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Rehab Continuum Report

Outcomes
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Quality Improvement

The essential monthly management advisor for rehabilitation professionals

INSIDE

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HCFA changes assessment tool, so what will happen to reimbursement rates?

MDS-PAC is out; FIM is in

The more than 400 letters and comments that rehab providers sent to the Health Care Financing Administration (HCFA) in Baltimore convinced the government to revise its proposed patient assessment instrument for the rehabilitation prospective payment system (PPS). The new tool will be far simpler and less time-consuming and is based on the adult Functional Independence Measure (FIM) instrument, which is what most rehab providers already use.

The new tool, called the Inpatient Rehabilitation Facility - Patient Assessment Instrument, will be used at assessment at admission and discharge. The tool has three pages with 54 numbered items. On the other hand, the Minimum Data Set - Post Acute Care (MDS-PAC) had more than 350 pages and would have required up to five assessments. The new tool is estimated to take about 30-40 minutes to complete, whereas the MDS-PAC would have required a couple of hours. **(See copy of revised proposed assessment instrument, inserted in this issue.)**

Another major improvement is that the new tool uses nearly the same rating scales as used in the FIM, while the MDS-PAC would have had a separate and completely opposite rating scale to the FIM.

Rehab industry experts and providers say they are very pleased with

Executive Summary

Subject:
The Health Care Financing Administration shelved its proposal to use a 350-page inpatient rehab assessment tool and instead will have facilities use a far simpler three-page instrument.

Essential points:
- ❑ Proposed tool is expected to take 30 to 40 minutes to complete.
- ❑ The tool is based on the Functional Independence Measure, which many rehab facilities already use.
- ❑ The revised instrument will only be used at admission and discharge.

the change, and they give HCFA credit for listening to their concerns. Now, the only remaining question is what HCFA will do in regard to the concerns centering around the weights applied to comorbidities and reimbursement rates.

"Basically, we're very pleased with the proposed assessment tool," says **Barbara Marone**, MBA, senior associate director of policy for the American Hospital Association in Washington, DC.

"We could fine-tune this and tweak it a bit, but we're really just pleased that they were so responsive to the field," Marone adds.

HCFA's move to make the major assessment tool changes is a clear indication that it understands that acute inpatient rehabilitation is a different level of service from either skilled nursing care or home health care, says **Susan Cerletty**, senior vice president and chief operating officer of Rehab Institute of Chicago. Rehab Institute is the top rehab provider in the country and has 39 locations in Illinois, representing more than 300 beds either through ownership or partnerships.

"Certainly with the adoption of the FIM tool, we know that rehab facilities will be able to transition to the new system more easily," Cerletty says.

Some small rehab units unfamiliar with FIM

While about 85% of rehab units use the FIM, 45% of the small rehab units inside hospitals still don't use the instrument, so the training and implementation process will be more complex for these facilities, Marone says.

"There will be a bit of a learning curve for our members who are more likely to be hospital-based units," Marone adds.

The other issue with the change is timing. Rehab providers wonder whether HCFA will be able to implement PPS by October because there's still a need to create software that will enable HCFA and rehab facilities to exchange information by computer, Cerletty notes.

Still, it's a good sign that HCFA has published its revised tool within a few months of the end of the comment period on the proposed rule, because it brings the industry a little closer to the Oct. 1, 2001, implementation date, says **Carolyn Zollar**, JD, vice president for government relations, American Medical Rehabilitation Providers Association in Washington, DC.

"There are some things that need to be clarified, and we hope that whatever HCFA has to do [to clarify its intent] can be done as quickly as possible," Zollar says.

Obviously, the shorter, new assessment instrument is a vast improvement over the MDS-PAC and will make life a lot easier for rehab facilities and their staffs, says **Sheldon Herring**, PhD, clinical director of the traumatic brain injury program at Roger C. Peace Rehabilitation Hospital, which is part of the Greenville (SC) Hospital System.

Rehab providers wait for other changes

"Everyone is breathing a sigh of relief and waiting for the other changes," Herring says. "We still don't know the financial information and the calculations."

Herring says he still is concerned about the cognition scales, which he views as somewhat weak for certain populations, and he'd like to know what HCFA intends to do about factors affecting cost and length of stay.

HCFA may find that it's necessary to look in more depth at the area of cognition for stroke and head injury cases. Neither the MDS-PAC nor the current proposed assessment instrument is psychometrically sound in that area, Herring states.

Another detail that needs to be addressed is the disproportionate share calculation, which is the effort to recognize the cost of serving low-income people. The buzz in the field has it that there will be an effort to make sure the adjustment is not so dramatic as it appeared to be in the proposed rule, Zollar says.

"If you ended up with a policy incentive and everyone is depending on the disproportionate share for how the payment is calculated, then it's not from a policy perspective what a prospective

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payment system is all about," Zollar says. "The net result of that is that it should increase, and we'd be hopeful it will increase the conversion factor."

Herring says the disproportionate share calculations could have a major impact on his facility's program. "It's nice to know that data collection will be easier, but we really need to know more about the actual reimbursement," he adds.

The Rehab Institute of Chicago also treats a fairly large share of people who are disadvantaged, Cerletty says.

