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INSIDE

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Integration and operations changes can improve rehab quality, efficiency

Physicians, other referral sources like change

The pit bull territorial philosophy of rehab facilities in the old millennium is not the best strategy for success and survival in the new one. Rehab providers who are part of larger health systems are finding new ways to improve patient satisfaction, clinical quality, and cost-savings efficiencies. One of the more successful strategies appears to be to change operations in order to integrate rehab services, documentation, and staff training across the continuum of care.

"Let's imagine that I'm a daughter and my mom has come into the acute hospital after a stroke," says **Cyndia Schreiner**, BS, CRRN, LNHA, director of rehab services and administrator of long-term care at Alliance (OH) Community Hospital's Center for Rehabilitation. The hospital has 100-plus beds, including 15 rehab beds.

"When my mom is on the acute care side she learns to do transfers one way, and then in rehab she learns to do it another way," Schreiner says. "Then she receives home care services, and she learns yet another way."

How likely is it the patient and her caregiver are going to be confused, dissatisfied, and inadequately trained to become independent?

That is the question that fuels the move to greater rehab care integration across provider settings.

Executive Summary

Subject:
Integration of operations is key to survival in new millennium.

Essential points:
- ❑ Rehab integration helps to provide consistency across care continuum.
- ❑ Integration of operations across rehab sites will lead to better quality and cost efficiencies.
- ❑ The flexibility helps providers fill gaps in staffing by shifting therapists from one site to another.

The choppy, departmentalized approach to rehab services also may confuse and annoy physicians.

Before Appleton, WI-based St. Elizabeth Hospital, a facility that is part of Affinity Health System, integrated all rehab services across the care continuum, physicians found that their rehab referrals were handled differently according to which rehab clinic received the referral. There was no standardization, even among departments with identical levels of care, says **Maija West**, OTR, MPA, manager of rehab services for St. Elizabeth, which has 17 rehab beds, 20 subacute beds, and about 190 beds total.

"Documentation was different; even the duration or frequency of many of our programs were handled differently," West says. "We received some feedback from physicians and our health plan that they wanted to know rehab would be handled the same way, wherever their patients went."

Whether a rehab provider plans to integrate across a continuum of care or across various sites on one level of the continuum, it's important to approach the process systematically and with sensitivity to its impact on staff. The goal is to improve patient care, with the additional benefit of saving money, West says.

"We now have much more efficiency with our management time and staff time," West says. "One manager can focus on one global task and facilitate all sites to complete it."

Rehab sites share tools, ideas

The rehab facilities associated with Affinity Health System now can benefit from improvements and products developed by their counterparts. For example, if one site develops a comprehensive training tool for therapists, then the other sites can download and use that same tool, West explains. **(See story on how Affinity achieved rehab integration, p. 20.)**

"One site does a lot of work investigating something, coming up with an idea, and another site will customize that process improvement to meet that site's needs," she adds. "Standardization has allowed us to share staff, including nurses who work on both inpatient rehab units and speech pathologists who work at any site."

Even occupational therapists (OTs) and physical therapists (PTs) will travel back and forth between sites if a therapist is on maternity leave or one site is particularly busy, West says. While the health system might have attempted to pool staff this way before the integration, it wouldn't have worked as well because the documentation and procedures might have been different between sites, making it difficult for therapists to quickly adjust to the new environment.

Integration affords flexibility in staffing

Alliance Community Hospital's operational change gives the facility greater flexibility in staffing rehab therapists to the department that has the greatest need. If the outpatient department needs some additional help, then a therapist from inpatient or from subacute or long-term care can step in to provide coverage, and vice versa, Schreiner says. **(See story on the steps Alliance took in making the organizational change, p. 19.)**

"We had everyone cross-trained," she explains. "So we have been able to provide a seamless service, and it improves hands-on patient care, outcomes, and communication."

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COMING IN FUTURE MONTHS

- Check out PPS comments by industry
- SCI project uses peers to assist newly injured
- Former grocery store becomes rehab facility's fitness center
- Cranial mandibular joint program proves very popular
- Inner city violence prevention program helps rehab patients, others

Customer satisfaction among both patients and physicians has risen in the three years since the hospital began cross-training rehab staff and providing a greater continuum of care, Schreiner says.

Patients often see more of the therapists who began their treatment, and they definitely receive more consistent education, all of which improves outcomes, she adds.

