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INSIDE

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Inpatient rehab rings in new year with costly changes, more documentation

Start now to stay ahead of PPS changes

The inpatient rehab inpatient prospective payment system (PPS) brought little cheer to the rehab industry when the proposed rule was published in November.

Unless the Health Care Financing Administration (HCFA) in Baltimore, makes major changes to the rule based on input from the rehab industry, inpatient rehab facilities may expect to make costly changes in how they document care and to lose the flexibility of the current payment system. **(See story on the major changes proposed in HCFA's PPS rule, p. 3.)**

HCFA is intent on having rehab facilities switch to a new and much more time-consuming documentation system, called the Minimum Data Set for Post Acute Care (MDS-PAC).

"One of the real burdens is the MDS-PAC," says **David Good**, MD, director of rehabilitation at Wake Forest Baptist Medical Center in Winston-Salem, NC.

"The problem is that costs are going to increase dramatically, and the most obvious cost is for the MDS-PAC, which will take professional clinicians to complete," Good says. "Also, there's a lot of room for reimbursement loss due to coding errors and things like that."

Other rehab experts agree.

"We're extremely concerned about the MDS-PAC, which has over 400 data items," says **Carolyn Zollar**, JD, vice president for government relations at the

Special report: Preparing for PPS

Rehab Continuum Report brings you this in-depth look at the inpatient rehab prospective payment system (PPS) for Medicare patients as proposed in the recently published rule in the *Federal Register*. Look for more coverage of PPS in coming months, as rehab facilities count down to its implementation date of April 1, 2001. ■

American Medical Rehabilitation Providers Association (AMRPA) in Washington, DC.

It's estimated that it will take a skilled assessor about 70 minutes to complete the MDS-PAC, which is a huge time commitment, says **Judy Waterston**, chief executive officer and president of Schwab Rehabilitation Hospital & Care Network in Chicago. Schwab has 125 beds, including 20 sub-acute beds, and is affiliated with Sinai Health System of Chicago. **(See story on the challenges of using the MDS-PAC, p. 5.)**

The proposed rule is slated to be effective as of April 1, 2001, which means rehab facilities have little time remaining in order to make all of the necessary preparations and changes. Reimbursement in the first two years under PPS will be based partly on the current payment system under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) law. But this shouldn't lull rehab providers into thinking they can put off making changes, advises **Rajan Patel**, an expert on medical reimbursement issues and a director at KPMG in Fort Lauderdale, FL.

"The hospitals that are going to feel less of a pinch under PPS are those that take these regulations very seriously and start getting prepared now within that two-year time frame," Patel says. "If hospitals get a false sense of security and say, 'Look, I got a transition period, and I really don't have to worry about it,' then those are going to be the ones who will be hit hard, and they won't be ready in time."

Patel and other PPS experts offer these suggestions for how inpatient rehab facilities can prepare for the change to PPS:

- **Analyze your assessment process.**

The MDS-PAC assessment form will be a new tool for all rehab facilities, and in most cases it will include a scoring system that is mirror-opposite the system therapists and other rehab professionals currently are using.

About 85% of inpatient rehab hospitals now use the functional independence measure (FIM) assessment tool, says **Richard Linn**, PhD, director of the Uniform Data System for Medical Rehabilitation and the Center for Functional Assessment Research in Buffalo, NY. The Uniform Data System markets the FIM system.

MDS-PAC scoring is opposite of FIM scoring

"Interestingly enough, the way the MDS-PAC is structured, the scoring system goes in a way that is opposite of FIM, so therapists will have to reject all previous training to learn the new system," Linn says.

This will not prove easy, Waterston says.

"We have bright staff, and they're professionals, but it's very confusing when you have two different systems and two different scoring mechanisms," Waterston explains. "And since this is going to determine how we're going to be paid, it's absolutely imperative that we get it right."

The first step rehab facilities will have to take, assuming HCFA continues to require the MDS-PAC tool, is to audit their current assessment forms to see how well these tie together with the medical record document, Patel suggests.

"Are we capturing everything we are doing?" Patel asks. "The first thing I would do is take an audit to see how well our scoring system reflects

Executive Summary

Subject:
Inpatient rehab prospective payment system (PPS) will pose significant financial and staff time constraints on facilities.

Essential points:
- ❑ The Health Care Financing Administration proposes using a new assessment tool called the MDS-PAC.
- ❑ Rehab facilities should begin training staff to use the MDS-PAC now, and they should run audits of their past cases and how these would have been reimbursed under PPS.
- ❑ Private payers and Medicaid likely will follow Medicare's example and make reimbursement changes similar to those under PPS.

COMING IN FUTURE MONTHS

- ■ Total quality service program gives patients greater care continuum
- ■ Facility offers neurodevelopmental technique training to staff
- ■ HCFA receives feedback on proposed rule
- ■ Increase self-referrals through fitness center/wellness program
- ■ Take pointers from rehab facilities that have begun preparing for PPS

what we did for the patients."

This will give facilities an idea of how extensive staff training will need to be during the transition period. If it appears that therapists have not been assessing patients in a way that captures all information that's pertinent to reimbursement under PPS, then an agency will have to start teaching staff the new philosophy of how the therapist's documentation will drive reimbursement. Once staff understand that concept, the next phase is to teach them how to use the MDS-PAC tool.

• **Conduct a financial audit using anticipated PPS reimbursement.**

It's important that rehab facilities conduct a financial assessment to see if their reimbursement under the PPS case mix group (CMG) system will be higher or lower than what they have received under TEFRA, Patel says.

"If it's going to be lower than what TEFRA paid, then you've got a two-year-period of transition," Patel says. "So what do you need to do to improve your clinical documentation processes to improve reimbursement?"

