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November 26, 2019

Ben Harder
Managing Editor and Chief of Health Analysis
U.S. News and World Report

Submitted Electronically

Re: 2020-2021 Best Hospitals for Rehabilitation Publication

Dear Mr. Harder:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), thank you for taking the time recently to talk to Academy representatives about the U.S. News and World Report change in methodology for publication of the 2020-21 Best Hospitals for Rehabilitation. It was an enlightening discussion. We also appreciate the opportunity to submit these formal comments and recommendations to you and members of your team.

AAPM&R is the national medical specialty organization representing physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

Maintaining high quality care in inpatient rehabilitation hospitals is a significant priority to AAPM&R members. Physiatrists have a well-established clinical and leadership role in rehabilitation units in acute care hospitals and free standing inpatient rehabilitation hospitals (collectively referred to as inpatient rehabilitation facilities, or IRFs). By virtue of their extensive training



and expertise in rehabilitation, impairment and function, physiatrists commonly serve as IRF medical directors and as the primary admitting physicians in these facilities. Appropriately, physiatrists are also typically the designated leader of the patient's interdisciplinary rehabilitation care team in this setting.

The Academy's Evidence, Quality and Performance Committee (EQPC) conducted an initial review of the two data sources identified by U.S. News and World Report, CMS Inpatient Rehabilitation Facility (IRF) Compare Measures and The American Hospital Association (AHA) Annual Survey Database. Following EQPC's review, a survey was created and sent out to Academy membership via email communications and our online member forum. After compiling the results, below is a summary of the AAPM&R recommendations to U.S. News and World Report for the 2020-21 Best Hospitals for Rehabilitation publication:

- AAPM&R urges U.S. News and World Report to delay use of a new methodology for the 2020-21 Best Hospitals for Rehabilitation publication. As of October 1, 2019, there are significant changes to how CMS uses data from the Medicare IRF Quality Reporting Program, and we believe these facilities need time to adjust to those changes. A new methodology would make more sense for 2021-2022 publications and beyond.
- As we discussed on the call, AAPM&R also respectfully requests that U.S. News and World Report consider the qualifications and credentials of the physicians in the roles of Medical Director of Rehabilitation and Rehabilitation Physician in inpatient rehabilitation hospitals as a criterion in the ranking methodology for the Best Hospitals for Rehabilitation publication. It was helpful to learn during our call that you are planning to consider accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) among your criteria for evaluating rehabilitation hospitals. We believe this is a step in the right direction toward assessing physician qualifications. We provide further discussion of these points in subsequent sections of this letter.
- AAPM&R urges U.S. News and World Report to factor in the average Case Mix Index or Severity Index to the IRF measures. Without it, we believe the data is meaningless.

- Regarding the AHA Annual Survey, AAPM&R does not have any data that shows the percentage of IRFs that have adopted this survey. As a result, the Academy is hesitant to recommend inclusion of the AHA survey data elements as that may unduly impose extra burden on IRFs to adopt a new survey tool annually. Therefore, we suggest not including any items from the AHA Survey without further information and engagement with AAPM&R.

- Of the IRF Compare Measures, AAPM&R believes the following are appropriate for use by U.S. News and World Report. *Measures can change annually, and therefore we believe these need to be reviewed annually.*
 - Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
 - Application of Percent of Residents* Experiencing One or More Falls with Major Injury (*technically, patients in the IRF setting are not residents)
 - Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
 - Discharge to Community–PAC IRF QRP
 - Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP
 - Potentially Preventable Within Stay Readmission Measure for IRFs
 - IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation
 - IRF Functional Outcome Measure: Change in Self-Care for Medical Rehabilitation Patients
 - IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
 - IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients

Qualifications of Director of Rehabilitation and Rehabilitation Physicians

AAPM&R recommends that conducting a review of the qualifications and credentials of the physicians in the roles of Director of Rehabilitation and Rehabilitation Physician in inpatient rehabilitation hospitals is a vital step in determining the Best Hospitals for Rehabilitation. AAPM&R published a position statement in January 2019¹ indicating, “the best practice for treating patients in IRFs calls for the Director of Rehabilitation and the designated Rehabilitation Physician to be a physiatrist.” The statement also offers minimum standards to define a Director of Rehabilitation and Rehabilitation Physician and describes the specific training and expertise of physiatrists that make them uniquely qualified to fill these roles. Unfortunately, AAPM&R was compelled to publish the position statement earlier this year due to concerns that some IRFs are allowing physicians with little to no training in rehabilitation to fill these roles as we noted during our call.