"Any person we serve could have contact with the same therapist throughout the service period," Schreiner says. "Everybody is talking the same language, and as a result of cross-training we see consistency and continuity." ■

Ohio rehab therapists learn the 24/7 standard

Changes mean happier patients, more efficiency

Alliance (OH) Community Hospital's Center for Rehabilitation decided not to wait for the prospective payment system (PPS) before making changes that would benefit patients, payers, and clinical care quality.

Three years ago the hospital's chief executive officer challenged the rehab director to eliminate inefficiencies and therapist shortfalls by moving from a compartmentalized approach to an integrated approach, recalls **Cyndia Schreiner**, BS, CRRN, LNHA, director of rehab services and administrator of long-term care for the hospital.

"I was given responsibility for the long-term care facility and all of the therapies across the continuum, and I was told to make it work," Schreiner says. "I had no long-term experience at all because I'm a dyed-in-the-wool rehab nurse, so it was swim or drown."

Schreiner formed a total quality service team that identified the facility's most urgent concerns and its greatest assets.

"We had a body of people committed to good patient care," Schreiner says. "That was one common thread that ran in every one of us, and we were able to weave those threads together and come up with a product called the continuum of care."

The result has been greater patient satisfaction, and the facility is building up physician referrals.

"We have a patient satisfaction tool, and patients are singing our praises," Schreiner says.

The change also helped the hospital to boost its outpatient rehab volumes. Physicians who might have sent patients to other outpatient facilities could see that Alliance offered patients consistent therapy care, often with the same therapists following a patient from acute through outpatient treatment, and this resulted in more referrals.

Here are the steps the facility took:

1. Identify problems.

"What we identified first was that we had a shortage of therapists," Schreiner says. "We saw that at any given point in time the acute care hospital or outpatient or long-term care facility could have either feast or famine."

Contract services now not necessary

When the departments had a shortage of rehab therapists they would use contract services to fill the gap. This not only cost money unnecessarily because there likely were qualified therapists elsewhere in the hospital who had open slots that week, but it also led to less consistent patient care. Since the change, staff fill in the gaps, saving the facility money on contract services.

"We wanted to give good patient care and that's why we got rid of all territorial barriers," Schreiner says. "If you're an outpatient therapist and your mom is on the rehab unit or in the nursing home, don't you want her to have access to the best services, and if you can be the one to provide those services because your workload is down, don't you think that would be a great thing to do?"

2. Cross-train staff.

Alliance Community Hospital had nurses do rotations through the various therapies, including physical therapy, occupational therapy, speech, and recreational therapy. "The nursing staff followed-through with the same approaches that therapists were doing," Schreiner says. "This way we had a 24/7 approach so that what patients learned in therapy was carried on with nurses working at 3 a.m."

Therapists were cross-trained and rotated to spend time in the various settings. For example, an inpatient rehab therapist would spend a day or longer in an outpatient rehab setting and then in the nursing home. This continued with the therapists who were primarily assigned to the other settings until every therapist knew how to work in any of the sites along the care continuum. The only exception was home health, where it was more cost-efficient to keep separate home

health therapists.

"After everyone was cross-trained, any therapist could fill in at almost any point in our continuum," Schreiner says.

3. Move closer to a 24/7 philosophy.

One of the big changes rehab facilities will experience under PPS involves the work-day philosophy. Therapists have grown accustomed to having evenings and weekends off. But this 8 a.m. to 5 p.m. schedule does not always work best for patients or for achieving the best quality of care.

Schreiner says that inpatient rehab facilities may have to change to a more flexible therapy schedule. Some long-term care facilities made that sort of change when their field was hit by PPS.

"When PPS came to long-term care, we needed to identify a mechanism where we could give the patient the biggest bang for the buck," Schreiner says. "At that time in our community for a therapist to even consider working on a Saturday was rare."

Saturday coverage standard

Now the hospital has Saturday therapy coverage in the acute hospital, inpatient rehab, subacute, long-term care, and outpatient rehab settings. Rehab therapists also provide some weekend coverage to a separately owned facility through a contract.

"We have therapists on call on holidays, and everyone is striving for the same goal of quality outcomes," Schreiner adds.

4. Achieve staff buy-in for changes.

"Some therapists were very resistant to the changes," Schreiner says. "But once they got into it, it was a wonderful learning opportunity for them."