AMRPA offers a service in which rehab providers can review their previous year's cases to gain a general idea of how their reimbursement would have been under PPS.

Outliers pose big problem under PPS

Schwab Rehabilitation Hospital has discovered through its trial PPS run that it will have a number of outliers because many patients are victims of violence who have additional medical problems. These types of patients are more expensive and have a longer length of stay than the typical rehab patient, Waterston notes.

HCFA has said it will have payment adjustments for outliers, and Schwab Rehabilitation will attempt to find out how those adjustments will affect the bottom line by using the AMRPA service to rerun its financial numbers based on the published proposed rule, Waterston says.

• **Adjust data systems to monitor cost and utilization.**

Hospitals will need to set up their own data systems to start monitoring cost and utilization based on the CMG categories, Patel says.

"I would challenge that hospitals pretty much have very little sophistication to be able to cost out services very well in a rehab facility," Patel says. "They haven't had to do it."

But that changes with PPS. Hospitals will have to develop a mechanism that allows them to monitor utilization and costs effectively.

"So they're going to have to go back to their data systems, each diagnosis-related group or whatever system they are using and try to manage their reporting systems," Patel adds. "Sometimes hospital information systems don't allow you to do that, so they're going to have to make an assessment of the process."

• **Prepare for other payers to make similar changes.**

Rehab providers should be prepared to see the same thing happen with their PPS that has happened with previous systems: Private insurers and Medicaid probably will jump on the bandwagon.

"Usually what's good for Medicare is good for the rest of the country," Patel says. "State Medicaid programs will see that they're paying a lot of money for rehabilitation care, and they'll tend to look at the new system to see if it will save them money."

Likewise, commercial payers will follow suit.

"Commercial payers love it when Medicare creates these systems for them," Patel says. "HCFA does all the work, and now commercial payers can borrow off that work and try to limit payments to facilities."

For this reason, KPMG experts tell their clients not to look at Medicare PPS in a vacuum. "Look at other payers doing this and try to figure out if you can operate your business in this new payment dynamic," Patel advises. ■

Special Report: Preparing for PPS

PPS rule rushes in like tidal wave with changes

Here's a quick look at what to expect

The inpatient rehabilitation prospective payment system (PPS) will leave little dry ground when it sweeps in.

Rehab industry experts predict PPS will result in a decline in salaries and cutbacks in highly skilled staff. They say rehab facilities will need to rely more heavily on care plans or maps, standardized care, and strategies that control the exorbitant expenses of outlying patients. Even pharmacy costs will need to be re-evaluated and

controlled.

"Obviously there will be winners and losers under PPS, and it'll be mostly losers, I'm afraid," says **David Good**, MD, director of rehabilitation for Wake Forest Baptist Medical Center in Winston-Salem, NC.

For most inpatient rehabilitation hospitals, payment under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) was higher than what it will be under PPS, Good notes.

"There will be some facilities that had a very low TEFRA rate and they may do all right under PPS," he adds. "These are facilities that have been around for a long time."

Likewise, when PPS was introduced for acute care hospitals, some actually did better financially, for a time, Good says.

The PPS losers could be comforted from the fact that there will be a two-year transition period in which their payments will be determined partly by TEFRA methodology. Then the PPS will be paid at 98% of the rate paid nationally under the current system. However, the PPS payment will not take into account the additional costs that rehab facilities will incur in order to implement the new system. Costs for the Minimum Data Set for Post Acute Care (MDS-PAC) are expected to be considerable.

Good and other rehab industry experts discuss some of the other challenges that inpatient rehabilitation facilities will face:

• **Documentation:** "Medicare's whole movement is toward documentation, documentation, documentation," says **Rajan Patel,** director at KPMG in Fort Lauderdale, FL. "The documentation level that really drives and justifies medical care is more significant now under PPS."

Documentation will be crucial under PPS

Clinical staff will need to fill out documentation forms appropriately, or else a facility will not receive the right level of reimbursement.

Under the old system, rehab facilities were paid the TEFRA rate, which was based on a certain base year, divided by Medicare discharges. The reimbursement had nothing to do with the level of clinical documentation, Patel explains.

"So if you had poor documentation it really didn't affect your TEFRA rate," he says. "It was non-documentation-driven."

Rehab facilities could enhance net income by increasing their costs and lowering their discharges. This gave them a higher cost-per-discharge rate, and the clinicians were not involved.

Under PPS, it's what clinicians document in the submissions to the Health Care Financing Administration (HCFA) in Baltimore, that will drive the payment.

"If clinicians have poor documentation that doesn't really support what they're doing, then HCFA will not know any better and will pay you less," Patel says.

• **Patient shifting:** One result of PPS in other post-acute care settings and Medicare's reimbursement changes in acute care hospitals has been a trend toward facilities shifting patients to a different medical setting, according to reimbursement.

"The acute cares have tried to transition patients to rehab and post-acute entities, and we've taken patients who are sicker, who have medical comorbidities and complications," says **Judy Waterston**, chief executive officer and president of Schwab Rehabilitation Hospital & Care Network in Chicago.

But now that rehab PPS greatly decreases payment for Medicare patients who stay longer than average, it will be more costly for inpatient rehab facilities to admit patients who have comorbidities and who are sicker upon rehab admission, Waterston says.

"We are going to have to look closely at our admission process and make sure we are taking patients who we are fairly certain will be able to complete their rehab program," Waterston adds. "We get our referrals from a variety of community hospitals, and I think this means we'll have to educate our referral sources about what are the most appropriate rehab patients."

There also is the possibility that some rehab facilities will stop taking patients with certain rehab problems, just as the home care PPS has resulted in some home care agencies turning away patients with diagnoses that require lengthier, more costly care.