"Refining the disproportionate share calculation is not a bad idea," she adds. "We just need to be certain it will do what it's intended to do, and that is to provide reimbursement to hospitals that are caring for more of these disadvantaged patients because they typically have more medical needs than patients from more affluent socioeconomic backgrounds."

Rehab providers should soon learn more about reimbursement under PPS, and that's the most important issue, Herring says.

"It's almost like the debate over the MDS-PAC was somewhat of a distracter to the field because the largest issue always has been the actual reimbursement levels and how it will impact individual hospitals," Herring says. "We still want to see the final formula so that we can begin to look at our actual costs in relationship to anticipated reimbursement levels." ■

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Facility goes from worst in market to best

Key was retooling staffing and direct sales

SSM Rehab of St. Louis had a $2.7 million loss in 1998, but after changing its operations strategy the facility increased its market share, grew 28%, and made a $900,000 profit a little more than a year later.

Moreover, the rehab facility improved its market share from fourth in its market to No. 1.

How did the rehab facility achieve this minor miracle? Managers took a hard look at operations, staffing, and the organization's overall philosophy and made a concerted effort to make changes, no matter how small or large.

"Our biggest problem was we were running at a 50% to 55% occupancy rate, and we were going along doing business as usual," says **Melinda Clark**, president of SSM Rehab, which owns or operates 104 rehab beds in St. Louis and 44 beds in Oklahoma City, OK. SSM Rehab also has 14 outpatient locations.

"We were consistently losing money and weren't paying attention to cost details," Clark adds. "So we pulled a group together and said, 'What are we going to do as an organization to change this?'"

Managers decided to assess all jobs and job functions for how that position could be improved to better enhance the organization and the employee. They also evaluated the referral and admission process, the marketing department's strategies, billing, transcription work, collections, and the organizations' core business and goals.

After completing a thorough assessment of operations, they decided to make some major changes, including cutting about 10% of jobs, all of which were nonclinical, Clark says.

"We looked at operational areas where we could gain efficiency with our processes," Clark adds.

Here are some of the strategies the organization employed in its efforts to improve operations, market share, and financial standing:

1. Re-evaluate the value of all staff positions.

While this was in some ways the most painful of the changes, it was enlightening and resulted in a far more efficient work force, Clark says.

"We went through the organization and

looked at the different functions people were doing," she says. "We found that the registration processes were not as good as they should be, and we learned more about what some employees were doing in their jobs."

For example, they discovered one employee who had spent the past seven years writing reports, but none of the administrators and executives had ever seen one of her reports. "She had a filing cabinet full of these reports, and she thought somebody somewhere would have need of one," Clark says.

Managers also took a closer look at their outsourced activities and found that there were areas among these that needed quality improvement.

For instance, the transcription work was done by a contractor, but it wasn't producing reports that met quality standards, because the transcriptionists did not accurately pick up all of the words that were dictated, Clark explains.

Sometimes FTEs are better than contractors

So the facility hired full-time transcriptionists who would work more frequently with various clinical staff and therefore have a better understanding of their dictation. Also, therapists were given a dictation template for their reports, and this makes it easier for the transcriptionists to follow their words, Clark says.

Although these changes have increased transcription expenses, they have also improved quality and made it easier for staff and physicians to dictate reports, Clark adds.

Also, the reports are transcribed and returned more quickly, which has enhanced physician satisfaction, Esrock says.

2. Shift focus of intake process.

"We wanted it clear that our focus was on putting people in rehab beds," Clark says. "We feel that people who come to rehabilitation will benefit and do better in their lives."

While this may sound like a simple philosophy, it actually was a change from the way the facility previously had operated, Clark says. "Before, physicians often said to us, 'You come up with more reasons to turn down my patients than to take them.'"

Previously, the admissions department strictly interpreted admissions criteria and would deny admission to many patients who were referred by physicians or hospitals, she said.

"Our definition of rehab was too tight," Clark admits. "We tried to make patients the perfect candidate instead of realizing that we had a whole lot of opportunity to serve patients that we weren't serving."

The intake process also made it difficult for physicians to make referrals. They would call and have to leave a voice mail message. Intake staff had spent time developing social/professional relationships with physicians by taking the physician and staff out to lunch or playing golf with doctors. All of this was background noise that didn't have a significant impact on the number of referrals the facility received, Clark says.

As a result, about 40% of the hospital's 60 rehab beds were unused, says **Brett Esrock**, chief operating officer and director of finance for SSM Rehab.

"Instead of our going after new business, we had a 'let's build it and they'll come' mentality," Esrock says. "So we decided to open these other beds so we could grow our business and meet the needs of our growing market, as well."

The intake staff's new philosophy is to simply determine whether a patient meets the criteria established for rehabilitation care. If the patient meets those criteria, then he or she is admitted and helped to reach a maximum level of independence, Clark says.

Intake staff assigned to regions

The facility added new intake staff and assigned each person to a region in which they would work with specific hospitals. Each intake coordinator has a specific number of admissions that he or she must deliver to the organization for the facility to meet its financial viability goals, and these admissions all have to meet Medicare criteria, Clark explains.

"We spent three and one half to four months pushing that process through," she adds.

Also, the facility added new services in cardiac and pulmonary rehabilitation care because the strategic planning process identified these as important needs in the market.