As background, the Centers for Medicare and Medicaid Services (CMS) indicates that “a primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the provision of intensive rehabilitation therapy services.” (IOM 100-02 Medicare Benefit Policy Manual, Chapter 1, Section 110.2.4) In order to serve as Rehabilitation Physicians and Directors of Rehabilitation in IRFs, physicians must meet the qualifications specified by CMS. According to CMS, a “Rehabilitation physician means a licensed physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation” (42 CFR 412.622(c)), and the Director of Rehabilitation is described as a physician that “has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation services.”(42 C.F.R. § 412.29(g))

The Rehabilitation Physician and Director of Rehabilitation have specific duties in the IRF setting that are regulated by CMS. For a hospital-based IRF unit, the Director of Rehabilitation must provide services in the facility at least 20 hours per week. Whereas for a free-standing IRF, the Director of Rehabilitation provides services in the facility on a full-time basis. CMS-regulated duties for a Rehabilitation Physician include a requirement to lead an interdisciplinary team that must implement appropriate treatment services; monitor and review the patient’s progress toward stated rehabilitation goals; identify any potential problems that could impede progress towards those goals; and where necessary,

reassess goals and revise treatment plans for the patient. Current regulations mandate that Rehabilitation Physicians are also responsible for:

- Reviewing and concurring with findings of a comprehensive preadmission screening that demonstrates that a patient meets several criteria, including medical and rehabilitation needs;
- Completing a post-admission physician evaluation within 24 hours of a patient’s IRF admission;
- Developing an individualized overall plan of care for the patient; and
- Conducting face-to-face visits with patients at least three days per week throughout the patient stay 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.

Clearly, the roles of the Medical Director of Rehabilitation and Rehabilitation Physician are substantial and vital for maintaining the specialized, intensive care that is expected in the IRF setting for patients with complex rehabilitation needs including patients with amputations, traumatic brain injury, spinal cord injury, stroke and many other illnesses and injuries. Unfortunately, AAPM&R is aware that not all IRF administrators prioritize having highly qualified Medical Directors of Rehabilitation and Rehabilitation Physicians and are loosely interpreting CMS regulations. For instance, one large, for-profit IRF chain has an established policy specifying that the “specialized training and experience” requirement for a Rehabilitation Physician can be met by a mere 20 hours of continuing medical education credits focused on inpatient rehabilitation – a standard that we believe is distressingly inadequate, and one that does not even comport with existing CMS requirements that require **both** specialized training **and** experience, not just one or the other. AAPM&R is also aware of at least one large, for-profit IRF chain where approximately 30 percent of its Rehabilitation Physicians are not physiatrists.

Physicians with insufficient training and experience may have a poor understanding of rehabilitation, and their limitations can lead to non-optimized outcomes for patients in IRFs. Poor outcomes can include slow progress in attaining improvements in clinical status; mis-management of co-occurring conditions including spasticity, dysphagia, or neurogenic bladder or bowel conditions; missing underlying diagnoses such as neuropathy and Parkinson’s disease, or inappropriate or poorly fitted devices (e.g. wheelchairs, prostheses,

and orthoses). Physicians without specialized training and experience in inpatient rehabilitation may also engage in practices that increase the improper and inefficient utilization of limited healthcare resources, such as inappropriate admissions of patients with insufficient rehabilitation goals or likelihood of benefitting from inpatient rehabilitation care. Unfortunately, quality measures do not adequately assess IRFs on all of these outcomes, and there is some variability in the functional assessment data results from measures related to function and mobility. These concerns reinforce our safeguard recommendation to consider the qualifications of the Director of Rehabilitation and Rehabilitation Physicians in the IRF in addition to the quality measures and survey data being collected to determine the Best Hospital for Rehabilitation.

