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Rehab Continuum Report

Outcomes
Reimbursement
Personnel Management
Quality Improvement

The essential monthly management advisor for rehabilitation professionals

INSIDE

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Special feature: Rehab in 2010+

Payment, staffing, aging baby boomers will be challenges in rehab's future

14 industry experts make predictions

(Editor's note: Rehab Continuum Report *presents this special report about how current reimbursement changes, market forces, and demographic trends will have an impact on rehabilitation care in coming decades. Included in this issue are snapshot articles about various rehab trends and how they will impact rehab's future. Articles about the future of rehab are presented in this issue and will be continued in the June 2001 issue.)*

Some monumental changes now under way likely will have a big impact on how rehabilitation services are delivered in the next decade or two, predict 14 rehab industry experts who were asked by *Rehab Continuum Report* to provide snapshots of future trends.

Those working with or in the rehab industry say there are three major forces (and many smaller ones) that are changing the industry. Medicare reimbursement, staffing shortages, and the aging baby boomer generation will have the biggest impact on the industry. Close behind will be technological improvements, including the move to paperless documentation, increased emphasis on quality by regulators, changes in private health insurance, an increased push for wellness programs and

Executive Summary

Subject:
What's in the future of rehabilitation care?

Essential points:

❏ Medicare's prospective payment system will continue to pave new roads for rehab industry to follow.
❏ Staffing problems will increase as need rises far faster than pool of qualified applicants.
❏ As baby boomers move through health care 'python,' they'll demand more education, technology.

diversification of services, and customized accreditation services.

Rehabilitation facilities will need to both improve their quality of care and cut the cost of delivering that care, says **Kurt Hoppe**, MD, medical director of rehabilitation and post-acute care services for the Iowa Health System and Iowa Methodist Medical Center in Des Moines. Hoppe also is the chair of the American Hospital Association section for long-term care and rehabilitation, and he's the chair of the American Academy of Physical Medicine and Rehabilitation health policy and legislation committee.

"It's going to require a greater understanding of the balance between quality, costs, and access," Hoppe says.

No matter how it's written, the final prospective payment system (PPS) rule for inpatient rehabilitation facilities will have an enormous impact on the way inpatient rehab operates in coming years, says **Martin Schaeffer**, MD, medical director of the department of physical medicine and rehabilitation at the DuBois (PA) Regional Medical Center.

"Up until now, rehab has been under an old cost-based system, so the incentive for managing costs wasn't there," Schaeffer says. "With the new payment system, it will greatly affect how all inpatient rehab facilities operate, and they're going to have to be very cognizant of the efficiency of the care they are providing and the costs and outcomes related to costs."

This will be a major paradigm shift in how rehab facilities operate, Schaeffer adds. "There has never been a major change like this in the history of rehab systems."

Medicare's reimbursement changes will have a dramatic effect on the industry, leading to more centralization and making it far more difficult for smaller rehab units to survive, predicts **Gary Ulicny**, PhD, chief executive officer and president of the Shepherd Center in Atlanta.

One of the changes PPS heralds is a push toward greater and more burdensome licensure regulation, says **J. Scott Gebhard**, senior vice president for Solaris Health System in Edison, NJ.

"This is going to shape the way we have to structure our systems, and they are invariably going to have the potential to add overhead requirements for each of us, making it more and more difficult to produce a [profit] margin," Gebhard says.

Medicare and other reimbursement changes will result in rehab providers having to focus more on patient and family education than they have in the past, says **Sheldon Herring**, PhD, clinical director of the traumatic brain injury program of Roger C. Peace Rehabilitation Hospital, which is part of the Greenville (SC) Hospital System.

"Under decreased length of stay, progressively sicker and sicker individuals are going home earlier and earlier, so the care demands on their families are going to continue to increase," Herring says. "Family training is an important part of rehabilitation, but in the future I think it will be of even greater importance because the family may be carrying the burden for what used to be seen as part of acute care rehabilitation."

While PPS and work-force shortages will have an immediate impact on rehab during the short term, one of the big trends to watch in the long term is the effect of the baby boom generation, typically defined as those born between 1946 and 1964, as they begin to age and need rehab services.

