As I mentioned in the Open Door Forum, the following needs are the most compelling:

1. IRF outcomes are collected in detail and robust data is readily available on cost, % of patients that return to community living, morbidity and mortality during the rehabilitative course. One can readily determine return on investment. Yet, no comparable robust data exists on sub-acute rehab programs.
    a. It is our experience that patients in sub-acute rehab programs have much lower rates of return to community living and greater morbidity and mortality while in the sub-acute program.
    b. Without the comparison of comparable robust data, no one knows if deflecting a patient from an IRF admission into a sub-acute admission, has in fact benefitted or harmed the Medicare beneficiary, or whether in the end it has even saved Medicare any costs.
        i. While a sub-acute program may be significantly less expensive than an IRF program on a rehab cost to rehab cost basis, any of the following may eliminate that cost differential and possibly may even **reverse** the cost differential.
            1. Overutilization of sub-acute rehabilitation in patients with no true rehab potential.
            2. Higher rates of re-hospitalization.
            3. Higher rates of patients requiring long term care placement with resulting higher long term medical care costs
        ii. It is no surprise that every nursing home in our region is seeking to open a “sub-acute” unit, which in fact often is no more than a name being given to a hallway in the facility. A few facilities are building entire new structures to create “Sub-acute Rehab Centers”. They all see this as their financial salvation!
2. IRF programs are strictly regulated to assure that every patient receives well coordinated, team based, multi-disciplinary, comprehensive rehabilitative care. Yet, sub-acute programs have absolutely no such requirements. With no minimum quality standards and no tracking of outcomes, it is not hard to provide a less expensive product and still make a profit. The question is, are Medicare beneficiaries the ones being “shafted”? Failure to succeed in rehabilitation is a form of death sentence to each patient; being relegated to dependency in a nursing home for the rest of their existence.
3. The need for clarification in “Medical Necessity”. Most truly medically unstable patient belong in an acute medical facility, not in rehab of any form. But there are a few medically unstable patients that can handle an IRF program and can be admitted. There is however the more common patient that is appropriate for IRF and NOT appropriate for sub-acute; the “**Medically Fragile**” patient.
    a. This is a patient who is only relatively and tenuously stable at rest but is at high risk for medical decompensation and complications with the activity required in a rehabilitation program,
        i. Examples abound. Patients with pre-existing heart & vascular disease and recent large volume total body surgical blood loss.
        ii. Patients with very low albumin levels and require Coumadin (Albumin is main protein carrier of Coumadin).
        iii. Patients with very low albumin levels and anasarca, bowel edema, etc..
        iv. Patients with acute urinary retention, uncontrolled hypertension and uncontrolled diabetes.
        v. Patients with signs of early infection and pre-existing renal and lung disease.
        vi. Etc.
    b. Please note that on the average IRF, one in eight patients develop medical decompensation and require readmission to an acute inpatient medical bed.
        i. This does NOT mean that the patient was discharged prematurely from inpatient medical bed. Again, patients lying in bed become stable and no

longer need the inpatient medical environment and are ready for discharge. We however, get the patient up and have that patient exercise fairly vigorously by having them walk climb out of bed, exercise, use walkers, etc. when they may have been in bed for the last few weeks. It is physically challenging and these patients are by definition in a very weakened state. If we wait longer to let them recuperate, they will just get weaker and weaker and have less and less of a likelihood of ever returning to a functional state.

David S Weingarden MD