitted with a stroke, spinal cord injury, brain injury, amputations and neurologic impairments have demonstrated a higher fall rate than patients admitted to an IRF with cardiac, pulmonary and orthopedic disorders (Forrest, et al., 2012).

Furthermore, impulsivity is a common consequence of individuals with stroke and brain injury and can impede patient progress and recovery. Such cognitive impairment has been shown to be a leading risk factor for falls in older adults (Hitchco et al., 2004; Hong, Cho & Tak, 2010). Individuals with cognitive impairment are at a greater risk of injury from falling (Holtzer et al., 2007; Rochat et al., 2008). Staffing ratios may also affect fall rate as well. Some studies have shown that hospital units that had more than five patients per nurse had higher fall rates than units with five or fewer patients per nurse (Krauss et al., 2005).

Looking at falls rates without looking at all of the above mentioned components would not be helpful. There are many confounding factors that may not be able to give an adequate comparison for a pay for performance model. Therefore, falls benchmarks are not one size fits all. We request that the IRF fall rate consider these factors and compare IRF fall rates to only other IRFs. In addition, stratification and analysis of patient populations (stroke, brain injury, etc) would be helpful in providing additional insight and benchmarks.

**IRF Functional Outcome Measure**

The IRF Quality Reporting System could be greatly enhanced by further developing and expanding core measures such as mobility and self-care. ARN supports these indicators with the caveat that they are risk-adjusted and diagnosis/impairment group specific with definitive inclusion/exclusion criteria. While we support these indicators, we do not agree with the exclusion criteria for S2633-IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients. The exclusion criteria for S2633 are as follows:

3) Patients in coma, persistent vegetative state, complete teraplegia, and locked-in syndrome are excluded, because they may have limited or less predictable self-care improvement. 4) Patients younger than age 21.

Both of these criteria are inappropriate for use because they are not representative of the IRF setting. The patient population listed in Criteria #3 is not usually admitted/treated in an IRF and most IRFs treat patients younger than 21 if needed (the FIM instrument/IRF-PAI is for patients 7 and older).
**S2510- SNF All-Cause 30 Day Post Discharge Readmission Measure**

It is ARN’s understanding that it is the intention and desire of NQF to align measures across the post-acute care continuum when possible. However, there are different measures for the different PAC venues including IRH/U and SNFs. Measure 2502, All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs) is based on data for 24 months of IRF discharges to non-hospital post-acute levels of care or to the community while measure 2510, Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) is based on 12 months of data. There should not be such disconnect if the original intent of NQF’s recommendation and selection of measures was to be both harmonious and parsimonious. We would encourage the committee to examine the measures across the PAC continuum for opportunities for alignment.

While we appreciate the work of the committee, we strongly disagree with the exclusion criteria for SNF stays where the patient had one or more intervening post-acute care (PAC) admissions to an IRF which occurred either between the prior proximal hospital discharge and SNF admission or after the SNF discharge, within the 30-day risk window. The exclusion criteria would not take into account a medically complex patient that is treated in an IRF and then readmitted within 30 days for an issue that may have been treated as a co-morbidity. We believe that IRFs should be considered a proximal hospitalization and disagree with the rationale provided for exclusion, that these patients are clinically different.

As determined in a recent OIG report, the readmission rate for SNFs is both problematic and concerning. The report found that an estimated 22 percent of Medicare beneficiaries experienced adverse events during their SNF stays and an additional 11 percent of Medicare beneficiaries experienced temporary harm events during their SNF stays. Over half of the residents who experienced harm returned to a hospital for treatment, with an estimated cost to Medicare of $208 million in August 2011. This equates to $2.8 billion spent on hospital treatment for harm caused in SNFs in FY 2011 (OIG, 2014). Readmission rates for IRFs do vary but are nowhere near the SNF rate. A study by Ottenbacher et al. (2012, 2014) found that the 30-day readmission rates for the six largest diagnostic impairment categories (stroke, lower extremity fracture, lower extremity joint replacement, debility, neurologic disorders and brain dysfunction) was 11.8 percent with 50 percent of readmissions occurring within 11 days of discharge from the IRF.

We also disagree with the 30-day readmission data utilized from claims data. Determining readmission rates will be difficult for IRFs or other post-acute settings to discern as claims data are cumbersome to use and access. Utilizing this indicator will not provide meaningful insight or have an impact on quality improvement efforts if the settings do not have access to the data.

While we appreciate the work of the committee, we are disappointed in the lack of awareness of the current processes in IRFs. ARN recommends that the LTC/PAC workgroup consist of members with additional insight and a greater understanding into the specialty of rehabilitation. We also encourage NQF to publish and respond to each comment (similar to CMS) versus summarizing so as not to omit or skew what is being addressed/commented on.
ARN very much appreciates the opportunity to provide comments to NQF. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement quality measures that address length of stay, all-cause admissions and hospital readmissions from applicable settings, such as SNFs and IRH/Us. We thank you for your consideration of our concerns, recommendations and requests. If you have any questions, please contact me or have your staff contact our NQF liaisons, Terrie Black at Terriern518@yahoo.com or Beth Demakos at bdemakos@verizon.net.

Sincerely,

Sharon Murphy-Potts, BSN RN CRRN
President