"Clearly there is the whole demographic issue of baby boomers getting older and having an impact on the whole health care continuum and needing more rehab services," says **Carolyn Zollar**, JD, vice president for government relations of the American Medical Rehabilitation Providers Association in Washington, DC.

Rehab services once were considered a separate health care entity, but now are ubiquitous throughout the health care system in both institutional and non-institutional settings, and this trend will only increase, says **Susanne Sonik**,

COMING IN FUTURE MONTHS

- Rehab facility uses electronic documentation to breeze through CARF survey
- Future rehab facilities will place greater emphasis on wellness, prevention programs
- Patients are active sooner in specialized head injury program
- Facility makes good use of muscle-building machine for SCI patients
- Reunions may be just the ticket to lift staff, former patients' spirits

director of the section for long-term care and rehabilitation of the American Hospital Association in Chicago.

The baby boom generation, which is a very sophisticated consumer group, recognizes the need for rehab in a variety of health situations and will ask for more flexibility and control about where and when their rehab services are offered, Sonik says.

"And their preference is not to be hospitalized or institutionalized whenever possible, so the preference might be home health rehab services," Sonik adds.

Baby boomers also have far greater expectations for recovery than did previous generations, notes **Nancy Beckley**, MS, MBA, president of the Bloomingdale Consulting Group of Valrico, FL.

"In our parents' generation, when a doctor told them that they had a stroke and so now they'll have to take it easy, they would take it easy," Beckley says. "People in the baby boom generation may have a stroke, but they'll ask what they need to do to get back to work the next week."

Baby boomers expect a lot from health care, and they think that whatever they want, health care should deliver, Beckley adds.

The baby boom also is more computer-savvy than previous generations. This means they have access to health care information on-line, which makes them more likely to ask tough questions of their health care providers, says **Peggy Neale**, MA, MBA, national director of medical rehabilitation for CARF…The Rehabilitation Accreditation Commission in Tucson, AZ.

"They want more information, and they have a lot of questions, and if they don't ask for it, their children will," Neale adds.

Neale also notes that the rehab industry will need to become more technologically advanced itself for a multitude of reasons, including improving patient care, improving documentation, and making the accreditation or regulatory survey process easier. **(See story about a rehab panel's identification of trends in medical rehab and how these would affect CARF, p. 67.)**

CARF recently began to experiment with web-based accreditation surveys and conducted a very successful intranet survey at Glancy Rehab Center of Gwinnett Hospital System in Duluth, GA, Neale says.

Glancy Rehab Center has reduced hours of staff time and paperwork by designing a web site, used in-house, that includes all of the center's documentation, compliance records, and

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standards, says **Katrina Stone**, MA, education coordinator of post-acute services.

A CARF surveyor had access to the facility's web site and conducted the paperwork review portion of the survey entirely by reviewing the electronic files, Stone adds.

As the baby boomer generation ages and begins to experience health catastrophes, the sheer size of this group will require rehab facilities to offer more diverse rehab services, including cardiac-pulmonary rehab and rehab for patients with neurological deficits secondary to the effects of cancer, brain tumors, spinal tumors, and other problems, says **Melinda Clark**, president of SSM Rehab in St. Louis.

Expected growth in the need for rehab services also will have a big impact on staffing, which already is a major concern for some rehab providers.

"It's clear to me, when you simply look at the demographics, particularly in a state like Maine with a very aging population, we'll have a greater demand for our services," says **Greg Gravel**, president of MaineGeneral Rehabilitation and Nursing Care in Augusta, ME.

"The challenge for us is: Where will we find the professional staff?" Gravel says.

The American Occupational Therapy Association (AOTA) in Bethesda, MD, has observed a diminishing enrollment in occupational therapy schools, which could present future problems unless it's reversed, says **Maureen Freda Peterson**, MS, OTR/L, practice department director for AOTA.

Part of the reason for the decrease in enrollment may be that women — who account for close to 98% of all occupational therapists — have more professional opportunities today than ever before, so they may be choosing non-health care fields more frequently, Peterson explains.

Since 1998, the number of applicants to the 212 physical therapy schools has decreased, but the schools still have an adequate supply of qualified applicants, says **Ben Massey Jr.**, PT, president of the American Physical Therapy Association in Alexandria, VA.