"There's definitely a concern that [PPS] is going to back up patients in acute care or shift those patients to other types of care," Waterston says.

Good also anticipates rehab facilities changing their relationship with referral sources.

"It's going to be especially true for freestanding rehab facilities," Good predicts. "They're going to be a lot less willing to accept high-cost cases."

Even rehab facilities contained within an

acute care health system will need to pay close attention to every clinical decision. For example, Good says, rehab facilities may decide that they will no longer provide swallowing tests and PEG (feeding) tubes to patients because that minor surgical procedure is moderately expensive. If a patient needs that procedure, the rehab facility might insist that it's taken care of in the acute care setting.

Time for tough decisions

"Some real tough decisions need to be made," Good adds.

For instance, some rehab facilities might decide that they can no longer afford to admit certain types of orthopedic patients because the PPS payment is so low, he says.

"So unless they can make it up on volume or if they need to distribute their overhead and are willing to take a loss on these patients, they won't take them," Good says.

- **Staff salaries/cuts:** "I think we'll see a downward trend on salaries of therapists, and that's going on for the acute rehab side as well," Good says. "This will make the job market tighter for graduate level therapists."

Physical therapists have already seen a decline in wages and job demand. In some places the decline has been so pronounced that physical therapy assistants are paid only slightly less than physical therapists, Good says.

"You'll see a downward pressure on graduate PT and occupational therapy salaries in a tighter job market, and there will be more mushrooming training programs for PT and OT assistants to fill that need," he adds.

Some clinical positions likely will be reduced or cut under PPS because unlike TEFRA, the new payment system doesn't have a cushion that makes it feasible to hire extra psychologists, social workers, or recreational therapists.

"If you aren't generating any margin by your case mix group, then those extra types of services you may want to provide in your rehabilitation unit you may not be able to do so anymore," Patel says.

Under the old system, rehab facilities could hire more disciplines. Now they should take a "wait and see" approach, he advises. "You will have to do a profitability assessment by each case mix group that accounts for your volume and see where your margin is."

- **Educating staff:** This may be the greatest challenge under PPS.

"The assumption that HCFA makes is that rehabilitation facilities have been filling out data sets on patient acuity, but the reality is that none of these clinicians have been filling this out with the mindset that it drives the revenue," Patel says. "So they don't necessarily include everything they do."

Therapists and other clinicians have not had the time to document care that precisely. Now they'll have to make the time, and this will cost rehab facilities thousands of dollars that will not be reimbursed by Medicare.

Rehab facilities will need to teach staff how to capture every essential detail in assessing patient care. If a therapist forgets to document one small item, it could adversely affect reimbursement.

"This is a long educational process that needs to be undertaken, to educate all of these clinical people how to fill in certain items," Patel says. "It's almost like filling out a tax form correctly." ■

Special Report: Preparing for PPS

Unpopular MDS-PAC embraced by HCFA

Agency intent on standardizing assessment

One of the most controversial aspects of the inpatient rehabilitation prospective payment system (PPS) proposed rule is the requirement that rehab facilities use a new assessment tool, called the Minimum Data Set for Post Acute Care (MDS-PAC).

The Health Care Financing Administration (HCFA) in Baltimore, states in its proposed rule that the rehab industry did not have an appropriate and widely accepted functional status measure for inpatient rehabilitation until the functional independence measure (FIM) was developed in the 1980s. Using FIM data, researchers from the University of Pennsylvania developed a patient classification system called the functional related groups (FRGs). The FIM-FRGs are used by a majority of inpatient rehabilitation facilities.

HCFA estimates that the extra cost incurred in completing an MDS-PAC instrument will be a maximum of $94.91 per case. HCFA also estimates

MDS-PAC Assessment Schedule and Associated Dates

MDS-PAC Assessment Type	Hospitalization Time Period and Observation Time Period *	MDS-PAC Assessment Reference Date *	MDS-PAC Must Be Completed By: *	Hospitalization Episode Covered By This Assessment:	MDS-PAC Must Be Encoded By: *	MDS-PAC Must Be Transmitted By: *
Day 4	First 3 Days	Day 3	Day 4	Entire Hospitalization Time Period	Day 10	Day 16
Day 11	Days 8 to 10	Day 10	Day 11		Day 17	Day 23
Day 30	Days 28 to 30	Day 30	Day 31		Day 37	Day 43
Day 60	Days 58 to 60	Day 60	Day 61		Day 67	Day 73

Example based on patient admitted on April 3, 2001

MDS-PAC Assessment Type	**Hospitalization Time Period and Observation Time Period**	**MDS-PAC Assessment Reference Date**	**MDS- PAC Must Be Completed By:**	**MDS-PAC Must Be Encoded By:**	**MDS-PAC Must Be Transmitted By:**
Day 4	First 3 Days	4/5/01	4/6/01	4/12/01	4/18/01
Day 11	Days 8 to 10	4/12/01	4/13/01	4/19/01	4/25/01
Day 30	Days 28 to 30	5/2/01	5/3/01	5/9/01	5/15/01
Day 60	Days 58 to 60	6/1/01	6/2/01	6/8/01	6/14/01

Source: Health Care Financing Administration, Baltimore, and the inpatient rehabilitation facility prospective payment system proposed rule, published in November 2000.

it requires a median amount of time of 85 minutes for a rehab professional to complete the MDS-PAC, and this compares with a median time consideration of 20 minutes to complete the FIM instrument.

Rehab industry experts want to know why HCFA officials decided to scrap FIM and force rehab facilities to use a new and untried measurement system that will cost them more money and staff time.

HCFA's chief argument in favor of the MDS-PAC over FIM-FRG is that the MDS-PAC will help to move Medicare toward HCFA's long-term goal of creating a more integrated post-acute care payment and delivery system.