3. Intake staff learned more marketing skills and targeted new referral sources.

Previously, the facility had focused primarily on obtaining referrals from hospitals within its own health system. Now, the intake staff — which include two registered nurses, a speech pathologist, a social worker, and an occupational therapist — visit outside hospitals to meet with physicians and hospital staff.

"Their responsibility is to build relationships

with physicians," Clark says. "They don't make social calls, and their objective is specific: it's 'How can we help you handle your patient population,' and 'If you have a referral for us, call this number.'"

When the intake / marketing staff first started speaking with physicians, they provided background information about SSM Rehab, what kinds of services the facility offered, and how to access those services, says **Jean Kestner**, PT, MS, manager of marketing.

Intake staff are more direct with doctors

"Now, we're much more focused and much more direct," Kestner says. "When we talk to a physician, we are focused on what we can do for them and we ask, 'Which patient do you have that we can look at today?' and 'What can we do to help you move this patient?'"

If the physician has a patient who had an aneurysm, for example, then the intake coordinator will discuss SSM Rehab's specialists and services available for aneurysm patients, and the coordinator might add that the rehab facility sees X number of these patients over the course of a year and therefore is very experienced in treatment of aneurysms, Kestner adds.

Intake and marketing staff also work with case managers of acute care hospitals to help them understand what a rehab patient looks like. These staffers emphasize to case managers that rehab patients don't comprise just a couple of diagnoses, but cover a broad spectrum of conditions, Esrock says. "We educated a lot of case managers in these competing hospitals to draw more visits."

4. Improve customer service for referral sources.

Physicians and other people calling to make referrals no longer have to wait long for a return call. They have the marketing / intake coordinators' cell phone numbers and pager numbers, and even if they do reach a voice mail box, they can expect a return call that acknowledges the referral quickly, Kestner says.

"We have a central intake person answer the phones in the department, and referral sources can speak with her directly," Kestner says. "Then we review the chart and speak with the physician or case manager about the case, typically within the same day or within 24 hours."

The goal is to make the process as easy it can be for referral sources, Kestner explains. "The marketing team is working on having a one-on-one relationship with referral sources, and we make it a point to let them know that we can handle whatever they need and we'll get information to the correct person so they won't get the run-around."

Soon there will be an on-line referral service available so physicians can send an e-mail message when they have a question to ask or a patient to refer.

The intake / marketing staff make the most of each visit to a referral source or to a patient. For example, Kestner recently drove three hours to see a patient. While she visited the patient, she picked up three additional referrals, and one of those patients was moved to the rehab facility the next day.

5. Improve billing and collecting process.

One of the major problems discovered during the organizational review process was that all outpatient billing and collection was done by an outsourced company that apparently was not doing an adequate job, Esrock says.

"They didn't know how to do physical therapy and occupational therapy billing," Esrock explains. "They were a physician billing company that was trying to broaden their horizons into something new, and it wasn't working."

Claims collection improves dramatically

So SSM Rehab canceled that contract and instead hired staff to do the billing and collections. A clinical and patient services system company was brought in to help streamline the process, which took about a year to complete, Esrock says.

As a result, the rehab facility's claims collection time was reduced from 105 days in accounts receivable to less than 65 days in accounts receivable, he says.

"This was a significant improvement, and a significant portion of our $2.7 million loss was due to that," Esrock says. "For example, for April 2001, they have collected 30% more than they ever have as a patient accounting group."

The billing department recently was recognized by the state of Missouri as a regional role model for its use of continuous quality improvement practices, Esrock adds.

Later, the facility further consolidated inpatient and outpatient billing so that it is all done in one central billing office, Clark says.

SSM Rehab also improved its collection of

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patient co-payments. Previously, the facility was collecting about $12,000 a year in copayments, which resulted from 85,000 patient visits, says **Rich Lehmuth**, planner and manager of decisions of support.

Now the facility collects about $300,000 a year in inpatient copayments alone, Clark says.

The problem was that the facility's office staff were uncomfortable asking for the co-payment, and it wasn't easy for them to do so because there were no credit card reading machines, Lehmuth says. Staff would often tell patients to not worry about paying anything that day because they would be billed for it later.

SSM Rehab added credit card machines to each front office and had the education department teach staff how to ask for the co-payment. At the staff's request, managers installed a sign saying that payment is required at the time of service.

"Today when we collect that co-pay, it's an expectation by the office staff and patients," Lehmuth says. "It's easy for patients."

Making sure improvements are sustainable

All of these changes helped the facility's financial standing and market share as well as improving quality in a way that will last for the long term, Esrock says.

"A lot of organizations go through a change from a financial loss to a gain, but it's the long-term sustainability of that which is important, and we've proven that over time that we can maintain those levels of income and provide quality of care that meets the needs of our community," Esrock says. "We had a $900,000 profit again last year, and this year we'll do a little more and will be asked to do more than what we're budgeted for."

Also, staff now understand that SSM Rehab intends to keep its No. 1 spot in the market share and to continue to improve both clinically and financially.

"One thing that changed for the staff is when the changes were occurring, we got a pretty consistent message that failure to meet the plan wasn't an option any more," Lehmuth says.