At rehab service meetings where all disciplines gather, Schreiner explained to the staff how PPS is changing the way rehab is done and the way its documented. Therapists were told that nurses, therapists, and other members of the rehab team needed to be speaking the same language and doing things the same way. All of these changes would result in better patient satisfaction, a goal that has since proved true.

"The greatest thing that helped us with buy-in was the fact that we wanted to see our outpatient referrals grow," Schreiner says. "So we identified that if we could streamline the inpatient length of stay by providing services on Saturdays, then we could get these patients out sooner and they'll go to outpatient care."

Also, inpatient therapists now communicate more closely and effectively with their counterparts in the outpatient setting, so patients can be assured of more consistent care. Occasionally an inpatient therapist may fill in for an outpatient therapist and follow the same patient across the care continuum.

While all areas now have Saturday coverage, soon, because of PPS, some Sunday therapy probably will be scheduled as well, Schreiner says.

"It would be so much more seamless and easier for patients," Schreiner says. "And we offer scheduled time off during the week for those working on weekends."

Schreiner sold therapists on the idea that it's not so bad to have a day off during the week every now and then.

"With the volume of therapists we have they don't have to rotate onto a weekend except for once every five or six weeks," Schreiner says.

Therapists also have grown accustomed to working on holidays, although that also required a buy-in.

"The key was to be empathetic and sensitive and listen to what they had to say," Schreiner explains. "I kept on reminding them, 'Remember, we all said we want to give the best patient care we can.'"

The final strategy to achieving staff buy-in was to give therapists flexibility. They could change days and hours with other therapists to accommodate child care, weekend family activities, and other requirements. ■

Integrated rehab improves referrals and cost savings

Health plans also like the change

Affinity Health System of Appleton, WI, had all rehab units integrate their documentation and operations to improve cost efficiency, quality of care, and staff time efficiency.

Now, more than five years after the health system started the process, the rehab departments are finding that it indeed provided all of those benefits. Plus, physicians and health plans express more confidence since the changes that their patients will be handled consistently across the health system.

Rehab staff now can fill in for colleagues at

various clinics across the health system, particularly when one site is busier than others or when therapists are on maternity leave, says **Maija West**, OTR, MPA, manager of rehab services for St. Elizabeth Hospital, a member of the Affinity system.

"Having documentation standardization makes it much easier for staff to walk in and out of different clinics," West says.

Managers of the various rehab units work together, meet monthly, and constantly compare processes, looking for ways to standardize systems, she adds.

Before the rehab departments integrated their processes, the rehab managers already were a cohesive group that shared ideas, West explains. "So we thought that we could use each other for our expertise and make our work more efficient if we share workloads and standardize the process."

Here are the steps the rehab managers took:

1. Standardize policies, procedures, and job descriptions.

Rehab managers asked the staff for their input, West says. "The staff gave us the blessing for the management team to go ahead with the changes."

Managers brought all of their site-specific policy manuals to a meeting. Then they reviewed all standards by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, and by CARF… The Rehabilitation Accreditation Commission in Tucson, AZ. They rewrote policies to form one standard manual for all sites.

Rewriting policies takes time

"It took time, over a year of writing and rewriting them," West recalls. "We started with the core policies and worked through those until we got down to the details."

Managers also acknowledged that occasionally there would be functions that needed to remain different for a particular site. "We have individualization in programs where it's appropriate, but we're always looking for ways to standardize," West says.

Next, they worked on job descriptions. The managers received a directive from the health system's human resources department that all job descriptions had to be rewritten, so it was a convenient time to standardize the new job descriptions. "This was handled pretty quickly," West says.

2. Revise documentation forms.

Since documentation is an enormous task, the group handled most of the changes by standardizing a form each time a documentation tool needed to be revised.

"We started with what the health information system required in forms and created a format or template of what rehab documentation would look like," West explains. "And anytime it was revised with notes, forms, clinical pathways, they all follow that format and have it done the same way across the system."

Although this started as a management initiative, staff soon formed a committee to assist with the project. The hands-on working committee, consisting of representatives from each site, is dedicated to making documentation changes.

The committee's first task was to create outpatient rehab pathways because that was something physicians and health plans often requested. They wanted to know why rehab services costs varied between sites, West says.