"Our goal of ultimately establishing a common system to assess patient characteristics and care needs for post-acute providers was endorsed by MedPAC in its March 1999 report to the Congress," says HCFA in the proposed rule.

The MDS-PAC system is based on the Minimum Data Set/Resident Assessment Instrument (MDS-RAI), which is used in long-term care settings and was the first standardized assessment instrument that Congress required to be used in a post-acute care setting.

HCFA says that a drawback of the FIM assessment instrument is that it is specifically focused on functional improvement and lacks detail on the needs of the patient during the course of admission. Compared to the FIM-FRG, the MDS-PAC contains additional data items related to quality of care.

HCFA makes quality an issue

"Clearly, HCFA speaks throughout the proposed rule that quality is a major issue, so what is interesting to us is that all of the things they say the MDS-PAC can do are things the FIM can do now," says **Carolyn Zollar**, JD, vice president for government relations for the American Medical Rehabilitation Providers Association (AMRPA) in Washington, DC.

The quality items that the FIM lacks could easily be added to the FIM-FRG system rather than scrapping it for a whole new instrument, says **Richard Linn**, PhD, director of the Uniform Data System

(Continued on page 11)

REHABILITATION
OUTCOMES REVIEW™

Rehab CE, seminars less costly than five years ago

Internet, teleconferences have become latest trends

(Editor's note: ***Nancy Beckley****, MS, MBA, president of Rehabilitation Seminars of Tampa, FL, a division of Bloomingdale Consulting Group of Valrico, FL, discusses some of the major changes that have occurred in recent years with regard to rehabilitation continuing education seminars and conferences.* Rehab Continuum Report *asks Beckley what forces are pushing these changes and what we might expect in the future.)*

RCR: What sort of changes have occurred in rehabilitation continuing education in recent years, and what are the forces that have contributed to these changes? For example, who is paying for the required continuing education in rehab now, and how has this changed?

Beckley: Throughout most of the '90s, continuing education was part of a recruitment and retention package offered by both large and small employers. Continuing education employer sponsorship was one of the first perks to go in the post-Balanced Budget Act of 1997 era. Another change is that state therapy associations seem to be making an effort to have additional opportunities for members to get CE credit.

RCR: Your company has tracked data about rehab continuing education seminars over the past five years. What has your research shown?

Rehab staff increasingly pay for own training

Beckley: I've tracked information primarily for continuing education courses for physical, occupational, and speech therapists for their biannual license renewal in Florida. Five years ago, the majority of attendees to these workshops had their registration fees paid directly by their employer. Three years ago the split was about 50% employer-paid and 50% therapist-paid, with about half of that being paid by personal credit card.

For registrations this year, 85% are personally paying for continuing education courses for license renewal, and within that 85%, nearly three-quarters are paying by personal credit card. About 15% of attendees this year report that they are no longer in the rehab field because of lack of employment. A disproportionate number are physical therapy assistants.

RCR: How are seminar companies such as yours keeping costs down to meet the rehab industry's demand for less expensive educational avenues?

Beckley: Well, we no longer serve orange juice as part of the continental breakfast. Seriously, bulk mail costs increased several times over the past several years; printing fees and hotel fees also have increased. So in a time of increasing prices, therapists are having to dig into their own pockets to pay for CE courses. I have attempted to keep the same pricing structure for the past five years — with only a slight increase for certain speakers or topics, especially where a large handout is part of the presentation, or extensive audiovisual requirements are present.

In networking with other colleagues around the country, I find that most are doing the same thing; the hotel selection is a critical component. We all are looking for a "decent" hotel where the guarantees are at a minimum — where it is possible to rent a meeting room for a reasonable fee without having to purchase breakfast, lunch, coffee breaks, and guarantee a minimum of sleeping rooms. At first I worried that people would be upset by these changes, but actually I have let attendees know that first and foremost affordability was our concern.

This year, for example, I held seminars at a new Homewood Suites Hotel in Orlando, and the room was wonderful. A box lunch was included, but gone was the continental breakfast, coffee breaks, and a block of sleeping rooms. For year-end seminars this year, Rehab Seminars eliminated coffee service. This allowed us to avoid raising prices by the $5 per person that coffee costs!

RCR: What are some of the non-technological trends that are emerging in the area of rehabilitation continuing education?

Beckley: In reviewing course evaluations this past year, the key item that attendees seem to point to when evaluating a course is its direct applicability to the work situation. The trend seems to be in practicability of application directly to the work setting. Attendees want to know techniques, procedures, or new methods that they can implement on Monday morning.

RCR: How has technology changed home-study continuing education coursework? What are some examples of new types of "classrooms?"

On-line classes, teleconferences offered

Beckley: Technologies of the new millennium bring new venues to continuing education. Several companies now offer "on-line" continuing education courses. Dynamic Online Seminars offers a full slate of courses that are certified for CE credit in multiple states. The idea is that you register online, receive a password to get your course materials and proceed with a course that has about 10 learning modules, comprising three lessons each.

Attendees take the course from the comfort of their home or office, complete assignments, and take a quiz. Then they are awarded their CE credits. No need to fight traffic, or take time off from work. These credits often count as "home-study" credits for the purpose of license renewal. Rehab Seminars also is developing a series of teleclasses. People register online and are given a phone number to call at the designated course time.

Special bridge lines hold from 30 participants to over 150 participants. Once again, there are no travel costs. Most courses taken in this fashion qualify as "live" courses, rather than home study courses. Presumably these courses also are more cost-effective to offer because the hotel and meeting costs are eliminated.

RCR: It seems that professional seminars and continuing education courses used to be a good excuse to send staff on a mini-vacation to an attractive city. For instance, many health care seminars are held in Orlando, where attendees can bring their families to visit Disney World. Are rehab facilities less likely now to pay for these types of professional trips, and why?