"In the mid-1990s, physical therapists were in high demand, and then with the Balanced Budget Act of 1997, there have been quite a few changes," Massey says. "Up until a year ago, we had about 3.2% unemployment for physical therapists, and now it's down to 1.8%, according to a recent survey, so in fact right now there are PTs that are looking for jobs." ■

Special feature: Rehab in 2010+

Rehab must use new technology to survive

Improved technology could only help rehab

Rehab industry insiders point to two key reasons why rehab facilities need to move to electronic documentation and use new technology in other ways. First, electronic documentation will improve the industry's appeal to young people entering college and deciding on a profession. Second, it will enable the industry to better meet tighter financial constraints.

The first issue, staffing, is now on everyone's minds as the entire health care industry faces shortages of staff in nursing, pharmacy, and other fields.

While it's a little easier for rehab facilities in some areas to find physical therapists, other regions of the country are experiencing shortages. New trends in occupational therapy school enrollment also indicate that shortages of OTs are not far behind.

A work force supply report issued by the American Hospital Association (AHA) in Chicago on Jan. 23, 2001, cites a number of reasons behind the current staffing problems, but the main reason listed is that hospitals and health care providers are no longer seen as the favored employer.

The AHA notes in its report that when the U.S. economy was chiefly a manufacturing economy, health care was seen as high tech, but now that the country is in an information economy, health care is seen as low tech.

"I think to a certain extent, health care is viewed as being somewhat archaic in its use of technology that now defines worker productivity," says **Kurt Hoppe**, MD, medical director of rehabilitation and post-acute care services for the Iowa Health System and Iowa Methodist Medical Center in Des Moines. Hoppe also is the chair of the American Hospital Association section for long term care and rehabilitation, and he's the chair of the American Academy of Physical Medicine and Rehabilitation health policy and legislation committee.

"For some reason, the industry has not been able to provide a positive or appealing picture of what it means to work in health care nowadays," Hoppe adds.

(Continued on page 65)

REHABILITATION
OUTCOMES REVIEW™

A rehab team deals with having one of its own as a patient

Quality care became personal for Alabama facility

(Editor's note: Staff at Healthsouth Rehabilitation Hospital of Montgomery, AL, found their normal empathy for patients stretched to the limit in February 2000, when one of the facility's case managers became a traumatic brain injury patient after suffering from two berry aneurysms. June Fowler, RN, nearly died from the aneurysms, which occurred during the Christmas season of 1999. Her slow and miraculous recovery was championed by the entire rehab staff, who helped her recover to the point that she's since returned to rehab work. Fowler and a co-worker/friend each wrote an article about their experiences when Fowler went from being a member of the rehab team to being a patient. Fowler's physician also wrote a brief piece explaining her injury. Rehab Continuum Report *presents their stories as follows:)*

A member of the rehab team's miraculous recovery

By **Joan Greene**, RN
Case Manager
Healthsouth Rehabilitation Hospital
Montgomery, AL

At lunch in December 1999, rehab case manager **June Fowler** had her usual salad and was smiling and looking ahead to a long-awaited trip with her husband over New Year's. We were talking about Christmas with our families when June suddenly looked around to the other case managers seated at the table and remarked, "I hope nothing catastrophic happens to me early in life."

Her remark surprised no one at the table, because in rehab we see this reality on a daily basis. What we also see is the wonderful work our team at Healthsouth Rehabilitation Hospital in Montgomery provides.

Later that afternoon, as I walked toward the front door, one of our rehab techs came running up to me, saying, "Come see about June, we think she's fainted!" A Dr. Stat was in progress. As I arrived in the room, I could not believe my eyes. There was my friend and co-worker in an apparently life-threatening crisis.

An ambulance took June to Baptist Hospital in Montgomery, and our rehab hospital's physiatrists were our eyes, ears, and messengers through the crisis period. Her status was listed as a massive subarachnoid hemorrhage. She was not expected to make it through the night.

We prayed, and our close-knit staff began an immediate outpouring of love, financial support, and other gestures of aid. Our human resource department set up an area for ongoing donations of cards, gifts, and food for the family as they kept vigil at the hospital. We did everything we could, but were not permitted to visit her during those first traumatic days.

June made it through that night. And another, and another.