"It was the first time we were focusing on business results," Lehmuth adds. "And it was the first time the leadership came up to the plate and said, 'We need to grow and you tell me how to do it and we'll get it done.'" ■

21st century accreditation preparation has arrived

Georgia agency prepares through Intranet

Many rehab industry experts say business survival in the 21st century health care world will require technological advances, including greater reliance on computerized documentation.

The chief obstacles to computerized documentation so far have been time and money, because developing or adapting useful software is both expensive and time-consuming. However, at least one rehab facility has found a way to make this initial investment worthwhile. Glancy Rehab Center of the Gwinnett Hospital System in Duluth, GA, now has its complete accreditation documentation and preparation process on computer.

Glancy Rehab Center was the first rehab facility to be surveyed with the use of Intranet technology by CARF…The Rehabilitation Accreditation Commission in Tucson, AZ. The survey, which took place in May 2000, resulted in positive feedback about the use of Intranet technology, and the facility received full accreditation. "Our surveyor said this was the easiest survey he's ever done," says **Katrina Stone**, MA, education coordinator for postacute services at the Gwinnett Hospital System.

The information is on an Intranet web site that can be accessed by staff or by others to whom staff give permission. The information is not available to the public. By having the information on-line, a surveyor can review the facility's

survey preparation materials from a hotel room on the evening before the survey visit, saving pounds of paper documentation. This also provides staff with easily accessible information on anything having to do with a facility's procedures, requirements, and standards, Stone says.

While it takes a great deal of time to put all of the information on computer, once it's there, future survey preparation will be substantially less time-consuming because most of the computerized documentation will be the same, and information that has changed will have been updated by staff during the interim between surveys, Stone explains.

Stone, whose husband Lee Stone is a computer expert who owns Web Functions in Norcross, GA, first came up with the idea of putting the rehab facility's accreditation information on computer.

"The paper compilation process to show a surveyor your process means hours and hours of time are taken away from patient care just to show that you provide good patient care, and this doesn't make sense," Stone says. "I've prepared for three surveys in my lifetime, and I was tired of standing in front of that copy machine and doing what I felt was busy work, so to avoid this busy work I suggested we do something differently this time."

CARF liked Intranet survey idea

Glancy Rehab Center's management gave her the go-ahead to implement the idea. Before starting to develop a plan, Stone called CARF and asked whether there were any other facilities that had switched to an Intranet survey process. No one had done this before, so CARF offered enthusiastic support of the idea, Stone says.

The next step was to develop a plan, which the Stones did together.

"Lee is a technological genius, and we spent a good amount of time at home discussing applications of the Intranet," Stone says.

They spent about a year on the project, which had to be started from scratch because the hospital was just beginning to use networked computers. There was limited support available internally.

"A lot of organizations already have webmasters on site and Intranet services that provide all kinds of technical support which I didn't have," Stone notes.

Most of their time was spent in preparing the documentation, whereas building the web site took only a couple of weeks, Stone recalls.

The main problem was that the facility's documentation was stored in various places and in different locations within the hospital system. Some of it was in paper format, and other parts were stored on disks that were stuck in desk drawers. Stone's goal was to take all of the documentation and put it on a computer database to shift the facility's dependence from paper-driven data.

Here's how the Stones developed the Intranet survey documentation project:

1. Consolidate and revise all policies and procedures.

The rehab center and the other system rehab departments organized a committee — consisting of a physical therapist, occupational therapist, recreation therapist, nurse, education coordinator, and speech-language pathologist — to learn how to use all paper policies and procedures in a computerized format. Some of the files already were in electronic format, and these also were revised and consolidated. The committee focused on the policy content and improved, consolidated, and revised where necessary.

For example, the committee found 15 policies across three rehab departments that were related to performance improvement. These were consolidated into one policy. **(See performance improvement policy sample, pp. 76-77.)**

"All of us put in our overtime," Stone recalls. "Closer to the accreditation survey time we met weekly, but most of the time we didn't need to meet frequently because we were doing everything over the network, and everybody could read each other's notes."

The committee took guidelines and policies from all three rehabilitation departments and consolidated them into one set of policies and procedures, eliminating all duplication. Initially there were more than 800 policies, and these have been consolidated into 120 policies.

Organizational leaders revised policies

For certain policies, the committee assigned organizational leaders who were responsible for writing the policy. Then other members of the team proofread the policy before it was sent to the medical director, the service line director, and the facility's vice president for approval.

(Continued on page 79)

01-03-01 Performance Improvement Plan

Original Date	Review Dates	Revision Dates
March 17, 2000		March 4, 2001

I. PURPOSE

To establish a framework for the Rehabilitation Division's performance improvement efforts such that appropriate information is obtained, efforts are organized, goal-directed and in alignment with Gwinnett Hospital System's overall efforts.