Beckley: This past year I ran courses in Las Vegas, Orlando, and Los Angeles, as well as less glamorous venues. The course content attracts people to the course — the content then is weighed by the potential attendee against the total cost of attending. That's where the strategy comes in. You want your whole package to be attractive to the potential attendee, but you want the price to be affordable. In general, the days are gone when you could offer a seminar in a destination city in a nice hotel and have the employer pay for it.

RCR: Have the cutbacks in money for rehab continuing education had any effect on the quality of advanced training and education that rehab professionals have received? For instance, are therapists less likely to learn a new technique if it means traveling to a more expensive site for a costly seminar?

Beckley: There are still "expensive" courses out there, and I suspect that courses with a specialty focus — such as dysphagia training, etc — that lead to therapist certification will continue to have participants. Now it is often the choice of therapists to determine if they will attend a more technically oriented course with a higher fee.

Therapists will have to take into consideration the total costs incurred — travel, time off work, seminar costs — and weigh those against the advantages of the training such as job advancement and future opportunities.

RCR: What do you believe will be some of the future trends in rehab continuing education?

Beckley: There are two distinct needs in the therapist continuing education market: education for the purpose of gaining new skills, and education for the purpose of meeting state licensing requirements. Companies offering continuing education will have to conduct target segment marketing to cost-effectively promote their seminars.

Postage increases are coming up again next year, so it will harder to keep the prices the same as this year. Technology will continue to advance so that opportunities for nontraditional learning will expand, such as Internet-based courses and teleclasses.

Employers, particularly medium to large employers, also are beginning to realize that offering continuing education courses in on-site formats is cost-effective and a nice employee

benefit. Savvy therapists should get a plan together and propose a continuing education program that is cost-effective for the employer, is perceived by the employee as a benefit, and provides education as well as continuing education credit. ■

Focus for 2001 is quality for rehab consumers

CARF is addressing this issue carefully

(Editor's note: ***Yolande K. Bestgen****, MS, vice president for strategic development at CARF… The Rehabilitation Accreditation Commission in Tucson, AZ, discusses some of the recent accreditation changes for rehab facilities and some new trends in the rehab industry in this Q&A interview.)*

RCR: In 2000, the CARF board adopted a new goal to increase consumer participation and cultural diversity in all of the accrediting body's activities. Would you please explain how this might change some of the day-to-day operations and clinical work done in rehab facilities that are accredited through CARF?

Bestgen: At CARF we support consumer involvement and have established a goal of enhanced consumer involvement at all levels of CARF. This goal reflects our belief that consumers being involved only with the survey itself limits their involvement to just one aspect of the accreditation process.

We have standards that address services directed to the individual's needs. CARF can assist rehabilitation facilities through the process of continuous quality improvement to enhance consumer involvement and to address the cultural needs of patients.

The reason we are focusing on diversity has to do with the changing demographics of our workforce and consumers. For example, in the year 2000, one-third of the nation's population represents a racial minority group, a significant population that includes both workers and consumers of service. So when you talk about day-to-day operations in clinical work, it's important to look at the strategic planning of rehabilitation facilities to make sure they are responding to the needs of consumers of services and also to what is becoming a diverse workforce.

We have people at international conferences, skilled in the area of cultural competence. They offer recommendations to organizations through presentations, work groups, and seminars. They provide guidance and techniques for organizations to expand their abilities in the area of cultural competence for the people they serve and in their workplace.

CARF's consumer involvement touches all areas, including the actual accreditation process.

RCR: Many rehab facilities already monitor patient satisfaction through surveys. What are some other strategies they can employ to better reach consumers and learn what consumers want?

Rehab facilities use focus groups

Bestgen: One of the strategies we have seen successfully employed by rehabilitation facilities is the use of focus groups within their service area. Focus groups allow providers to obtain direct feedback from the consumer on what it is the consumer would want them to do within the community. The rehab facility explains to the focus group that this input will help the facility plan for its future. The consumers become a planning partner in regard to where resources could be allocated.

When we're discussing the aspects of a facility's operations having consumer involvement, this doesn't mean that you have to have a consumer on staff in every place. It doesn't mean you have to have a consumer shadowing the facility's chief executive officer. But it does mean you use as many of the methods you can to maximize the consumer's input, including the focus group example.

RCR: The federal government now expects hospitals to accommodate non-English-speaking patients by offering translation services or hiring bilingual staff whenever possible. CARF also has shifted its focus to diversity. What are some of the industry trends that have encouraged rehab facilities to make diversity training and programs a priority?

Bestgen: We need to be sensitive to the people we're serving. For example, in New York City one accredited organization has a high number of people of Chinese descent who are the facility's consumers. They have staff skilled in translating information so that all of their consumers are fully informed. It would appear that the federal government wants hospitals to be sensitive to their own demographics and to respond to the

needs of the individual.

RCR: When the prospective payment system (PPS) finally is implemented, rehab facilities will need to make a number of major changes, requiring time-consuming staff education and training. How can facilities manage all of these new issues at the same time they continue to prepare for accreditation surveys and maintain their accreditation? Has all of the required documentation grown to be too much for many rehab facilities to handle, and if not, how can they best cope?

Bestgen: The PPS changes are on the front burner for inpatient rehabilitation providers. Meeting CARF standards and PPS requirements are not necessarily mutually exclusive. Effective blending of the CARF standards and the systems that are mandated relative to PPS implementation could be approached as a way to integrate systems and strengthen the program, as well as enhance the delivery of services.

Clearly, this will involve open minds, teamwork, and increased flexibility on the part of providers as well as CARF.

It is now more critical than ever in this changing environment that rehabilitation facilities have continuous quality improvement efforts and a long-range planning process in place. These are concepts that are already imbedded in the CARF standards.