Finally, the ventilator was discontinued, and June was transferred to an Atlanta hospital to be seen by a neurologist who specializes in aneurysms. The MRI revealed not one but two aneurysms, one of which had bled massively. June was diagnosed with having had berry aneurysms, which we knew made her outlook bleaker.

She remained unconscious. New crises emerged regularly, and it began to look as if June's time for recovery was running out. Then June began to defy all odds. Her extremities began to move, and she began to recognize her family and friends. She began to speak, asking about her

patients at Healthsouth, and she even woke up one day worrying about being late to work.

Weeks passed. The staff continued to pray for her, and the Atlanta hospital continued with many tests and surgeries. At last in February, 2000, June was transferred to our own rehab hospital, and William Rogers III, MD, was her physiatrist.

Although June had many challenges ahead, we were encouraged by how she remembered each of us by name. Only her short-term memory was absent. The staff did everything we could to help her, including eating with her, bringing her homemade soup, and spending time with her.

Soon, she was trying to convince us to give her scissors so she could cut off her pelvic restraint, or "just untie me," she said.

One day, she rolled her wheelchair into the case managers' office and went straight to her desk where she proceeded to pick up a pencil, access her voice mail, and retrieve all of her messages. We had left her messages intact because no one had her personal voice mail code. We were so excited! Words cannot describe the utter joy we felt as we witnessed her triumphs.

There were disheartening times, such as her double vision, but we were still convinced she was on her way to recovery of an independent life. We were glad we could assist her in this objective, because as with all of our patients, she was going to get our best efforts, and the staff had moved into high gear.

Before we knew it, June was discharged home. She continued to visit Healthsouth for her outpatient therapy, despite the 45-minute drive, each way, three times a week.

What happened next was no surprise, because it was what we had been planning and hoping for to happen: June returned to work in the case managers' office. Our administration had supported June by keeping her job secure. Then, as part of her outpatient treatment, Darlene Barnes, speech therapist, designed a vocational rehab program for June in which she would work in our office. So June sat in on team conferences, discharges, and admissions, while under supervision and while receiving staff support. We used competency checklists and other tools to make certain June was getting what she needed in order to return to independent work, play, and life.

June's double vision, sleepless nights, and headache persisted, and so did we. On the last day of June's therapy, she visited our office once more. She was chomping at the bits to be 100% recovered, and we assured her that with time her vision would clear. Her cheerleading squad of myself, Marlene Herring, Sharlotte Rogers, Elizabeth Eiswerth, Joane Green, and a host of other staff sent her home with well wishes and continued hope.

Weeks later, I was called to the clinic. My heart raced as I sped there, hoping all was well. June had already been through so many challenges! When I walked in I immediately saw June, sitting beside her husband, Bennie Fowler. Smiling like a new penny from ear to ear and wearing no eye patch, she exclaimed and laughed, "I can see perfectly. I'm ready."

June now has been discharged by her physicians as "100% cured." She's begun attending continuing education unit programs and is back to full-time work. The members of the rehab team stop and smile each time we see her walk confidently down the hall, talking with patients, or driving her car. It's such sweetness to be able to welcome her home. ■

Here's an explanation of berry aneurysms

By **William N. Rogers III**, MD
Healthsouth Rehabilitation Hospital
Montgomery, AL

A berry aneurysm is a small, localized widening or outpouching of an artery that looks a lot like a berry. Berry aneurysms usually occur at branching points of arteries.

Classically, they can be found at the point at which a cerebral artery departs from the circular artery known as the "Circle of Willis" at the base of the brain. They are thought to occur due to the congenital absence of media and internal elastic lamina within the blood vessel wall, with ballooning occurring as blood pulsates through the vessels over the years.

That is to say, one is born with the abnormality, and high blood pressure or straining can ultimately cause the aneurysm to rupture. This may result in subarachnoid hemorrhage and the patient reporting the worst headache of his or her life. Rupturing most commonly occurs when the patient is in middle age, and it can cause neurologic deficits and even coma. The treatment includes surgical clipping to stop the bleeding, followed by rehabilitation. ■

Rehab care is high-quality in this patient's opinion

It's hard work being on the other side of rehab care

By **June Fowler**, RN
Case Manager
Healthsouth Rehabilitation Hospital
Montgomery, AL

Joan Greene, a friend and co-worker, has done a good job telling the story of my injury and recovery. What she cannot do for me is thank everyone on the Healthsouth rehab team who contributed to my recovery. I had to ride in the wagon a while with some of the staff pulling and the rest pushing.