"We wrote those pathways and when we finished them we started to make the evaluation forms match the pathways," she adds.

Then the committee worked on inpatient forms and brought in a physical therapist and occupational therapist to assist them in drafting new forms.

3. Assess quality assurance.

Rehab managers formed a quality assurance committee that began with identifying who the customers are and what sort of feedback is needed from those customers.

"We designed a method for reporting quality information from each site and putting it into a quarterly report," West says. "All of our reports are on the same e-mail system, and we have rehab resources in our library."

The quality assurance committee looked at patient satisfaction surveys and standardized those for both inpatient and outpatient. They made recommendations for how to report information from a rehab site's quality team. Each quarter the rehab site uses the quarterly reporting mechanism the team created.

The committee didn't require rehab sites to follow a cookie-cutter approach, but there are standardized outcomes reporting tools for outpatient, inpatient, and nursing staff.

Each site selects its own quality improvement projects. A rehab quality manager can share the project with managers from other rehab sites, so that if one site has a solution; that improvement can be shared by all involved.

"They're using each other's knowledge and

working on things to save from repeating," West says. "For example, if someone is working on improving a process or productivity you can look at what they're doing and how it worked and maybe revise your own processes."

4. Form orientation and competency team.

The managers formed a team to handle standardizing the orientation and competency processes.

The team created a standardized format that each site could customize to meet particular orientation needs.

"We came up with the definition of what a mentor would be and what were the orientee's rights and responsibilities," West says.

Years earlier, managers had organized staff to assist in writing competencies, and these were turned over to the team to assess and make available for all to use. For instance, one site might have a competency for iontophoresis, a modality for pain relief, that none of the other sites has used. Now all sites can pull up that competency if there is a need for that service.

The team lets sites know which competencies will be needed for the next year for various staff.

"We keep a monthly calendar for all sites' inservices so the staff can go to any of these," West says.

This way an employee who needs a particular competency but cannot attend the inservice that's held at his or her site can go to the inservice held at a different site on the same topic.

Since the sites can pool staff to attend the inservices, this has made the process more efficient. Sites can hold fewer inservices, but make them available to more staff at one time.

5. Focus on marketing and continuing education.

Rehab managers have formed a new team to handle marketing issues for all of the rehab sites. The team includes a marketing representative from the health system.

"They'll look at what we'll do when new physicians move into the area," West says. "Also, they'll address what we will do for community service, such as health fairs and job fairs."

The marketing team also will come up with ideas for getting publicity for the rehab facilities and ways to promote rehab services.

The continuing education team identifies educational needs within the health system and makes recommendations for courses that the system might sponsor. For example, if a physical therapist attends a conference and learns about a new technique, the team might decide to hold a course on that so all therapists may learn the technique.

"The education team looks at the budgeted dollars we have and polls the staff on what their priorities are," West explains. "Then they determine what courses we'll sponsor and assist with coordinating that sponsorship."

Each site still has its own continuing education budget to pay for off-site education for staff. The education team's budget comes from one line item that is intended for sponsoring courses, West adds. ■

Proposed rehab PPS continues to draw ire

Can HCFA really make April 1 deadline stick?

The Health Care Financing Administration (HCFA) has set unrealistic deadlines for commenting on and implementing the rehabilitation inpatient prospective payment system (PPS), hospital rehab experts say.

The American Medical Rehabilitation Providers Association (AMRPA) in Washington, DC, the American Hospital Association (AHA) in Chicago, and other organizations representing rehab providers asked HCFA to postpone its 60-day comment period, saying that it didn't provide enough time for people to analyze its 700 pages of rule making and supplemental materials.

As a result of the requests, HCFA announced it would extend the deadline and give hospitals and organizations an extra month to comment.

"We were hoping we would have a 90-day comment period because in order to get the kind of background information or supporting information that HCFA would like in terms of validating our concerns, hospitals need time to look at this complicated regulation and see how it is going to affect our facilities," explains **Susanne Sonik**, director of the Section for Long-Term Care and Rehabilitation for the AHA.

HCFA remained silent on the request for weeks after the organizations sent a Nov. 21, 2000, letter, and so the AHA and AMRPA worked through the year's end to complete their comments and suggestions for the PPS rule. **(See the January 2001 issue of *Rehab Continuum Report* for article on industry's comments on PPS.)**

But the rehab industry has far more concerns

about the proposed PPS rule than just the time constraints it imposes.

