March 14, 2014

Patrick Conway, M.D.
Chief Medical Officer
Director, Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Functional Status Quality Measures for Inpatient Rehabilitation Facilities (IRFs) and Long Term Care Hospitals (LTCHs)

Dear Dr. Conway,

On behalf of the Association of Rehabilitation Nurses (ARN), representing nearly 12,000 rehabilitation nurses that work to enhance the quality of life for those affected by physical disability and/or chronic illness, I appreciate the opportunity to comment on the Functional Status Quality Measures for Inpatient Rehabilitation Facilities (IRFs) and Long Term Care Hospitals (LTCHs). ARN concurs with the need for standardized terminology and assessment items. Specifically, 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.
ARN supports efforts to ensure people with physical disability and chronic illness have access to comprehensive quality care in whichever care setting is more appropriate for them. Specifically, as a part of its missions, ARN stands ready to work with policymakers at the local, state, and federal levels to advance policies and programs that promote maximum independence for people living with physical disability and/or chronic illness.

2.1 Quality Measure: IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients
ARN believes that understanding the functional improvement of the patients we treat is critical to ensure these patients receive quality care and thus supports the four measures identified for IRH/Us in the draft report. We would like to highlight that while the information in the draft report is helpful in outlining CMS’ direction in the development of functional outcomes, the full measure specifications are not included. Learning from the experiences of rehabilitation nurses working with people with physical disability and chronic illness, we encourage CMS to recognize that functional measures are not “one size fits all” and they should take into account the benefits of the quality of life domain for patients with these extreme conditions. We also suggest that any measures chosen reflect the following attributes: a low collection burden for providers and beneficiaries; comprehensibility for beneficiaries; a high level of significance to patients and providers; and data is routinely captured. Finally, the purpose of the single post-acute care instrument was to compare outcomes across settings. The proposed quality measures are not aligned for the IRF and LTAC settings.

2.1.3 Population
ARN is concerned with the exclusion criteria for IRF patients, specifically those who are independent with CARE self-care activities at the time of admission. Would a patient be excluded if they were independent for one component within the indicator or must they be independent for all items in the indicator? Patients should not be excluded because they may not make gains within a certain functional item.

2.1.6 Risk Adjustment
Risk adjustment is a tool that is meant to level the playing field regarding the reporting of patient outcomes. In order to fulfill this goal, similar patients should be compared. ARN believes that quality measures should take into consideration all risk adjustors (such as wheelchair use prior to injury/illness) because risk adjustors should not reflect whether or not a patient is an appropriate candidate for a particular setting of care. ARN has the following concerns about the risk adjustment controls for specific patient characteristics including age, primary rehabilitation diagnosis, and the presence of a severe pressure ulcer at admission.

1. Age should be better stratified as the grouping of patients into a 65 and younger age group at the time of an IRF admission would eliminate them from the quality indicator/count. Additionally, the inclusion criteria states that it is for patients who are aged 7 and older which is problematic if the goal is to risk adjust for the population that the data is being collected on there are major differences between a 7 year old and a 64 year old.

2. The groupings of conditions under the primary rehabilitation diagnosis are too broad—there are too many differences and variability among conditions and diseases to be so exclusive. Examples include stroke (different types with different outcomes), spinal cord injuries (huge outcome differences in paraplegics and tetraplegics), and amputees (above knee versus below knee) and orthopedic (comparing a joint replacement/hip fracture).
3. The response choices are too broad in multiple categories including functional status prior to current illness/injury and wheelchair use prior to current illness/injury, independent or unknown/missing are included in the same variable. Additionally, under cognitive abilities, intact and not assessed are also grouped under the same variable. These broad groupings can cause misinterpretation of data as the lack of a value is not the same thing as a value of zero.

4. The Presence of a severe pressure ulcer at admission should not be considered a risk factor for self-care. Pressure ulcer history is a more viable measure of pressure ulcer outcomes than measures taken at single point in time.

ARN very much appreciates the opportunity to provide comments to the Center for Clinical Standards and Quality on the Functional Status Quality Measures for IRFs and LTCHs. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement quality measures that improve functional status for patients in IRFs/LTCHs so that the patient can complete self-care and mobility activities as independently as possible and, if feasible, return to a safe, active, and productive life in a community-based setting. If you have any questions, please contact me or have your staff contact our Health Policy Associate, Jeremy Scott (Jeremy.Scott@dbr.com or 202-230-5197). We thank you for your consideration of our concerns, recommendations, and requests.

Respectfully Submitted,

Kristen L. Mauk PhD, DNP, RN, CRRN, GCNS-BC, GNP-BC, FAAN