II. DEPARTMENTS/ASSOCIATES AFFECTED

☑ DIVISION ☐ REHAB SERVICES ☐ GRC INPATIENT ☐ GRC OUTPATIENT

☑ ALL STAFF	☐ PHYSICAL THERAPY	☐ CHAPLAIN
☐ SPEECH LANGUAGE PATHOLOGY	☐ THERAPEUTIC RECREATION	☐ REHAB AIDES
☐ NURSING RN/LPN	☐ NURSE TECH	☐ SUPPORT STAFF
☐ NEUROPSYCHOLOGIST	☐ OCCUPATIONAL THERAPY	☐ PHYSICIAN
☐ ATHLETIC TRAINER	☐ CASE MANAGEMENT	☐ MARKETING
		☐ FITNESS

III. POLICY

The Gwinnett Hospital System's Rehabilitation Division:

- Establishes/reviews/revises division performance goals
- Defines aspects of care/key processes to be monitored and how they will be measured
- Identifies, collects, analyzes and trends data from improvement initiatives
- Ensures that goals and improvement initiatives are in alignment with the Gwinnett Hospital System's mission, vision, values and strategies
- Communicates the performance improvement plans, efforts, results and opportunities with all rehabilitation division associates
- Communicates with the organization through the interactive planning board structure

The Rehabilitation Division's Interactive Planning Boards (the IPB's for Glancy Rehabilitation Center and Rehabilitation Services) are responsible for implementing this policy.

IV. PROCEDURE/GUIDELINE

1. All Performance Improvement plans, decisions, and efforts are developed in alignment with the mission, vision, values and strategies of the Gwinnett Hospital System, Rehabilitation Division and division departments.
   A. GHS Mission, Vision, and Values Policy #300-100
   B. Rehab Division Mission, Vision, Values and Philosophy Statements - Policy #01-01-01
2. Records of performance improvement discussions and activities are included in the Interactive Planning Board (IPB) minutes. Minutes are available to all Rehabilitation Division associates. All Rehabilitation Division associates are encouraged to give feedback to the IPB members. Information from the

Rehabilitation Division IPB's is reported to the Post Acute Service Line IPB and the Leadership and Executive Levels when appropriate. Information from Executive, Leadership and Post Acute Service Line IPB's will flow through the Rehabilitation Division IPB's. See Organizational Structure Policy #01-02-01

3. A variety of decision-making and prioritization techniques are used to develop the following:
   - A. Performance Goals - See Rehabilitation Division Performance Improvement Plan
   - B. Aspects of Care/Key Processes that are important to monitor for continued satisfactory performance.
4. The IPB's track, aggregate and trend quality indicators from the following categories:
   - A. Outcome information
   - B. Follow up information
   - C. Patient satisfaction
   - D. Associate satisfaction
   - E. Financial information
   - F. Clinical and operational processes
5. The IPB's will evaluate and prioritize opportunities for improvement using the following process:
   - A. Investigate the situation (**FOCUS**-PDCA)
   - B. Make/implement improvement plans (FOCUS-**PD**CA)
   - C. Measure changes (FOCUS-PD**C**A)
   - D. Make adjustments in the improvement efforts until results are satisfactory (FOCUS-PDC**A**)
   - E. The IPB's can charter teams to accomplish A-D above. The IPB's establish a charter to give the teams direction:
     - a. scope
     - b. purpose
     - c. desired outcomes
     - d. project timeframes
     - e. teams are accountable to the IPB's.
6. Inter-departmental and inter-service line improvement opportunities are brought to the Post Acute Service Line level or beyond as appropriate for direction and planning.
7. Internal opportunities or small improvement projects may be resolved within the program or department without an IPB charter. The results are presented to the appropriate IPB.

Performance Improvement External Communication

Standard/Requirement	NARRATIVE EXPLANATION OF HOW WE MEET THE STANDARD	Supportive Documentation
Performance Improvement		
36. Describe the process used by your program to establish areas for improvement. Who is involved in making decisions about what areas to address?	**Contact: Diana Potts, Katrina Stone** The GHS Balanced Score Card identifies the four key results for the system, and we monitor indicators that influence these results. The key results are margin, associate satisfaction, customer satisfaction and internal processes. We also look to the PROMINA Rehabilitation Network to help us make decisions based on what is happening in the market, at the PROMINA level and with respect to future trends. With the new reorganization, the department Interactive Planning Board (IPB) determines a significant portion of the PERFORMANCE IMPROVEMENT efforts for the rehabilitation center. We use information such as pending changes in reimbursement (PPS, managed care), financial information from the system, client/staff satisfaction information, and clinical outcome information as quality indicators. Data trends and/or predictions indicate a need to focus on certain quality indicators. The IPB studies the information and determines if further investigation is necessary. A performance improvement team may be chartered if the further investigation warrants. Implementation of "quick fixes" or "accelerated replication" of another solution may solve the problems without need for a formal team.	Rehabilitation Division Policy 01-03-01 Performance Improvement Plan 01-02-05 Marketing Plan Staff Meeting Minutes PROMINA Satisfaction Surveys Satisfaction Benchmarking with other PROMINA facilities UDS/Follow Up studies Financials IPB minutes Balanced Score Card

Source: Gwinnett Hospital System, Duluth, GA.

(Continued from page 75)

"Now the entire rehab division staff use the same set of policies and are responsible for the same material, and life is much easier for them as a result of this change," Stone says.

The revised policies and procedures were placed into Microsoft Office software templates, which had been designed by the Stones and another organizational improvement educator.

"We met way before the committee got together," Stone says. "In the organizational improvement department there was a policy and procedure class that had recommended a format for policy, and we closely followed that format."