HCFA's proposal to use the Minimum Data Set for Post Acute Care (MDS-PAC) is one of the industry's chief concerns, says **Barbara Marone**, senior associate director of policy for the AHA in Washington, DC.

Too little benefit to MDS-PAC

"Our attitude is that the benefits do not outweigh the cost of the MDS-PAC," Marone says. "We believe the data collection instrument that 60% of the field has used, the FIM [Functional Independence Measure], is a reasonable instrument for HCFA to use for PPS."

The FIM is shorter and has had its reliability tested by HCFA's own contractors, Marone says. "It's significantly less burdensome, and the field understands how to use it, and it's better designed for rehabilitation than is the MDS-PAC."

HCFA's proposed rule stated that one of the main reasons the agency decided to recommend use of the MDS-PAC was because it is similar to the instrument already used by the long-term care industry and thus would potentially improve the post-acute care continuum.

Marone says that while this is a good goal, it just doesn't work the way HCFA has proposed it. "They have the MDS for skilled nursing facilities, and then they have a separate system for home health care, and then they're trying to retrofit the skilled nursing facilities' instrument for rehab," Marone says. "It's not a good fit."

Instead, HCFA should let the rehab industry use the FIM instrument and conduct supportive research to develop a small core of common data elements between the post-acute care settings.

"Where they made their mistake is they try to get everything and have cast their net really wide before they figure out what they really need," Marone says. "In this era that's an incredibly wasteful and inefficient strategy."

Marone attended the December meeting of the Medicare Payment Advisory Commission (MedPAC) and says she came away from that meeting hopeful that MedPAC would recommend use of the FIM over the MDS-PAC.

"They've been on record supporting some commonality across the post-acute continuum, but [at the meeting] they said they'd like to see that ultimately, but it's not so easy to get there, and we need to be more careful," Marone recalls.

MedPAC staffers reported at the December meeting that hospitals have seen an average total margin decline to 2.8% in fiscal 1999, down from 4.3% in fiscal 1998. MedPAC also reported that about 37% of all hospitals lost money on their operations in fiscal year 1999 and 34.1% of hospitals had negative margins that year from their inpatient Medicare operations.

The AHA also takes issue with how the proposed PPS deals with the medically complex patient. "The payment won't be adequate," Marone says. "When patients have comorbidities and are complex and require a lot of resources, the system does a good job of predicting costs by length of stay, but doesn't do a good job of predicting cost by intensity of resources."

The adjustment the proposed PPS makes for comorbidities is not enough to level the playing field, she adds.

As far as HCFA's April 1 deadline, Marone predicts it will be extended.

"With a new administration coming in, there's no way the final rule will turn around and get out the door by the end of January, which is what they have to do to provide the 60-day lead time between the final rule and implementation of that rule," Marone says. "It's not going to happen." ■

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Therapy-in-park concept gives patients a little fun

Chicago hospital combines therapy and games

Inpatient rehabilitation patients have few opportunities to see a change of setting, particularly if that setting is outdoors. So Schwab Rehabilitation Hospital and Care Network in Chicago provides some rehab patients with an outdoor recreational day, called Therapy in the Park.

The event has grown to be such a big celebration that it is held only once a year. But that one day gives the hospital an opportunity to celebrate rehabilitation along with sugar-coating therapy sessions by providing patients with fun and games.

"One of the primary focuses when we began this program was the idea that therapies could be fun," says **Donnell Langston**, director of therapeutic recreation for the rehab hospital.

"We have a playground and park across the street, and we have a cooperative program between us and the park district which has made the playground wheelchair-accessible," Langston says.

Each year's theme different

Each year a different theme is selected, and this past year's was tied with The Face of America millennium ride/roll in which people with disabilities walked or rode wheelchairs across the country, meeting in St. Louis. The ride/roll was sponsored by World TEAM Sports, which stands for The Exceptional Athlete Matters. Schwab's theme was The Faces of Schwab.

Participants from both coasts stopped in Chicago at the park near Schwab over Memorial Day weekend, and the Schwab patients supported their athletic endeavor by taking a walk around the park with them, says **Lisa Rosen**, MS, CPRS, recreation therapist for the rehab facility.

"We had breakfast in the morning and some speakers from the community, and then we did the walk," Rosen says. "Vendors serving people with disabilities had different stands in the park."

