Points to Consider Re: open door forum.

Regarding Point # 5

"The current 13 conditions do not include numerous cases that are increasingly being treated in IRFS"

In my position as Program Director for Medical and Orthopedic patients at Idaho Elks Rehabilitation Hospital, Boise ID, I am in a position to be in constant communication with the area acute hospitals. I am told that one type of patient they most rely on the IRF level of care for is the complex medical patient. **These are patients that, due to great advancements in life support, treatment of critical illness, and intensive care medicine, are surviving massive assaults to their health.**

Their diagnoses vary from cancer, sepsis, multiple system organ failure, adult respiratory distress syndrome, cardiac emergencies and non-healing wounds. Once through the acute phase of their illness, these patients are left with a variety of challenges to cope with either temporarily or long term. In many cases they have been hospitalized from one month to two, and even 3 months.

Not uncommon temporary problems include: Weaning from TPN to oral nutrition in patients at high nutritional risk, Completing IV antibiotics, or arranging for home infusion, removing Foley and bladder retraining, bowel management, wound care, colostomy management, urostomy management, weaning from supplemental 02, skin care, DVT prophylaxis, and psychological support are a few of the challenges this population faces as they attempt to pick up the pieces of their lives.

IRF services with this population:

The **rehab physician** makes almost daily medication changes, monitors labs and treatments, coordinates with other physicians (most of these patients have multiple consulting physicians) and confers with the patient and family and treatment team.

Rehab nursing does family training in tube feedings, administering IV infusions, urostomy and colostomy management, wound care, bowel management, pain management, skin care etc. Rehab nursing is also working on getting patients off 02, IVs, Foleys, TPN, pain medications, normalizing as many systems as possible prior to discharge.

A number of other services are very active with these patients, including **respiratory therapy, dietary, and pharmacy.**

Social work must set up the complex after-care systems needed to maintain these people in their homes- often taking days or weeks to procure funding and set up equipment and skilled support for the patients and families.

Therapy clinical staff deal with swallowing disorders, critical illness neuropathies and myopathies, severe weakness, sub-functional endurance, cognitive issues and carefully progress them, monitoring their fragile cardiac and respiratory tolerance even as they attempt to progress their mobility and ADLs. Many come to us, barely able to turn over in bed, and leave ambulating with a walker or able to navigate their homes from a wheelchair.

Outcomes

Our outcomes with these people are excellent- with length of stays varying between 2-4 weeks, with most returning to home. They are rehab candidates in every sense. Whether included as additional diagnoses(‘s), or in a complete modification of the rules for classifying an IRF, their competent management should count in the classification of a facility as an inpatient rehabilitation facility.

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