2. Train staff to use a shared network drive.

Typically, any organization that has networked computers will have more than one shared drive that groups use together, and everyone involved has access to those drives. Gwinnett Hospital System had such a network, although it wasn't being heavily used, so Stone began to educate the staff about what a network drive is and how they can use it.

Changing the 'that's my stuff' mentality

"We convinced everybody that sharing their documents was positive, because at first the idea was threatening to people," Stone explains. "People would say, 'That's my stuff, why would anybody want to see my stuff?'"

Stone answered these concerns by explaining how a network drive would allow staff to cut down on paperwork through having people share documentation rather than duplicating information and forms that may already exist.

Staff also feared that other employees would lose or inadvertently ruin their data, so Stone had to explain that the hospital system backs up information on a daily basis. If something is lost, it can be easily retrieved by the information systems department.

Once the staff began to use the network drive, they could see how it enabled them to spend less time copying reports or talking on the telephone to other employees when they needed information.

Staff training has been ongoing with hospital computer education classes, mentoring, and one-on-one training when necessary, Stone says.

3. Create grid structures for documentation and put these on a web site.

The facility bought an electronic version of an accreditation preparation guide from CARF. The accreditation preparation guide was used to cut and paste CARF standards information into a three-column table created in Microsoft Word. This part of the process was tedious, but necessary, Stone says.

The grid lists the standard in the first column. It has a short narrative on how the facility meets that standard in the second column, and then in the third column it includes a list of the documentation that provides proof of compliance with that standard. **(See sample performance improvement plan grid chart on p. 78.)**

With the grids, they created web pages with hyperlinks so that a surveyor reviewing any particular standard could click on any piece of

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documentation that is offered for proof and open it for review.

"The biggest challenge was to make it intuitive," Lee Stone says. "A really good web site is one where things are easy to find, and the bad ones are where you can't find anything you need."

So the Stones took structures that were navigable and replicated those examples in the web site for the rehab facility. By the time they completed putting all of the facility's documentation and charts and standards into the web site, they had reduced 18 feet of binders on a shelf to one CD-ROM.

The web site includes information about the rehab facility, pictures of the facility, instructions on how to use the web site, and other basic information, **Lee Stone** says.

"Surveyors can access the policy and procedures, the standards/compliance section, a general information page about Glancy Rehab Center, and a section about the team and leadership of the hospital with digital photos of the preparation team and their biographies," he adds.

"Our next goal is to have it all maintained on a continuous basis so during the next survey you would not have to do anything extra," he says. "All the benefits that derive from using the application are used on a daily basis."

The facility still will have to review the standards before an accreditation survey to make sure the facility is in compliance, and there are always new standards to meet, but that will be all that remains of survey preparation, Katrina Stone says.

"What we're cutting out is all that busy work, and what we're getting in return is a product that your staff can use on a daily basis," Stone says.

4. Make new forms and documentation instantly available to staff.

An additional benefit of the Intranet web site is that when someone develops new forms, guidelines, documentation, or educational materials, they are put on the web site and are immediately available for staff use and review, Stone says.

Any information that needs to be kept private from all but certain employees, such as financial information, is password-protected on the network, so only the people who need access can get it, Stone adds.

In the event the computer network is inaccessible because of a mechanical problem, staff still have access to the paper versions of some files. Soon, however, paper access will be all but unnecessary, Stone notes.

Now that the hard work is complete, Stone says staff and management are pleased with the results, particularly because their Intranet accreditation survey was so successful.

"This was a whole lot of fun," Stone says. "It was a wonderful process, and it got us a lot of attention, as well as an Intranet our staff can use each day." ■

Need More Information?

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INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT

Identification Information*

1. Facility Information
   A. Facility Name
   _____
   _____
   _____
   B. Facility Medicare Provider Number _____
2. Patient Medicare Number _____
3. Patient Medicaid Number _____
4. Patient First Name _____
5. Patient Last Name _____
6. Birth Date _____ MM/DD/YYYY
7. Social Security Number _____
8. Gender (*1 - Male; 2 - Female*) _____
9. Race/Ethnicity *(Check all that apply)*
   - *American Indian or Alaska Native* A. _____
   - *Asian* B. _____
   - *Black or African American* C. _____
   - *Hispanic or Latino* D. _____
   - *Native Hawaiian or Other Pacific Islander* E. _____
   - *White* F. _____
10. Marital Status _____
    (*1 - Never Married; 2 - Married; 3 - Widowed; 4 - Separated; 5 - Divorced*)
11. Zip Code of Patient's Pre-Hospital Residence: _____