"Four of our [former] patients traveled at least a couple hundred miles with World TEAM Sports," Langston says. "We had a celebration in Grant Park and a great big welcome for them with bands and food and revelry."

The patients who were able to walk or roll around the park joined the TEAM athletes. Others participated in other therapy activities, including a basketball game, dancing to a blues band, and other recreational sports activities.

In other years, the Therapy in the Park has had themes of the Olympics, a fair, music through the decades, and the Caribbean.

Langston and Rosen describe how they were able to tie therapy to games and events tied to these themes:

- **Olympics:** "Therapists had to come up with games related to the Olympics," Langston says. "One physical therapist came up with a tandem wheelchair race, not singular but tandem."

This meant that therapists and patients could work together as a team, with the therapist pushing the patient.

"Patients who had a stroke and one-side weakness could have a therapist working with them to keep the car straight," Langston says.

- **Fair:** Therapists replaced the traditional pie-in-the-face toss with a Jell-O toss. Therapists would sit in a chair with a large canvas or plastic tarp behind them. Then patients could take a small square of Jell-O and toss it at the therapist.

The patients' therapeutic responsibility was to hit the target. "Patients tried harder than some of the therapists had ever seen them doing in therapy, because they really wanted to throw that Jell-O," Langston recalls.

"They'd have fun and do therapy at the same time, and the clean-up was environmentally sound because Jell-O would melt like water," he adds. "No one got hurt."

Another fair activity simulated the greased pig chase by having a greased small watermelon that patients had to pass from one to the other without dropping. This was a high-level activity, and since the watermelon often fell and smashed open, therapists had several watermelons on hand.

One of the all-time most popular activities was the dunk tank, filled with 500 gallons of water. The hospital's president, administrators, physicians, and therapists took turns being targets. Some patients used a baseball and others a larger plastic ball.

These types of activities and the whole Therapy in the Park festival-like atmosphere is very beneficial to the psychological status of the patients and their families, Langston notes.

"We invited the family to participate because this is a way they can have fun with their loved one who has a disability," Langston says.

- **Caribbean:** Therapy for patients at high level included making a paper chain that could be hung like a lei around their necks. Patients also were given visors and sunglasses to wear, and the park's atmosphere was moved south of the border by a Caribbean band, Rosen says.

For low level patients, there was a parachute with a ball on it and a game that involved "Name that suntan lotion." There also was beach ball basketball and tube ring toss. Dancing was also available as a therapeutic activity.

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• **Music through the decades:** Each rehab department took charge of creating therapy games corresponding to a different decade. The decades of the 1950s and 1960s were put together. The decades represented were from the 1950s to 1980s.

Various therapy activities included tie dying, wheelchair dancing to disco music, tongue twister poems, bowling, swing dancing, and games such as "Name that Tune" and "Family Feud," Langston says.

Other games employed in the name of therapy have included palm reading, shell games, passing water balloons, using a real hot potato to play a hot potato passing game, and even a more recent "Who wants to be a millionaire?" game. With the millionaire game, patients had to toss a bean bag at a roulette wheel with questions. Whatever question they hit they had to answer, Rosen explains.

Generally, the Therapy in the Park day has been a big success, both in giving patients and staff at least one day to have fun with difficult therapy work, and in opening therapists up to the possibilities of taking clients outdoors, Langston says.

"After our Therapies in the Park, our therapists are a little more at ease with taking patients out to the park," he says. "It's one of the big benefits." ■

Cost tool will make PPS transition easier

'Cross-walks' ready system for MDS-PAC

When the prospective payment system (PPS) descended on skilled nursing facilities, RehabCare Group of St. Louis decided to figure out how providers could determine the profitability of patients under the new Medicare payment system.

"What we were trying to do for our clients was to manage these skilled nursing units effectively, and we found we didn't have the information readily available to do that," says **Tom Davis**, president of inpatient services for RehabCare Group, which manages 113 acute rehab units based in hospitals, 60 outpatient therapy units, and 30 hospital-based skilled nursing units.

"That need really drove us to develop what we refer to as our cost tool," Davis adds, "and what that allows us to do is accumulate RUGS [resource utilization groupings] revenue data and match that against the direct cost of treating those patients."