We expect some growth in the outpatient rehabilitation arena as organizations are shifting some of their services to outpatient.

Also, consumers are asking for services that are more accessible. Some rehab facilities are extending services on-site to employers with large numbers of employees. I think we're going to see some interesting changes as to how services are going to be delivered and where they're going to be delivered. It will be a challenge. ■

Conference to target cost and quality in SDS

Experts will share their proven ideas for managing successful same-day surgery services at Balancing Cost and Quality: The Secrets of Successful Ambulatory Surgery Programs, to be held March 14-16 in Atlanta. The conference is sponsored by American Health Consultants, publisher of *Rehab Continuum Report*.

The timely topics offer something for every same-day surgery manager, whether your program is hospital-based, freestanding, or office-based. Speakers will address issues including:

- interpreting financial information;
- monitoring quality trends and their impact on finances;
- improving physician, employee, and patient relations;
- recruiting and retaining physicians;
- addressing sentinel events;
- understanding new federal regulations;
- following construction requirements;
- adding pain management services;
- using creative marketing strategies;
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(Continued from page 6)

for Medical Rehabilitation and the Center for Functional Assessment Research in Buffalo, NY, which provides rehab facilities with a FIM system.

Instead, HCFA is telling rehab facilities that they will have to completely retrain their staff to use a new and lengthy assessment tool that has a scoring system exactly opposite the FIM system. This will make it very difficult for therapists and others to produce accurate and high-quality data, especially during the first years of using the instrument, Linn says.

"If you suddenly had to learn that the color red means "to go," and green means "to stop" at a stoplight, how would feel about that?" Linn adds. "How many intersections would you go through by accident, and that speaks to the potential reliability of data as people are collecting information and learning the new system."

Moreover, the rehab industry has no way of knowing how HCFA will use the quality information it collects through the MDS-PAC, says **Judy Waterston**, chief executive officer and president of Schwab Rehabilitation Hospital & Care Network in Chicago.

"We're not against gathering and benchmarking ourselves on quality; that's what we're in the business to do," Waterston says. "But we're not quite sure what HCFA plans."

There's the added dilemma of what to do with non-Medicare rehab patients. Should rehab facilities continue to use the FIM-FRG or other instruments to assess them, or should everyone be switched to the MDS-PAC for simplicity's sake?

Waterston weighs in on the side of using one instrument for everyone. "Eventually, that would be the preferable thing, to have one measurement tool and measure all patients on that," she says. "But the reason the industry is a little nervous is because we don't know how long that's going to take, and of course we're not paid for time spent doing the assessment."

But the alternative would make the assessment process very confusing for therapists and others, she notes. "We have only a third of our patients on Medicare, and so if we continue to use the FIM system for our other patients, we're going to have staff using two systems, which increases the likelihood of error, and that's a concern."

Nonetheless, HCFA is less concerned about the inconvenience to rehab facilities that must train staff to use an entirely different assessment tool than HCFA is intent on using an assessment tool that is similar across post-acute rehab settings

"Our proposal to use an MDS-based approach comes from our conviction that the use of common item labels and definitions across different provider settings would be essential to monitoring patient care across different provider settings," HCFA writes.

PPS Terminology in a Nutshell

Here's a quick look at some of the terminology found in the proposed rule of the prospective payment system (PPS) for inpatient rehabilitation facilities:

- CMGs: case mix groups
- CMI: case mix index
- DRGs: diagnosis-related groups
- FIM: functional independence measure
- FIM-FRG: functional independence measure - function related group
- HCFA: Health Care Financing Administration
- IRF: inpatient rehabilitation facilities
- MDS-PAC: Minimum Data Set for Post Acute Care
- MedPAC: Medicare Payment Advisory Commission
- RICs: Rehabilitation Impairment Categories
- TEFRA: Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248
- UDSmr: Uniform Data Set for medical rehab

Instrument wasn't tested

HCFA considered using the FIM instrument as the post-acute tool, but found that nursing home staff did not feel comfortable making the level of distinctions required in the FIM.

Critics of HCFA's proposal also point to the issue of whether the MDS-PAC even will work as a means of determining the PPS payment.

"The government currently does not know whether or not this MDS-PAC instrument can be used for payment because it's never been tested," Linn says.

HCFA constructed payment rates using FIM data. HCFA also used the FIM-FRG classification system to develop the case-mix groups, which will be used to classify patient discharges by FRGs based on a patient's impairment, age, comorbidities, and functional capability. HCFA

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officials wanted to improve upon the FIM-FRG system in the ability to predict resource use.

"We have a new instrument, and the government doesn't even know if it's going to work," Linn adds. "How could they propose a rule using an instrument that's unknown for validity and use for this payment system, which is its primary purpose?"

An initial draft of the MDS-PAC was developed in September 1997, and the subsequent pilot and field testing focused on the inter-rater reliability, clinical validity, and administrative feasibility and burden associated with the MDS-PAC instrument. HCFA plans to conduct field testing to establish validity, reliability, and equivalence for payment before the final inpatient rehabilitation PPS rule is published.

Despite the rehab industry's criticism about the choice of the MDS-PAC, HCFA appears poised to continue with the new assessment system. The proposed rule says that inpatient rehabilitation facilities must complete a successful transmission of test MDS-PAC data to HCFA's system during the month of February 2001. Then on April 1, 2001, rehab facilities must use the MDS-PAC for all assessments.

The assessment must be completed at set time points in the patient's inpatient rehab stay, including day four, day 11, day 30, and day 60. The data from the day four assessment determines the case mix group classification, which in turn determines payment for the first three days of admission. **(See HCFA charts of MDS-PAC schedule, p. 6.)**

The implication is that rehab facilities will have to begin using and training staff to use MDS-PAC now, even if it's still uncertain whether the assessment instrument is included in the inpatient rehabilitation final rule for PPS.

