



Association of  
Rehabilitation  
Nurses

**JUN 21 2011**

June 21, 2011

Donald Berwick, M.D.  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health & Human Services  
Attention: CMS-1349-P  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2012; Proposed Rule [CMS-1349-P]**

Dear Administrator Berwick:

On behalf of the Association of Rehabilitation Nurses (ARN) – comprised of more than 5,700 Registered Nurses (RNs) who work to enhance the quality of life for those affected by physical disability and/or chronic illness – we appreciate this opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) regarding the proposed Medicare Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) for 2012. 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. Specifically, as part of its mission, 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, particularly among the Medicare population.

Rehabilitation nurses help individuals affected by physical disability and/or chronic illness adapt to their condition, achieve their greatest potential, and work toward productive, independent lives. They take a holistic approach to meeting patients' nursing and 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. They continue to provide support and care, including patient and family education, which empowers these individuals when they return home, or to work, or 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. These nurses base their 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, long-term acute care facilities, comprehensive outpatient rehabilitation facilities, home health, and private practices, just to name a few.

On behalf of our members and the patients and families to whom we provide care, thank you in advance for your attention to our comments and concerns, as well as those submitted by our colleagues in the rehabilitation community.

## OVERVIEW

As you know, IRFs play a critical role in the delivery of rehabilitation care. They provide an intensive rehabilitation program and patients who are admitted must be able to tolerate three hours of intense rehabilitation services per day. To that end, ARN very much appreciates that the proposed rule seeks to clarify policies in 42 CFR Part 412. More specifically, ARN agrees that:

- IRF preadmission screening must be reviewed and approved by a rehabilitation physician prior to each prospective patient's admission by requiring the physician to document the reasoning behind the decision to admit a patient to the IRF;
- Close medical supervision means that the patient receives at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process; and
- Discharge planning, in addition to the assessment of the patient's goals and progress toward these goals, is an integral part of the interdisciplinary team approach to care that is provided in IRFs.

We would also like to take the opportunity to provide comments on CMS's proposed quality measures for the IRF Quality Reporting Program.

### QUALITY MEASURE #1: HEALTHCARE ASSOCIATED INFECTION MEASURE - URINARY CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

ARN concurs that patient safety is a priority for any healthcare setting and that this indicator is highly relevant for IRFs. Patients are often admitted to rehabilitation hospitals or units with a catheter in place. It is our prudent practice to generally discontinue the catheter within 24-48 hours of admission, followed by a urinalysis with culture and sensitivity as indicated. If a patient then presents positive for UTI, which in many cases they do, the rehabilitation facility or unit should not be negatively scored for that quality indicator.

ARN does agree with CMS' intent to seek support and endorsement of this specific measure through the National Quality Forum (NQF). While the data submission to the Center for Disease Control and Prevention's (CDC) National Healthcare Safety Network is free, there is a detailed process for its collection and submission. We would request that the CDC provide free webinars, in-services, webcasts, or similar resources for training of this system – comparable to the CMS training on the implementation of the IRF PPS. By providing free, standardized training for the convenience of the IRFs, burden to IRFs can be minimized, and data accuracy in terms of validity and reliability can be maximized. We also agree that data should be collected on all patients regardless of payer source to avoid any perceived discrimination of patients.

### QUALITY MEASURE #2: PERCENT OF PATIENTS WITH PRESSURE ULCERS THAT ARE NEW OR HAVE WORSENE

While the current IRF Patient Assessment Instrument (PAI) does contain data elements on pressure ulcers, as CMS has acknowledged, only a minimal number of IRFs elect to collect and submit data on the

optional quality elements. Thus, if this is to become mandatory, it will be an additional burden for IRFs to collect and submit the data. ARN would ask that CMS consider either using the existing fields on the IRF-PAI; and/or use data elements from the CARE Tool if that is indeed the data collection tool CMS envisions healthcare facilities using in the future. The MDS 3.0 is setting specific and does not meet the needs of the IRF patient population.

**QUALITY MEASURE #3: 30-DAY COMPREHENSIVE ALL CAUSE RISK STANDARDIZED  
READMISSION MEASURE**

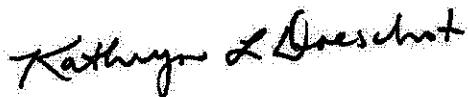
ARN supports the need for this type of quality measure and would urge CMS to develop a system for matching claims data, such that data on this indicator can be collected and trends can be identified. We would also urge CMS to establish clear, standard definitions on what "all-cause" readmissions explicitly encompass. Furthermore, ARN, as the premier association for rehabilitation nurses, would welcome the opportunity to collaborate and provide input as this measure evolves.

Finally, with respect to the possible future measures and topics for IRF Quality Reporting Program (Table 13), we would ask that CMS consider partnering with other organizations such as NQF and the Joint Commission (with respect to the National Patient Safety Goals) so that work efforts on data collection and reporting will be minimized for IRFs.

**SUMMARY**

ARN very much appreciates the opportunity to provide comments to CMS regarding the CY 2012 Inpatient Rehabilitation Facility Prospective Payment System proposed rule. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement payment policy changes that ensure access to quality care for Medicare beneficiaries with physical disability and/or chronic disease. We thank you for your consideration of our concerns, recommendations, and requests.

Respectfully submitted,



Kathryn Doeschot, MSN RN CRRN  
President  
Association of Rehabilitation Nurses