RehabCare has its own proprietary system for accumulating outcomes information on all patients, so the organization will adapt that system to the Minimum Data Set for Post Acute Care (MDS-PAC) that the Health Care Financing Administration (HCFA) in Baltimore proposed for inpatient rehabilitation PPS, Davis explains.

"What we've done is write cross-walks between outcomes information and the case mix groups [CMGs]," he says. "We've already accumulated all of our CMGs by unit for the last several years, so we already know the array of CMGs by unit."

Essentially, the organization has already been collecting within outcomes data the case mix-type scores for motor skills, cognitive skills, age, and comorbidities. "Since we had all the clinical information and the outcomes information on these patients, we were able to cross-walk that out-

Executive Summary

Subject:
Inpatient rehab company uses a cost tool to examine inefficiencies, best practices, and how rehab facilities will be reimbursed under PPS.

Essential points:
- ❑ Facility "cross-walks" data from outcomes data and case mix groups to show how a particular case would be paid under PPS.
- ❑ A cost tool will provide information on specifics, such as pharmacy costs per discharge.
- ❑ Data from a cost tool may help guide decisions on staffing levels and discipline mix.

comes information to show how it would appear as a payment or CMG," Davis says.

Once a facility obtains cross-walk information, it can determine how well it is going to do under PPS when compared with cost-based reimbursement.

"You go to the cost report and determine what your costs are," Davis says. "The real missing piece is what your revenues will look like under CMGs, so it's critically important to determine the number of CMGs you're going to have and the various 177 different payment groups because that determines your revenues."

There are some additional benefits to developing a cost tool. For one, a cost tool can be used to create a database for specific information, such as pharmacy costs per discharge, nursing costs per discharge, or radiology costs per discharge. Health systems or companies with more than one rehab facility can use that information to determine which site is the most efficient and then use that site as a basis for developing best practices or protocol.

Alternatively, a rehab provider could use the data to identify problem areas, such as rehab facilities that are outliers in a particular service cost. "That gives us a quick indication of where we need to do some work," Davis says.

Whether the higher costs are due to differences in ancillary utilization or nursing costs, or are a reflection of the type of patients on the unit who result in higher costs, the provider could make changes to bring the costs more in line with expectations. For example, Davis says, a facility may want to emphasize different types of patients depending on its complement of CMGs, and this information may signal the need to add new services.

Developing such a tool is not as time-consuming as implementing it, he notes. "It took probably three months to develop the tool itself, but the real difficult part was getting it implemented in the units."

Rehab staff will need to have a certain level of computer skills and be able to work with spreadsheets. Those who don't have those skills will need to learn them, Davis says.

Know your ancillary costs

Another challenge is figuring out the cost of ancillary services that are used for patients on the rehab unit.

"We have spent a lot of time with our clients, writing special computer reports that allow the hospitals to pull this information out of their computer system into a format that made sense for us," Davis says.

For instance, the hospitals are accumulating lab charges in the laboratory department, and the rehab facility will need to be able to show what the lab costs were for the rehab patients, he adds.

Another challenge for rehab providers, in general, will be to look at nursing costs because those costs have always been seen as a pass-through cost that didn't need scrutiny, Davis notes.

"Through our database we're looking at nursing best practices for nursing man hours, including looking at nursing man-hours per discharge, and using our database to look at how those costs might be restructured," he says.

"What we found on the skilled nursing units was we were able to give more nursing hours but the components were changed significantly," Davis adds. "The mix of RNs to LPNs changed, so we had reduced nursing costs, but increased man hours so patients did better and patient outcomes reflected that improvement."

The same dynamics apply to the therapy side. "This forces you to look at your mix of therapists," Davis says. "We've made changes through the years so our therapy costs are very efficient, but they can always get better."

Davis says he's grateful the company created its cost tool two years ago because now there is a database readily available for use and comparisons. "It's usable now that we know how the revenues will be generated in the units because of the CMG conversions," he adds.

RehabCare Group is poised to sprint right into using Medicare's MDS-PAC if and when this is part of the final rule goes into effect.

"We don't anticipate huge changes in our cost tool, and the only piece now that's missing is HCFA still has not published the software which is the MDS-PAC, and that's the thing we're anxiously awaiting," Davis says. ■

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Brief educational program gives staff quick update

Therapist teaches peers about neurodevelopment

Rehab facilities have limited education and training budgets these days, so it helps when a therapist decides to share new information through informal staff education sessions.