Due to a short-term memory deficit during the early stages of my illness, my memories were through the eyes and ears of my husband, Bennie Fowler. Now my memory is intact, and when I think of where I was then and where I am today, I can only smile because I know how many dedicated and professional rehab people helped me get here.

What I remember most during my experience as a patient is how positive and caring the staff were to me. I cannot recall any one specific therapist during the time I was an inpatient because all of their smiling faces parade through my mind. Still, I know that each and every person on the rehab team was involved in some way, if only by a smile or encouraging word.

My family kept a book for me. It was a testimony to the love and support the rehab staff provided us. Some members of the rehab team even devoted time at home to cook for Bennie, who spent every spare minute at my side. My physicians, Felix James Allen, MD, and Thomas Rigsby, MD, were supportive and willing to refer me to an expert on aneurysms when it became medically necessary. When I returned to Healthsouth Rehabilitation Hospital, William Rogers III, MD, became my physiatrist, and despite my antics he carried on and got me through the ordeal. The doctors and entire staff cheered me on.

As a patient, I was no exception. I tried everything, including escape, and as a result I had to sleep in a vail bed and use a pelvic restraint. The difficult part was probably the fact that I am a nurse and thought I knew it all. Yet, the staff persisted in their dedication to their job and to me and gently prodded me to go on.

By the time I was discharged to outpatient rehab therapy, I was so geared up that I wanted it all, and I wanted it NOW! However, there was Ted Price, physical therapist, cracking the whip. You can believe that he knew how to keep me in line. My stubbornness kicked in a few times when he insisted I jump flat-footed on a 2x4 and stand in the middle of the gym like the crane bird on one foot. But you know what? I did it all! Now I'm back to work.

Since returning to work, I have been meeting one of the biggest challenges of my life. It would have been far more difficult for me to meet this challenge if it weren't for the support of everyone in the rehab hospital, including the administrators who held my job, speech therapist Darlene Barnes who was instrumental in my vocational rehabilitation, and especially the support I received from the other five case managers, who have cried, laughed, and sacrificed to have me back to work with them. ■

CARF involves consumers in accreditation process

By **Yolande K. Bestgen**
Vice President of Strategic Development
CARF…The Rehabilitation Accreditation Commission
Tucson, AZ

Consumers are a very important component of the accreditation process, and the CARF survey process considers their input. This is a brief update on how CARF includes consumers in decisions that affect rehab facilities' accreditation.

Areas in which consumers are involved in CARF, including areas to further develop, include:

- **Board of Trustees:** Persons who are recipients of the services of CARF-accredited programs serve on the CARF Board of Trustees. They are primarily listed as at-large members and are recruited for their expertise as consumers of services.
- **Standards Development:** When accreditation standards are developed or revised, CARF holds a planning meeting called a National Advisory Committee (NAC). There are anywhere from 15 to 30 stakeholders who participate on this committee to review and/or to develop standards. These stakeholders include providers, consumers, funders, government regulators, and

advocates. The CARF Board of Trustees has established a policy that a minimum of 20% of the participants be consumers.

• **Field Review of Standards:** Once the NAC has developed the new or revised standards, they are sent to the "field" for review and feedback. All stakeholders are included in the mailing for this review. It is typical to have 500 to 700 copies of the draft standards mailed out.

Every piece of feedback is reviewed and brought to the CARF Board of Trustees for final approval of the standards. With such a close scrutiny, we find that once the standards are finalized, there is a significant consensus from all of the stakeholders regarding the new standards.

• **Survey Process:** The Medical Rehabilitation Division has a cadre of parent liaison surveyors who participate when an organization seeks accreditation for pediatric/family-centered rehabilitation programs. All parent liaison surveyors have children with impairments who have participated in rehabilitation programs. Parent liaisons were selected and trained by CARF and were all nominated by accredited programs.

The parent liaisons telephone parents of children in the program being surveyed and ask parents additional questions about how they were included in the rehabilitation process. The chance for a parent to discuss with another parent, who had the experience of having a child in a rehabilitation program, brings not only additional insight but also the opportunity to talk openly with someone who has been through similar circumstances.