Admission Information*

12. Admission Date _____ MM/DD/YYYY
13. Assessment Reference Date _____ MM/DD/YYYY
14. Admission Class _____
    (*1 - Initial Rehab; 2 - Evaluation; 3 - Readmission; 4 - Unplanned Discharge; 5 - Continuing Rehabilitation*)
15. Admit From _____
    (*01 - Home; 02 - Board & Care; 03 - Transitional Living; 04 - Intermediate Care; 05 - Skilled Nursing Facility; 06 - Acute Unit of Own Facility; 07 - Acute Unit of Another Facility; 08 - Chronic Hospital; 09 - Rehabilitation Facility; 10 - Other; 12 - Alternate Level of Care Unit; 13 - Subacute Setting; 14 - Assisted Living Residence*)
16. Pre-Hospital Living Setting _____
    (*Use codes from item 15 above*)
17. Pre-Hospital Living With _____
    (*Code only if item 16 is 01 - Home; Score using 1 - Alone; 2 - Family/Relatives; 3 - Friends; 4 - Attendant; 5 - Other*)
18. Pre-Hospital Vocational Category _____
    (*1 - Employed; 2 - Sheltered; 3 - Student; 4 - Homemaker; 5 - Not Working; 6 - Retired for Age; 7 - Retired for Disability*)
19. Pre-Hospital Vocational Effort _____
    (*Code only if item 18 is coded 1 - 4; Score using 1 - Full-time; 2 - Part-time; 3 - Adjusted Workload*)

Payer Information*

20. Payment Source
    A. Primary Source _____
    B. Secondary Source _____

    (*Score using 01 - Blue Cross; 02 - Medicare non-MCO; 03 - Medicaid non-MCO; 04 - Commercial Insurance; 05 - MCO HMO; 06 - Workers Compensation; 07 - Crippled Children's Service; 08 - Developmental Disabilities Service; 09 - State Vocational Rehabilitation; 10 - Private Pay; 11 - Employee Courtesy; 12 - Unreimbursed; 13 - CHAMPUS; 14 - Other; 15 - None; 16 - No Fault auto insurance; 51 - Medicare MCO; 52 - Medicaid MCO*)

Medical Information*

21. Impairment Group _____ Admission _____ Discharge
    Condition requiring admission to rehabilitation; code according to Appendix A, attached.
22. Etiologic Diagnosis: _____
    (*Use ICD-9 codes to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation*)
23. Date of Onset of Etiologic Diagnosis _____ (MM/DD/YYYY)
24. Comorbid Conditions; Use ICD-9 Codes to enter up to ten medical conditions existing prior to this rehabilitation admission

    A. _____ B. _____
    C. _____ D. _____
    E. _____ F. _____
    G. _____ H. _____
    I. _____ J. _____

Medical Needs

25. Is patient comatose at admission? _____ 0 - No, 1 - Yes
26. Is patient delirious at admission? _____ 0 - No, 1 - Yes

	Admission	Discharge
27. Swallowing Status:	_____	_____

3 - Regular Diet: solids and liquids swallowed safely without supervision or modified diet
2 - Modified Diet/ Supervision: subject requires modified diet and/or needs supervision for safety
1 - Tube /Parenteral Feeding: tube / parenteral feeding used wholly or partially as a means of sustenance

	Admission	Discharge
28. Clinical signs of dehydration	_____	_____

(*Evidence of oliguria, dry skin, orthostatic hypotension, somnolence, agitation; Score 0 - No; 1 -*

Yes)

INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT

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Function Modifiers*

Complete the following specific functional items prior to scoring the FIM™ Instrument:

	ADMISSION	DISCHARGE
29. Bladder Level of Assistance (Score using FIM Levels 1 - 7; 8 if unable to assess)	☐	☐
30. Bladder Freq. of Accidents (Score as below)	☐	☐

7 - Continent
6 - Continent; uses device such as catheter
5 - Incontinent every 8 days or more
4 - Incontinent every 4 - 7 days
3 - Incontinent every 2 - 3 days; not daily
2 - Incontinent daily; some control
1 - Incontinent with every void
8 - Does not void (e.g., due to dialysis)

Score Item 39G (Bladder) as the lowest (most dependent) score from Items 29 and 30 above.

	ADMISSION	DISCHARGE
31. Bowel Level of Assistance (Score using FIM Levels 1 - 7; 8 if unable to assess)	☐	☐
32. Bowel Freq. of Accidents (Score as below)	☐	☐

7 - Continent
6 - Continent; uses device such as ostomy
5 - Incontinent every 8 days or more
4 - Incontinent every 4 - 7 days
3 - Incontinent every 2 - 3 days; not daily
1 - Incontinent daily
8 - Could not assess, no bowel movement in 8 days

Score Item 39H (Bowel) as the lowest (most dependent) score of Items 31 and 32.

	ADMISSION	DISCHARGE
33. Tub Transfer	☐	☐
34. Shower Transfer	☐	☐

(Score using FIM Levels 1 - 7; 8 if unable to assess)
Score Item 39K (Tub/Shower Transfer) as the lowest (most dependent) score of Items 33 and 34.

