



# American Burn Association

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To: Department of Health and Human Services  
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Proposed Rules 42 CFR Parts 411, 412, 413, 422 and 489  
File Code: CMS-1390-P

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The American Burn Association (ABA) appreciates the opportunity to comment on the Medicare Program Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates. The American Burn Association represents the nation's burn surgeons, nurses, therapists, and other members of the burn team, and the nation's leading medical institutions with burn centers which provide therapeutic and surgical services for burn patients and other patients diagnosed with extensive and/or life-threatening skin diseases. Burn centers in the US are a critical national resource, particularly in regards to disaster preparedness – whether from potential terrorist acts or natural calamities – to the extent that the proposed regulatory changes jeopardize reimbursement for hospital burn centers; this would weaken the national preparedness capacity for mass burn casualty situations.

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Specifically, we wish to comment on Section F. Preventable Hospital-Acquired Conditions (HACs), Including Infections (Page 23547, Federal Register/Vol.73, No. 84, April 30, 2008).

## **TREASURER**

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We are particularly concerned about the application of potential HAC “candidates” of delirium and ventilator-associated pneumonia to burn patients. Critically-ill burn patients often present with inhalation injury and large open wounds and present significant risk for developing each of these hospital acquired conditions because of the underlying nature of their admitting diagnosis.

## **PROGRAM CHAIR**

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Pneumonia following inhalation injury must be categorized more as a post-injury pneumonia rather than a typical ICU acquired ventilator associated pneumonia since the inherent pathophysiology of an inhalation injury naturally sets the patient up for tracheitis, bronchitis and alveoli injury. Inhalation injury defined as airway mucosal injury and has a high subsequent risk for pulmonary secretions, plugging and pneumonia.

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For patients with large burns who are in an ICU or even in the acute floor of the hospital for several months delirium is a frequent complication. This is especially true for patients with large wounds who require significant daily doses of narcotics and anxiolytics to tolerate daily wound care, therapy and even activities of daily living. As patients progress from their critically ill state to a serious or stable condition, delirium is a frequent diagnosis. It is often difficult to differentiate resolving ICU psychosis from a cognitive deficit due to hypoxia at the time of the injury—which may not be apparent on admission either by radiographic findings or physical exam. Eliminating a work-up and treatment would be a disservice to our patients.

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Staphylococcal and streptococcal infections have long been known to increase morbidity and mortality for burn patients with moderate to large size burns. Unfortunately, with destruction of the skin barrier and necessity to provide wound care daily, they are at risk for systemic infections and line infections with both organisms. Standard of care for these wounds is topical antimicrobial therapy but systemic prophylactic antibiotics have been proven to result in worse complications. Even patients who undergo early excision and grafting – the single most significant intervention to improve survival and decrease infections – does not eliminate systemic infection. Infections that burn patients have mostly come from their own respiratory tract and GI tract and that with manipulation of the wound, there is showering of bacteria into the blood stream. With serious burn patients who have suffered inhalation injury, tracheobronchitis is a result of the inhalation injury leaving damaged lining of the trachobronchial tree that becomes colonized leading to the

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observed infectious situation.

While the above examples are by no means exhaustive of the unique and extremely complex conditions that burn patients may develop, despite the application of the highest standard of care, they do demonstrate why it is very reasonable that serious burn patients should be exempted from any addition of delirium and ventilator-associated pneumonia if these are added to the HAC listing.

We greatly appreciate your consideration of our comments.

A handwritten signature in cursive script that reads 'John A. Krichbaum'.

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