At the CARF Board of Trustees meeting last August, several other initiatives were passed to enhance consumer participation in the survey process for all divisions of CARF. The interview policy was expanded so an organization still can identify a consumer to be interviewed, but CARF surveyors now may also choose one or more consumers to interview during the site survey.

In keeping with the spirit of consumer involvement, surveyed organizations will now also be sent a form to be posted at least 30 days prior to their survey notifying the public of the survey. The poster provides interested individuals several ways of contacting CARF if interested in being included in the survey, including a toll-free comment line as well as increased information on the web site.

CARF added a toll-free consumer comment line as well as increased the information on the web site on how consumers can respond to CARF regarding an accredited organization.

A new standard will be added in all divisions' 2001 standards manuals stating that the organization should review all complaints received by consumers and analyze the complaints for trends. The standards specifically refer to complaints received only from consumers and do not cover those complaints an organization receives from other parties.

CARF has already received positive comments from consumers, payers, and providers regarding this expanded consumer involvement.

• **Education and Training:** CARF has several publications that are devoted to consumers and will assist them with techniques to use in selecting a quality provider. This includes a brochure with quick checklist-style questions for the consumer to use when selecting a service provider. There also is an extensive consumer guide on selecting a provider and how to design individualized services.

CARF holds three international conferences each year in the fields of behavioral health, medical rehabilitation, and employment and community support divisions. In recent years, consumers have provided valuable contributions to these conferences through keynote addresses, seminar presentations, and other educational offerings.

Finally, CARF has a web site that is open to the public, and more information can be obtained there. The web site address is: www.carf.org. ■

(Continued from page 60)

The Iowa Health System has staff openings on an ongoing basis in the areas of nursing, pharmacy, and medical transcription, Hoppe says.

MaineGeneral Rehabilitation and Nursing Care in Augusta has had a more severe staffing crisis that includes therapists and therapy assistants, and it does not appear to be improving, says **Greg Gravel**, president.

"Our biggest challenge is finding people, particularly for long-term care jobs," Gravel says.

"We're seeing declines in enrollment for physical therapy assistants and occupational therapy assistants at our local vocational tech college," Gravel adds.

Students are gravitating toward gadget-oriented jobs, such as computer technology. Unless rehab facilities start to use bedside computers or Palm Pilots and other high-tech devices to make rehab jobs seem sexier, they'll continue to lose potential workers, Gravel predicts.

Improved technology also will assist rehab facilities financially as they move into the prospective payment system environment, some rehab experts predict.

Rehab facilities will need to do cost-efficiency analyses that will require electronic data and sophisticated computer software.

Computerized cost analyses will help a rehab facility prioritize therapy services and take a close look at which services need to be offered on a less routine basis because they are less beneficial in an analysis that compares costs and outcomes, says **Martin Schaeffer**, MD, medical director of the department of physical medicine and rehabilitation at DuBois (PA) Regional Medical Center.

Information reporting systems will need to interact with third-party payers and others requesting information, and they'll need to speak the Medicare terminology, according to **J. Scott Gebhard**, senior vice president for Solaris Health System and administrator of JFK Johnson Rehabilitation Institute in Edison, NJ.

"We have to have those data systems in place both as communication tools and internal management tools for utilization and outcome measurement purposes, and it's a big challenge," Gebhard says.

In the future, rehab facilities will need to make better use of computer technology for documentation and perhaps even for accreditation surveys, says **Peggy Neale**, MA, MBA, national director of medical rehabilitation for CARF...The Rehabilitation Accreditation Commission of Tucson, AZ.

Also, rehab facilities may find that the Internet and other uses of computer communication technology are a good way to supplement hands-on health care. Already, consumers are using the Internet to do their own research about their health problems, Neale says.

"I think health care has been the slowest to get on the technology bandwagon, but consumers are pushing for it, and there will be more advances in web-based use of health care," Neale says. ■

Special feature: Rehab in 2010+

'Continuum of care' will be key words in 21st century

HCFA is hinting at a one-stop rehab shop

The government's move in the past decade to change Medicare reimbursement for every segment of the health care continuum foreshadows what some industry experts say is a long-term plan to move to a system where Medicare makes one payment to one provider for all of a patient's health care needs.