"Every Thursday we have a group meeting where therapists share expertise with those who don't pursue certification in a particular area," says **Jackie Kirkwood**, LMSW, program director for acute rehab at Tuomey Health Care System in Sumter, SC. The 250-bed hospital has 19 acute rehab beds.

One therapist, in particular, has provided weekly training and demonstrations of neurodevelopment technique (NDT), and has been very well-received by the staff, Kirkwood says.

"We've gotten very good feedback," she says. "Particularly, the patient demonstrations have been very helpful."

Archna Chadha, OT, a clinical coordinator for the rehab facility, completed the extensive NDT training, passed the certification tests, and then shared her education with colleagues. NDT was founded in England by Berta Bobath, MBE, PhD, who has worked with cerebral palsy patients.

"Since October 1999 I've been teaching every Thursday what I learned about positioning and handling techniques for stroke patients," Chadha says.

Her first free courses were attended by up to 15 therapists, and while that number has dropped, she still speaks to about four colleagues each week.

"It was very motivating to me that there are people who want to learn more about this," Chadha says. "People are interested in learning about stroke patients and using these very specialized techniques that you don't learn a whole lot about in school."

Chadha's weekly educational sessions have received positive feedback from staff, Kirkwood says.

"We've had some new graduates, and it's been very helpful to them because they haven't gotten this experience working with neurological patients in school."

Chadha also developed a stroke support group for the Sumter community, which has a very high stroke rate. There have been times when more than 60% of the patients on the inpatient unit have been stroke patients, Chadha says.

"National studies show that Sumter is the stroke belt for the whole nation," Chadha says. "We have a large number of people having strokes because of a lack of education, poor socioeconomic lifestyles, and poor diets."

The educational classes are marketed with bulletins advertising a "Neuro-Interest Group" that meets every Thursday afternoon. The bulletins read, "These classes will help you to gain understanding of neurodevelopmental treatment techniques; improve the ability to analyze normal/abnormal movements; apply NDT techniques with function in adult hemiplegia; learn handling skills useful in gaining range of motion and

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mobility with CVA patients; and most importantly, apply teamwork and overall management of the adult hemiplegia."

The bulletins are directed toward physicians, nurses, therapists, therapy assistants, rehab techs, social workers, nursing assistants, and any caregivers, including family members, Chadha says.

The weekly sessions are hands-on, with patient demonstrations using former patients who have volunteered to participate, Chadha says.

"I believe in teaching by hands-on participation," she explains.

She also discusses patients' emotional needs in the course. For example, Chadha says she does not believe therapists and clinicians should speak to a stroke patient by referring to "your good arm" and "your bad arm."

These labels send patients a message that they have a "bad" arm, and that negative message could be a self-fulfilling prophecy.

The NDT training involves learning a whole new language, rehab techniques, and a different philosophy in dealing with patients, and Chadha has tried to impart that knowledge to her colleagues at the hospital.

"I don't want to tell therapists what to do but I thought that a free education would be the best way to show them NDT," Chadha says.

After the educational sessions continued for a year, Chadha found that therapists were using these to clarify certain points about NDT or to solve certain therapy problems.

Therapists ask peer instructor about finer points

Therapists might ask her how they should address an upper body problem, for instance. "So we problem solve and when the time permits I'll co-treat with them," she says.

"The team we have is excellent and very interested in learning," Chadha says. "They say, 'I don't know what I was doing before coming to these classes,' and they say, 'My patient is doing much better than he did before.'"

Chadha's objectives for the NDT educational group are:

- to gain an understanding of neurodevelopment (Bobath) treatment principles (NDT);
- to improve the ability to analyze normal and abnormal movement;
- to apply NDT techniques to the management of the adult with hemiplegia;
- to identify problems interfering with function necessary for controlling postural tone and facilitating normal functional activity.

The group sessions focus on the following:

- observation and analysis of normal postures and functional movement;
- observation and analysis of various problems interfering with postural control and movement;
- assessment and management of the adult with hemiplegia;
- handling skills useful in gaining range of motion and mobility;
- positioning of the affected side, bed mobility, transfers training, seating in a chair and wheelchair;
- handling skills to promote normal movement, postural control, and functional activity;
- teamwork and overall management of the adult with the hemiplegia. ■

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