Physiatry Training and Qualifications

Physiatrists gain unique experience and expertise during their residency training that is not replicated in any other Accreditation Council of Graduate Medical Education (ACGME) program. A residency in physical medicine and rehabilitation consists of one year of general clinical training (internship/postgraduate year 1) followed by three years of physical medicine and rehabilitation training (postgraduate years 2-4). AAPM&R believes that having Directors of Rehabilitation and Rehabilitation Physicians with this type of specialized training and expertise differentiates IRFs from other settings and maximizes the potential for patients to receive the most effective, high-value care possible in an IRF setting. At the same time, AAPM&R recognizes that other physicians may develop expertise in inpatient rehabilitation care through other routes besides PM&R residency training, for example through sub-specialization or fellowship training in related rehabilitation fields (e.g. spinal cord injury medicine, brain injury medicine, and neuromuscular medicine), and they may be sufficiently qualified for the Rehabilitation Physician role. **In order to be recognized by U.S. News and World Report as a Best Hospital for Rehabilitation, AAPM&R recommends that the publication's reviewers consider the qualifications of the Director of Rehabilitation and Rehabilitation Physicians at each facility, and enhanced merit should be granted to hospitals that meet the above standards (e.g., completion of a residency in PM&R).**

During our call, you asked for a potential source to verify the qualifications of the Director of Rehabilitation and Rehabilitation Physician. At this time, we are not aware of a public source for this information. To our knowledge, CMS does not collect this data, although we have urged them to do so. While it is far from a guarantee that the above standards will be met, CARF accreditation should indicate that the qualifications of the Director of Rehabilitation have been assessed to verify adherence to CARF standards. To that end, Section 2.B.11 in the 2019-2020 *CARF International Medical Rehabilitation Standards Manual*² contains the following requirements:

“The medical director for the inpatient program:

- a. Is certified in his or her specialty area by a nationally recognized board.
- b. Demonstrates appropriate experience and training to provide rehabilitation physician services through one or more of the following:
 - 1) A formal residency in physical medicine and rehabilitation.
 - 2) A fellowship in rehabilitation for a minimum of one year.
 - 3) A minimum of two years’ experience as a collaborative team member providing rehabilitation services in an inpatient rehabilitation program.”

AAPM&R cannot verify how all CARF surveyors are tracking whether or not a rehabilitation hospital meets the above standards. **However, we support U.S. News and World Report in applying CARF accreditation as a minimal starting point for ensuring that the Director of Rehabilitation has appropriate training and experience.** In the future, we hope to provide a reference to you for a more stringent resource to ensure that Directors of Rehabilitation and Rehabilitation Physicians in rehabilitation hospitals across the country satisfy our recommended qualifications for these positions.

Thank you again for the opportunity to comment on the proposed change in methodology for the 2020-21 Best Hospitals for Rehabilitation publication. We welcome the opportunity for further engagement as these changes are made and look forward to reading the publication.

Sincerely,



Michelle Gittler, MD
President

CC: Meera Suresh, Staff Writer
Murrey Olmsted, RTI, Senior Methodologist and Research Psychologist
Thiru Annaswamy, MD, Chair, Quality, Practice, Policy and Research
Committee
Peter Esselman, MD, Immediate Past President
Joseph Hornyak, MD, PhD, Chair, Evidence, Quality and Performance
Committee
Darryl Kaelin, MD, Past President

References

¹ Laker SR, Adair WA, Annaswamy TM, et al. American Academy of Physical Medicine and Rehabilitation Position Statement on Definitions for Rehabilitation Physician and Director of Rehabilitation in Inpatient Rehabilitation Settings. *PM&R*. 2019; 11(1): 98-102.

² *CARF International Medical Rehabilitation Standards Manual*. July 1, 2019–June 30, 2020, Section 2.B.11: 133.