"Until we use MDS-PAC, we won't really know how it works out," Waterston says.

Nonetheless, Waterston and others plan to send comments to HCFA about their concerns over the choice of MDS-PAC.

"I don't know how willing HCFA will be to change things based on our comments," Waterston says. "But the rehab industry is committed to at least bringing the issue forward." ■

Incontinence program meets community need

Program deals with pain, dysfunction

Rehabs can place themselves in a position to provide services otherwise met on a limited scale — or not at all — in most communities.

That's what Howard Young Medical Center of Woodruff, WI, did by establishing an incontinence program providing specialized services in treating pelvic pain, incontinence, bowel and bladder dysfunction, and bladder dysergia for children.

The 99-bed hospital, which has eight rehab beds, began the program with a goal to offer incontinence services not being addressed in the small resort community, says **Susanne Porter**, PT, CertMDT, a physical therapist with Howard Young. "We address any form of pelvic problem, whether its incoordination or weakness or hypertonicity," Porter says. "We had been seeing patients who had these complaints, but we wanted to address it in a formal program."

Porter spent six months marketing the program by meeting with urologists, gynecologists, family

(Continued on page 14)

Physical Therapy Treatment for Pelvic Floor Muscular Dysfunctions

PT evaluation for any dysfunction includes an assessment of:

- ❑ Muscle length and strength imbalances
- ❑ Tenderness or trigger points
- ❑ Functional movement patterns
- ❑ Joint dysfunctions
- ❑ Bony alignment
- ❑ Behavioral patterns

Common signs and symptoms of pelvic floor muscular dysfunctions:

- ❑ Poorly localized peri-vaginal or rectal, lower abdominal, suprapubic or coccyx pain
- ❑ Referred pain into the posterior and anterior/medial thigh
- ❑ Sense of heaviness in the vagina, bladder or rectum
- ❑ Dyspareunia — both superficial and deep
- ❑ Urinary dysfunction: urgency, frequency, hesitancy, incontinence (mixed, stress, urge), nocturia or pain with urination
- ❑ Constipation
- ❑ Back pain or other dysfunction that does not get better with conventional treatment - visceral causes ruled out
- ❑ Frequent UTI
- ❑ Suprapubic pressure
- ❑ S/P urogynecologic surgery
- ❑ S/P radical prostatectomy
- ❑ Other symptoms of hypotonus, hypertonus, or incoordination dysfunctions

Treatment can include:

- ❑ Stretching
- ❑ Strengthening - pelvic muscle exercises, vaginal cone retention
- ❑ Relaxation of pelvic floor musculature
- ❑ Modalities - heat, ice, ultrasound, electrical stimulation, biofeedback, massage
- ❑ Education - bladder training, habit training, prompted voiding, functional movement retraining, dietary changes, bowel or bladder habits, posture, body mechanics
- ❑ Home program - may include education and instruction in self massage, assisted massage, stretching, strengthening and/or relaxation of pelvic floor and surrounding muscles, walking
- ❑ Physiological quieting

ICD 9 codes that PT can treat for the above types of pelvic muscular dysfunctions:

- ❑ 728.2 Muscle wasting and tissue atrophy not elsewhere classified
- ❑ 728.85 Spasm of muscle
- ❑ 728.9 Unspecified disorder of muscle, ligament, and fascia

Source: Howard Young Medical Center, Woodruff, WI.

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practitioners, and internal medicine doctors. "I also met with nurse practitioners, nurses, and the medical staff of various departments," she adds.

She met physicians for lunch or breakfast or for 15 minutes in a staff meeting. Porter gave them one-page handouts that identified the signs and symptoms of pelvic dysfunction the program could treat. It also described how Porter would assess the program and which ICD-9-CM codes she could treat, so they would know exactly how to write the order. **(See sample marketing tool, p. 13.)**

"We only have 40 physicians in this community, and I met with 20 physicians," Porter says. "It took about a month for referrals to come in." She now sees about 10 patients a week in the incontinence program, an ideal workload since Porter also spends time doing regular physical therapy work at the rehab facility. "If I wanted to make this a busier practice, I could, because it's being reimbursed by all payers," she says.

The program typically involves Porter meeting with patients for one to four visits. The initial evaluation lasts 45 minutes to an hour, depending on how complicated the problem is. Follow-up visits are 15 to 30 minutes, and some are simply phone checkups.

Porter teaches patients how to use their bodies, especially abdominal muscles, properly so they're not putting increased stress on their pelvic area. She also teaches them how to do the Kegel exercise, a form of pelvic muscle contractions. "Most of the people I see are doing the contraction improperly, or they haven't learned how to have the proper rest-contraction cycle," Porter says. "So I teach them how to relax and do it properly."

She also teaches patients how to perform self-massage to help their muscles work properly, and she teaches some patients how to improve bowel and bladder habits.

"The other component is prenatal instruction to teach patients how to relax for a delivery and to help them with bladder function," Porter says. "So I have a prenatal education and exercise class that I incorporate a lot of this stuff into." ■

Pilates techniques move to rehab world

OTs achieve good outcomes with method

Pilates, the method of exercise and movement gaining in popularity among celebrities in recent years, has proved to be an excellent rehab niche for a hospital-based facility in Wisconsin. Pronounced "puh-lah-tees," the technique is named after Joseph Pilates, who founded the method and first taught it to dancers.

"One of the tremendous things about Pilates is it offers such a variety of rehab training," says **Angela Kneale Buckholtz**, OTR, occupational therapist with Howard Young Physical Medicine & Rehabilitation in Woodruff, WI.

