January 20, 2016

Senator Orrin Hatch, Chair
Committee on Finance
U.S. Senate
Washington, D.C

Senator Ron Wyden, Ranking Member
Committee on Finance
U.S. Senate
Washington, D.C.

Senator Johnny Isakson, Member
Committee on Finance
U.S. Senate
Washington, D.C.

Senator Mark R. Warner, Member
Committee on Finance
U.S. Senate
Washington, D.C.

RE: Comments for Chronic Care Reform in the Medicare Program

Dear Chairman, Ranking Member, and Members of the Finance Committee:

On behalf of the Association of Rehabilitation Nurses (ARN), representing more than 5,300 rehabilitation nurses and more than 13,000 certified rehabilitation registered nurses (CRRN0 that work to enhance the quality of life for those affected by physical disability and/or chronic illness, we appreciate the opportunity to provide comments on the Bipartisan Chronic Care Working Group's Policy Options Document.

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' 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. We continue to provide support and care throughout the continuum of care by 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 navigate various heath care systems and access 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 and 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

inpatient rehabilitation facilities (IRFs), hospitals, long-term subacute care facilities and skilled nursing facilities, long-term acute care facilities, comprehensive outpatient rehabilitation facilities, home health, and private practices.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

ARN is supportive of the Senate Finance Committee's (Committee) policy consideration to establish a new high-severity chronic care management code that clinicians could bill under the Medicare Physician Fee Schedule. Every year, more than 10 million Medicare beneficiaries are admitted to a post-acute care (PAC) setting;[i] moreover, approximately two out of three Medicare beneficiaries have multiple chronic conditions.[ii] ARN recommends that the Committee allow providers to use this new code when treating patients who have one or more chronic conditions coupled with an impaired functional status.

We believe that Physicians and Advanced Practice Rehabilitation Nurses (APRNs) are the most appropriate providers to bill under this code, as such providers actively engage in care coordination and are likely to determine the discontinuation or modification of the code based on effectiveness, clinician and patient feedback, utilization of the code, and other factors. Specifically, in PAC settings, APRNs integrate clinical practice, education, research, leadership, and consultation; APRNs also possess and demonstrate advanced levels of expertise in providing, directing, managing, and influencing the care of rehabilitation patients. APRNs provide clinical expertise in supporting the functions of other nurses and healthcare providers in a variety of settings.[iii]

ARN also recommends that the CRRN be integrated in the role of care managers. While CRRNs do not directly bill, they provide integral care coordination services and are paid under the auspices of the provider.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

ARN appreciates the Committee's efforts to improve the care of patients with chronic disease. ARN supports the Committee's recommendation to allow Medicare Advantage (MA) plans to offer a wider array of supplemental benefits that improve the overall health of individuals with chronic disease. Rehabilitation is a philosophy of practice and an attitude toward caring for people with disabilities and chronic health problems.[iv] As rehabilitation nurses, we support the optimum utilization of therapies and community resources, and integrate psychosocial factors using disease management concepts. We design and implement treatment strategies that are based on scientific nursing theory and evidence-based practice related to self-care while promoting physical, psychosocial, and spiritual health. ARN also is supportive of complementary and alternative medicines (CAM), defined as practices and therapeutic modalities outside of the realm of biomedicine,[v] including but not limited to the use homeopathy, massage, acupuncture and acupressure, supplements, naturopathy, aromatherapy, and music therapy.

ARN recommends the Committee consider mandating the inclusion of a fitness benefit across all MA plans. The Commission on Accreditation of Rehabilitation Facilities (CARF), an

independent, non-profit agency that provides accreditation to a variety of rehabilitation and health services, added wellness and integrated health standards to its accreditation manual in 2012. CARF continues to expand the wellness and integrated health standards, which are now included in its brain injury rehabilitation and stroke rehabilitation sections, thus illustrating how a fitness benefit can extend beyond maximizing functioning and prevention of further debilitation, while addressing wellness, opportunities for socialization, community integration, and overall creating a healthier lifestyle.[vi]

Active engagement in disease management also can improve the overall health of individuals with chronic disease. A study by Chouinard, Gagnon, Laberge, Tremblay, Côté, Leclerc, & Mathieu examined a disease management plan for Myotonic Dystrophy 1 (MD1) – one of the most prevalent adult-onset neuromuscular disorders that generally presents with several comorbidities. The authors concluded that the evaluated disease management model appeared to be the most suitable for managing MD1 and allowed for knowledge to be transmitted more efficiently between all healthcare partners.[vii]

Technology continues to evolve and becoming simpler to use, not only for patients and family members, but also for providers. ARN is supportive of the increased utilization of electronic evaluations and assessments when appropriate. A study by Gies, Pierce, Steiner, van der Bijl, & Salvador on the deliverance of a psychosocial assessment for caregivers of persons with Dementia found there were no statistically significant differences between a web-based and in-person assessment. Both groups rated the assessment instrument as excellent or good, finding it easy to complete and capturing real needs they frequently denied or ignored. APRNs also reported the web-based format was less complicated and less time consuming to utilize than performing the assessment in-person.[viii] However, as the operation of Remote Access Technologies increases, to maintain confidentiality, security, and privacy related to patient care, additional precautions must be implemented.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth

ARN believes that telehealth could effectively be expanded to help increase the provision of services to those individuals whose mobility has been compromised by chronic illness or disability, as well as those individuals in rural areas with accessibility issues. Following an acute-care stay, many patients are discharged to home settings – even in well-served urban areas – which create a physical barrier for them to receive vital, medically necessary services. By expanding telehealth services, such individuals could promptly receive assessment, evaluation, and/or educational services. Examples of such services could include the use of therapy or nurse call centers; triage; and symptom management.

