September 25, 2007

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development-C
Attention: Bonnie L. Harkless, Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Agency Information Collection Activities: Proposed Collection: Comment Request, CMS-10243, 4. *Data Collection for Administering the Medicare Continuity Assessment Record and Evaluation (CARE) Instrument,* 72 F.R. 41328-41329, July 27, 2007

Dear Ms. Harkless:

On behalf of our 42 hospitals in Arizona, California and Nevada, Catholic Healthcare West (CHW) appreciates the opportunity to respond to the Proposed Continuity and Assessment Record and Evaluation (CARE) instrument. Eleven of our hospitals have inpatient rehabilitative facilities and we have over nine-hundred skilled nursing beds system-wide. As the eighth-largest non-profit hospital system, we are committed to our mission of providing compassionate, high quality health care to all.

Please see below our comments on the proposed CARE instrument:

Background

CHW agrees the development of the CARE tool is an important step in creating uniform patient assessments and believes the focus of the project is appropriate, particularly because inpatient rehab facilities and skilled nursing facilities, as well as long term care hospitals and home health care agencies, play and integral role in the provision of medical rehabilitation services and transitional services for patients going from hospital to home and community settings. Creating a single tool to record patient assessments and data would eventually replace portions of existing assessment tools, including the Minimum Data Set (MDS), IRF Patient Assessment Instrument (IRF-PAI) and the Outcome and Assessment Information Set (OASIS).

CHW appreciates and agrees with the current project's focus on the post acute continuum of care. Inpatient rehabilitation facilities and skilled nursing facilities, as well as long term acute care hospitals and home health care agencies, play an essential role in the provision of medical and rehabilitation services and in the transition of patients from hospital to home and community. We support CMS's goal of collecting relevant data regarding patient characteristics, clinical assessment, treatment needs, and outcomes of care provided in post acute settings. We also support the continued refinement of patient

assessment processes and tools combined with reimbursement mechanisms that recognize the time required to establish patient status and recovery potential, consistency in assessment standards, maximize communication across and between levels of care, and to ensure patient access to appropriate services. However, we have serious questions regarding the proposed CARE tool and its implementation, beginning with the time required to administer it, its ability to collect reliable and valid information, and its impact upon treatment planning and patient access.

Process and Implementation

CHW is concerned the requirement to complete the CARE tool will add an additional burden to clinical staff and Health Information Management (HIM). Although CMS estimates an average 20-60 minutes to complete the form, a survey of providers suggests it would take an individual discharge planner 60 – 90 minutes per CARE tool to complete CARE tools, further limiting our time at the bedside with patients and families and imposing a delay in efforts to coordinate arrangements for the next level of care. This is in part due to the requirement to provide certain data elements that may not be readily available. For example, some information may be readily available in a patient's medical record; other information is only available though patient interview or direct observation. If the patient is unable to provide the information necessary, the staff will be required to locate family or others to obtain the information. In addition, this type of data collection requires the coordination and communication with multiple hospital departments and staff and will necessitate an increase in time away from direct patient care to coordinate responses with all providers. As a result, CHW is concerned the CARE tool will require departments to hire additional personnel responsible for filling out the form, though CMS will not provide additional reimbursement. **For these reasons, CHW strongly urges CMS to redevelop the tool to minimize the time necessary to complete it.**

Availability and Accuracy of Data

CHW is concerned about the limited availability of required information within the designated time frame for the tool to be completed. For example, ICD-9-CM coding information requested in Section III is usually not available until several days, sometimes weeks, after discharge, following the completion of the physician discharge summary and medical record coding. Accessing and reporting this information at or before the patient's discharge will be time consuming, cumbersome and administratively challenging. In addition, the two day assessment window for some data is problematic, especially in acute care settings when short lengths of stay and immediate patient needs can make assessment difficult. For example, a stroke patient would typically be in an acute care hospital for three to four days post onset before being discharged to a post acute facility or home. This three to four day "window" does not provide adequate time to fully assess functional status and potential for rehabilitation, or a complete picture of the patient's clinical and functional need as s/he transitions to a community or post-acute setting. This requirement will be additionally onerous for Mercy Mt. Shasta, CHW's only Critical Access Hospital (CAH), because of the requirement to maintain lengths of stay under 96 hours. **For these reasons, CHW urges CMS to reconsider its requirement on patient assessments.**

Reliability and Validity of Data

CHW uses established assessment tools in the post acute care continuum, including the IRF-PAI, OASIS and the MDS, which have a demonstrated track record of effective use. **CHW strongly urges CMS to incorporating existing assessment tools in the development of the new CARE tool, thereby building upon current practices that have been validated.** Reducing the redundant assessment processes does not lead to improved understanding of patient need or aid in guiding the arrangement of continued care.

Staff Training and Qualifications

Current communications from CMS do not specify guidelines for administration or for staff training or qualifications, particularly since many data items in the CARE tool appear to require subjective, clinical observations done by a trained evaluator. **CHW seeks further guidance on this issue.**

Other Reporting Functions

CHW must comply with other reporting requirements regularly, including quality data and reimbursement reporting. The assessment form is incredibly complex and most certainly interdisciplinary. The amount of time and number of personnel involved in its completion and complexity of the information required is enormous. **CHW strongly CMS to consider this value of this information and its use.** Furthermore, it is unclear if the CARES tool will fulfill some already-existing reporting requirements or if it will be in addition to what is already required. If it is an additional requirement, it would be helpful to understand the value of the data collected. **Given the high cost of data collection, CHW requests consideration of the nexus of other reporting and give specific guidance on how the new CARES tool fulfills these requirements.**

Thank you again for the opportunity to comment on the proposed tool. While CHW supports the development of an effective tool to aid in continued care arrangements, we encourage CMS to look closely at the tool, its usefulness, planned implementation and the administrative burden this process places on the entire professional care team, negatively affecting our ability to provide care to our patients. If you have any questions, please feel free to contact me at (916) 851-2007 or at clara.evans@chw.edu.

Sincerely,

Clara E. Evans
Director, Public Policy & Fiscal Advocacy
Catholic Healthcare West