Rehab therapists can use Pilate machines and techniques to treat patients with low levels of function, such as those who have difficulty moving due to chronic pain or a stroke, or a high-level athlete who is recovering from a hamstring injury, Buckholtz says.

Strengthens patients' core control

The rehab facility, which has eight beds and satellite sites in Mercer, WI, and Eagle River, WI, purchased a Pilates clinical reformer machine two years ago. The facility's physiatrist learned about Pilates and pushed for the rehab facility to buy the $3,500 unit, Buckholtz explains.

"The machine is unlike most anything else I've ever seen," she says. "It's described as about the size of a twin-sized bed with a system of springs and a carriage that moves, with a foot bar and lots of adjustments available for tension and positioning."

Clients lie supine on the clinical reformer, which helps to strengthen their muscles and forces them to focus on core control. The a goal if for all their movements to become comfortable, Buckholtz adds.

"I work with people who have chronic pain in a variety of body regions, and so this is specifically appropriate for them to strengthen their core control," she says. "You can put people into position and select exercises they'll be very successful at."

Buckholtz helps chronic pain patients see that they can move without pain on the first set of exercises, and then she builds on that until they can stand and walk more freely.

"It helps improve body awareness and posture, confidence in movement," she says. "It's the ultimate mind-body workout."

People trained on Pilates soon incorporate its method of proper positioning into their daily activities.

Buckholtz uses Pilates techniques chiefly for chronic pain and musculoskeletal patients. She's also used it when working with patients recovering from a cerebral vascular accident. She hasn't used it for spinal cord injury or traumatic brain injury patients.

Staff trained extensively

The staff received a day and a half of training on Pilates from a Pilates expert who has a dance background. The trainer showed them how to use the clinical reformer and also how to do some mat exercises that patients could continue to practice while at home. The Pilates reformer arrived with training videos.

Buckholtz received further training through Stott's Conditioning in Toronto, with the goal of becoming certified for teaching others the technique. Some Pilates courses focus specifically on rehabilitation injuries and special populations, others on dance theory, using the machines, and movement during pregnancy.

Soon after the rehab facility began to use the Pilates equipment and technique, the staff held an open house attended by about 100 people. "We've had a lot of interest from healthy people because we all have our little quirks," Buckholtz says.

The one machine has been put to good use, with the facility's physical therapists and occupational therapists incorporating it into regular therapy for inpatients and outpatients. It's also incorporated into the multidisciplinary pain management program.

Reimbursement isn't an issue since the technique doesn't require a physician's order, and it's not reimbursed separately from other therapy interventions, Buckholtz says.

Since the rehab facility currently has space limitations, preventing the purchase of more Pilates machines, there hasn't been the need for further marketing, she adds. "We hope the program will expand, and we'll purchase other pieces of equipment."

Although the rehab facility has not measured outcomes from the use of Pilates, Buckholtz says the anecdotal evidence proves its value.

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"I've seen people learn to move comfortably for the first time in a very long time in their lives, and especially those with chronic pain," Buckholtz says. "They've been able to successfully relearn and rebalance muscles, relearn motor control, and become comfortable with activities in their daily lives." ■

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Pain management Web site now available

Pain.com offers info for professional, consumer

Pain management awareness is growing among both patients and health care providers as the media focuses more and more attention on the issue. It is especially a hot topic for health care facilities because the Joint Commission on Accreditation of Healthcare Organizations is set to implement new standards in 2001 for the assessment and management of pain in recognition of patients' rights.

How can professionals and consumers stay abreast of the latest information on pain control? The Dannemiller Memorial Educational Foundation, based in San Antonio, TX, has created pain.com, a comprehensive Web site devoted to pain and pain management for both professionals and pain sufferers. "Our goal is to be the Web site for pain for a health care provider or patient seeking information. They can come to our site and obtain all the information they need," says **Ed Dyer**, MA, information manager for the Dannemiller Foundation. The uniqueness of the site is that it is so vast, he says. **(For additional Web sites that focus on pain, see resource list at right.)**

Some of the site's features include a library with more than 3,000 articles, case studies, and abstracts that can be searched by author, title, or key word. Thirty new articles are added each month.

A pain news column is published daily for professionals and patients. A recent news release, for example, announced that Temple University Health System in Philadelphia had successfully used a new pump called On-Q, which is a pain management system that drastically decreases postoperative discomfort by providing continuous infusion of a local anesthetic directly into a patient's operative site.

Professionals can get 36 hours of free CME/CE credit sponsored by Abbott Laboratories on the site. Online slide lectures and videos from professional workshops and presentations keep health care providers up to date on pain management.

Interviews with experts on back pain, headache pain, or cancer pain are conducted frequently. Several pieces on the Joint Commission's new standards on pain management were recently added to the site. "The purpose of the site is to assist in the education of the health care provider and the patient. A secondary purpose is to offer hope," says Dyer. ■

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- **American Academy of Pain Management**, 13947 Mono Way #A, Sonora, CA 95370. Telephone: (209) 533-9744. Fax: (209) 533-9750. World Wide Web: www.aapainmanage.org. The purpose of the organization is to meet the challenges of multidisciplinary pain management.
- **American Chronic Pain Association**, P.O. Box 850, Rocklin, CA 95677-0900. Telephone: (916) 632-0922. Fax: (916) 632-3208. World Wide Web: www.theacpa.org. This association offers support and information for people with chronic pain.
- **The National Foundation for the Treatment of Pain**, 1330 Skyline Dr. #21, Monterey, CA 93940. Telephone: (831) 655-8812. Fax: (831) 655-2823. World Wide Web: www.paincare.org. A not-for-profit organization dedicated to providing support for patients who are suffering from pain as well as their families, friends, and the physicians who treat them.