"What I think the government wants is a move towards total management," says **Martin Schaeffer**, MD, medical director of the department of physical medicine and rehabilitation at DuBois (PA) Regional Medical Center in DuBois, PA.

Schaeffer predicts that the Health Care Financing Administration (HCFA) in Baltimore will use the data it collects from rehab facilities and other health care providers to determine what the total cost is to take care of any particular patient illness or catastrophe.

"I think they're going to say, 'Based on historical data, we know what the total cost should be, and we'll now pay one entity that total cost, and that entity can provide the ambulance, hospital, nursing home, rehab unit, and home health with that one lump payment,'" Schaeffer says.

This shift will force rehab facilities to form more contractual alliances, affiliations, and networks with other providers in order to create that seamless continuum of care from the moment a patient is injured or ill to the moment the patient is discharged from home health care, Schaeffer adds.

To survive, rehab facilities will need to be more flexible and less encumbered by physical or departmental walls, says **J. Scott Gebhard**, senior vice president for Solaris Health System and administrator of JFK Johnson Rehabilitation Institute in Edison, NJ. The health system has two acute care hospitals, three long-term care facilities with more than 600 beds, 100 comprehensive rehabilitation beds, and 20 outpatient settings.

"Rehab facilities cannot lose focus on the skills needed to provide care, but they will need to provide it in different settings that may change from year to year," Gebhard says.

"Within a very large health care system with acute hospitals, long-term care [LTC] facilities, outpatient, home care, etc., we'll need rehab services that can effectively and efficiently work across those different environments," Gebhard adds.

Rehab facilities will have to cross-train staff and give therapists opportunities to work in different settings.

For example, the Solaris Health System has a team of 80 physical therapists who rotate and cross-train for work across the entire continuum of care, Gebhard says.

Rotation provides learning opportunity

"We have permanent positions in LTC, but we'll rotate the permanent positions, and this gives the therapist an incredible learning opportunity," he explains. "It affords the health system the ability to have some flexibility in its staffing, and it's been set up so it's not done as an onerous burden, but to give therapists options and to award them the ability to move from environment to environment without having to leave our system."

At Solaris Health System, staff physicians also cover the entire continuum of care, including acute care, inpatient, and subacute care, Gebhard says.

"It'll be the same team, but not necessarily the same physician," he notes. "We have 20 full-time physiatrists with a common medical leader."

Large health systems, such as Solaris, may find it easier to own their entire continuum of care. Most other systems will probably have to struggle with the pros and cons of ownership, says **Kurt Hoppe**, MD, medical director of rehabilitation and post-acute care services of the Iowa Health System in Des Moines. The health system's rehab unit has 54 inpatient beds and provides outpatient services.

"The question all health systems have to wrestle with is how much of the continuum do you own, and how much do you outsource?" Hoppe says. "It used to be easier to manage those [rehab] patients, but nowadays, given the fact of inadequate reimbursement, especially in skilled nursing, it's hampered our ability to move those people as efficiently as possible along the continuum."

Health systems that increase their flexibility to move rehab patients through a continuum of care, whether it's through ownership or partnerships, still will have to contend with HCFA's regulations that are intended to thwart providers from moving patients to less expensive levels of care without consideration of clinical outcomes.

HCFA will watch for 'gaming'

"We do know that HCFA sees that scenario as a potential for gaming the system and has tried to build into each different step in the PPS [prospective payment system] process measures to prevent people from being inappropriately transferred," says **Sheldon Herring**, PhD, clinical director of the traumatic brain injury program at Roger C. Peace Rehabilitation Hospital in Greenville, SC.

HCFA will have penalties for providers who discharge patients too quickly to inappropriate levels along the continuum of care, Herring adds.

Nonetheless, it's clear that HCFA would love to see all acute care, rehab, home health, and other types of medical care bundled under one super-payment, Herring says. This is not necessarily a bad thing, but for it to succeed there will need to be certain conditions, he maintains. Herring outlines these conditions for success:

- The amount of reimbursement must be reasonable.
- The purchaser, whether it's the U.S. government or an insurance company, should give the provider some significant clinical latitude along with the financial burden.
- The purchaser should purchase a level of outcome and not try to prescribe the process or different options to be considered.