Expanding Use of Telehealth for Individuals with Stroke

As reported in a study by Lutz & Young,[ix] stroke is an unexpected traumatic event that can quickly force family members into caregiving roles, and as a result, caregivers often experience an overwhelming sense of burden, depression, and isolation; a decline in physical and mental health; and reduced quality of life. Expanding the use of telehealth for individuals with stroke has the ability to effectively meet the complex needs of both patients and caregivers. Such

interventions include follow-up post discharge planning and supportive counseling, as well as web-based support groups and educational resources. Moreover, telehealth monitoring could be utilized to measure long-term outcomes of patients who have suffered a stroke.

Developing Quality Measures for Chronic Conditions

ARN believes that expansion of core quality measures, such as mobility and self-care, that are risk-adjusted and diagnosis/impairment group-specific with definitive inclusion/exclusion criteria, are key elements of quality reporting. Measures should be clinically relevant or representative for a given setting or patient population – measures must be meaningful to be useful. The collection and reporting of measures should not present an undue burden on the organizations or facilities implementing them; there also must be inclusion of patient-reported outcomes and measures that are meaningful to patients, family members, and caregivers.

The Nursing Alliance for Quality of Care has defined patient and family engagement in decisions regarding care as "essential to improving quality."[x] Additionally, the National Quality Strategy has identified three aims for the healthcare system, one of which directly relates to patient involvement, and suggests that to improve the overall quality of care, health care must be more patient-centered, reliable, accessible, and safe. ARN's white paper, *The Essential Role of the Rehabilitation Nurse in Facilitating Care Transitions*, emphasizes the current lack of coordination in practice. Our paper discusses how the provision of care is fragmented, disorganized, and guided by factors unrelated to the quality of care or patient outcomes; moreover, decision-makers often lack adequate information to render the most suitable decisions during care transition planning.

Rehabilitation professionals have identified the importance of including the patient and family members in the decision-making process regarding the most appropriate location for PAC. ARN consistently emphasizes that measures should include both the receipt of information needed to coordinate care and the transmittal of information. Additionally, in an effort to improve the patient's experience during the transition from the acute setting to another facility or to home, ARN encourages the presence of a rehabilitation nurse prior to, and during discharge, to discuss the patient's PAC goals and treatment preferences. Rehabilitation nurses are key contributors to the care of individuals with chronic conditions and disability, and they are uniquely prepared to lead team-based care coordination, including transitional care. Rehabilitation is provided by additional professionals who collaborate with each other and the patient and family to develop patient-centered goals and objectives. This team approach values all members of the team, with the patient and family in the center of the team. A multi-site study by Nelson and colleagues showed an inverse relationship between the number of CRRNs and length of stay (LOS) in IRFs. Nelson's study showed a six percent decrease in LOS for a one percent increase in CRRNs.[xi]

Empowering Individuals & Caregivers in Care Delivery

ARN recommends that because individuals in low socioeconomic status communities often have a higher rate of chronic conditions and diseases, it may be prudent to waive the beneficiary co-payment associated with the current chronic care management code as well as the proposed high severity chronic care code. Waiving the beneficiary copayment would help to ensure individuals

can access follow-up appointments and clinical observation, which may be beneficial to the management of chronic conditions. Moreover, increasing meaningful utilization of such services could result in fewer hospital admissions and decreased morbidity.

Communication also is a key component of care delivery. Hospital staff must effectively communicate discharge instructions to patients and/or their caregivers and be available to discuss and answer patients and their caregivers' questions about post-discharge obligations. It is imperative that all health care professionals responsible for a patient's care are aware of the instructions afforded to the patient and the prescribed course of action. To do so, hospitals should be required to communicate the capabilities and limitations of PAC facilities so that a patient's clinically assessed needs match the level of care determined by decision-makers, which include the patient and family member or caregiver. Additionally, hospitals should be required to promptly transmit a comprehensive list of medical information and applicable discharge documents to the receiving facility, which will help to ensure patients experience a more efficient, smooth discharge and/or transfer. Moreover, requiring hospitals to provide patients with rehabilitation education prior to discharge will result in more appropriate transitions with the potential to reduce 30-day readmission rates and the unnecessary utilization of limited healthcare resources.

Conclusion

ARN very much appreciates the opportunity to provide comments to CMS regarding potential chronic care reform in the Medicare program. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement changes to the Medicare program that ensure access to quality care for Medicare beneficiaries with physical disabilities and/or chronic disease. 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.

Sincerely,

Cheryl Lehman, PhD RN CNS-BS RN-BC CRRN
President

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[xi] Nelson, A., Powell-Cope, G., Palacios, P., Luther, S. L., Black, T., Hillman, T., Gross, J. C. (2007). Nurse staffing and patient outcomes in inpatient rehabilitative settings. *Rehabilitation Nursing*, 32(5), 179–202.