"Where it becomes a losing situation for the provider is when we absorb the entire financial risk, and then the payer comes in and says we don't want any of that money spent for adult day care or for transportation," Herring says. "I think in the beginning, HCFA's checks and balances might end up being intrusive." ■

Leadership panel identifies future trends

CARF pulls together 22 people

CARF…The Rehabilitation Accreditation Commission in Tucson, AZ, asked 22 people — representing the rehab industry, rehab consumers, and others — to identify the major trends that will affect the industry's future.

The Medical Rehabilitation Leadership Panel met in June 2000 and came up with this list of the major rehab trends and their implications: consumerism; decreased payment for medical rehabilitation services; E-health; technology; a need for improved access to service; increased regulatory environment; strategic alliances, partnerships, and linkages; increased scrutiny on the value of accreditation; increased need for flexibility and innovation in rehabilitation; and globalization.

The panel identified these five top trends:

1. Consumerism.

• Aging baby boomers will press for increased attention to cultural diversity, increased need for information, and broadening of CARF's image to include more than rehabilitation.

• Consumers want more specific information. Some examples include risk-adjusted outcomes, efficiency measures, comparative shopping measures, and ways to differentiate providers.

• CARF's response to consumers' demand for information may cause discomfort among providers, leading to a short-term risk for CARF as such providers weigh the pros and cons of CARF accreditation.

• CARF's consultative style may be challenged, so CARF may need to take a more prescriptive and inspective role.

• CARF has the potential to play a role as an information broker.

Striving to maintain flexibility

2. Increased need for flexibility and innovation in rehabilitation.

• CARF needs to be able to adapt easily in this fluid environment.

• What is being analyzed: Multiple providers, networks, and programs may create duplicative accreditation among organizations.

• There will be tension between evidence-based rehab services and innovation, such as in the alternative medicine movement. CARF has a responsibility to respond to consumers' requests for information in these areas.

• Organizations will continue to have an expanding and changing scope.

• There will be a renewed emphasis on knowing CARF's customers.

• The boutique survey model has the potential to become the norm.

• If CARF became more flexible, it could increase revenue by focusing on education to consumers and payers.

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3. Decreased payment for medical rehabilitation services.

• There is a greater need for providers to be able to document the value of rehabilitation in terms of cost and outcomes.

• The cost of accreditation is now prohibitive for some organizations.

• CARF needs to show financial and other tangible values of accreditation.

• CARF is challenged to maintain standards in a shrinking reimbursement environment.

• A change in funding offers opportunities for CARF.

• Long-term acute care hospitals have more rehabilitation occurring, and it is outside the prospective payment system.

• Determine the impact on the quality of outcomes: PPS or other funding streams for services to high need individuals may affect what services the organization can provide in the future.

• Providers want higher value and distinct accreditation recognition.

How is accreditation valued?

4. Increased scrutiny on the value of accreditation.

• The lag in numbers of organizations seeking accreditation will continue.

• The goals of providers and accrediting bodies will continue to conflict.

• There is a perceived lack of distinction among accreditation awards.

• Many organizations do not recognize the value of accreditation.

• There is a need to increase the value that accreditation has for health care consumers. The National Committee for Quality Assurance health plan report cards are problematic and not easy to develop, but useful. Further exploration is needed on how to identify benchmarks of quality.

• Consideration should be given to developing a method of providing services and information during the crisis period for the newly injured / disabled.

• There is a greater need to inform the public about CARF and the value of accreditation.

• The value of accreditation varies across the country: It has more value in a competitive environment and less value if there is only one major provider in the area.

• Consumers will continue to seek quality review and answers to their questions about health care, rehab, and accreditation.

• Payers want a way to control costs.

5. E-health.

• Develop E-health as a service for consumers, providers, and payers.

• E-health and CARF are a match. CARF communicates with the world, including stakeholders and potential clients.

• E-health is here to stay.

• Consideration should be given to the role of a "filter" for web information.

• Some consumers still do not have access to technology.

• Internet accreditation should be considered.

• There is a great need to enhance CARF's current web site.

• CARF may need to shift its current operational structure to keep pace, such as through an E-unit.

• There exists a business opportunity for CARF and new virtual E-health sites. CARF could be the organization to distinguish quality. ■