	ADMISSION	DISCHARGE
35. Distance Walked (feet)	☐	☐
36. Distance Traveled in Wheelchair (feet)	☐	☐

(Score Items 35 and 36 using the following scale: 3 - 150 feet; 2 - 50 to 149 feet; 1 - Less than 50 feet or unable; 8 - Not applicable)

	ADMISSION	DISCHARGE
37. Walk	☐	☐
38. Wheelchair	☐	☐

(Score using FIM Levels 1 - 7; 8 if not applicable)
Score Item 39L (Walk/Wheelchair) as the lowest (most dependent) score of Items 37 and 38)

39. FIM™ Instrument*

	ADMISSION	DISCHARGE	GOAL
SELF-CARE			
A. Eating	☐	☐	☐
B. Grooming	☐	☐	☐
C. Bathing	☐	☐	☐
D. Dressing - Upper	☐	☐	☐
E. Dressing - Lower	☐	☐	☐
F. Toileting	☐	☐	☐
SPHINCTER CONTROL			
G. Bladder	☐	☐	☐
H. Bowel	☐	☐	☐
TRANSFERS			
I. Bed, Chair, Whlchair	☐	☐	☐
J. Toilet	☐	☐	☐
K. Tub, Shower	☐	☐	☐
LOCOMOTION (W - Walk; C - wheelChair; B - Both)			
L. Walk/Wheelchair	☐☐	☐☐	☐
M. Stairs	☐	☐	☐
COMMUNICATION (A - Auditory; V - Visual; B - Both)			
N. Comprehension	☐☐	☐☐	☐
O. Expression	☐☐	☐☐	☐
SOCIAL COGNITION (V - Vocal; N - Nonvocal; B - Both)			
P. Social Interaction	☐	☐	☐
Q. Problem Solving	☐	☐	☐
R. Memory	☐	☐	☐

FIM LEVELS

No Helper
7 Complete Independence (Timely, Safely)
6 Modified Independence (Device)

Helper - Modified Dependence
5 Supervision (Subject = 100%)
4 Minimal Assistance (Subject = 75% or more)
3 Moderate Assistance (Subject = 50% or more)

Helper - Complete Dependence
2 Maximal Assistance (Subject = 25% or more)
1 Total Assistance (Subject less than 25%)

8 Activity does not occur; Use this code only at admission

INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT

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Discharge Information*

40. Discharge Date _____ (MM/DD/YYYY)

41. Patient discharge against medical advice: _____ *(0 - No, 1 - Yes)*

42. Program Interruptions _____ *(0 - No; 1 - Yes)*

43. Program Interruption Dates
(Score only if Item 42 is 1 - Yes)

A. 1st Transfer Date _____ MM/DD/YYYY

B. 1st Return Date _____ MM/DD/YYYY

C. 2nd Transfer Date _____ MM/DD/YYYY

D. 2nd Return Date _____ MM/DD/YYYY

E. 3rd Transfer Date _____ MM/DD/YYYY

F. 3rd Return Date _____ MM/DD/YYYY

44A. Discharge to Living Setting: _____
01 - Home; 02 - Board and Care; 03 - Transitional Living; 04 - Intermediate Care; 05 - Skilled Nursing Facility; 06 - Acute unit of own facility; 07 - Acute unit of another facility; 08 - Chronic Hospital; 09 - Rehabilitation Facility; 10 - Other; 11 - Died; 12 - Alternate Level of Care Unit; 13 - Subacute Setting; 14 - Assisted Living Residence

44B. Was patient discharged with Home Health Services? _____ *(0 - No; 1 - Yes)*
(Code only if Item 44A is 01 - Home, 02 - Board and Care, 03 - Transitional Living, or 14 - Assisted Living Residence)

45. Discharge to Living With: _____
(Code only if Item 44A is 01 - Home)
Score using 1 - Alone; 2 - Family / Relatives; 3 - Friends; 4 - Attendant; 5 - Other

46. Diagnosis for Transfer or Death: _____
(Score using ICD-9 code)

47. Complications during rehabilitation stay
(Use ICD-9 codes to specify up to six conditions that began with this rehabilitation stay)

A. _____ B. _____

C. _____ D. _____

E. _____ F. _____

Quality Indicators

RESPIRATORY STATUS

	Admission	Discharge
48. Shortness of breath with exertion	_____	_____
49. Shortness of breath at rest	_____	_____
50. Difficulty coughing and clearing airway	_____	_____

(Score items 48 to 50 as 0 - No; 1 - Yes)

Quality Indicators

PAIN

51. Rate the highest level of pain reported by the patient within the assessment period:
Admission: _____ Discharge: _____

(Score using the scale below; report whole numbers only)

0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Worst Possible Pain

PUSH SCALE©

Pressure Ulcers

52A. Highest current pressure ulcer stage
Admission _____ Discharge _____

(Score as: 0 - No pressure ulcer; 1 - Any area of persistent skin redness (Stage 1); 2 - Partial loss of skin layers (Stage 2); 3 - Deep craters in the skin (Stage 3); 4 - Breaks in skin exposing muscle or bone (Stage 4); 5 - Not stageable (necrotic eschar predominant; no prior staging available)

52B. Number of current pressure ulcers
Admission _____ Discharge _____

SELECT THE CURRENT LARGEST PRESSURE ULCER TO CODE THE FOLLOWING. Calculate three components (c through e) and code total score in f.

52C. Length multiplied by width (open wound surface area)
Admission _____ Discharge _____

(Score as 0 - 0 cm^2; 1 - < 0.3 cm^2; 2 - 0.3 to 0.6 cm^2; 3 - 0.7 to 1.0 cm^2; 4 - 1.1 to 2.0 cm^2; 5 - 2.1 to 3.0 cm^2; 6 - 3.1 to 4.0 cm^2; 7 - 4.1 to 8.0 cm^2; 8 - 8.1 to 12.0 cm^2; 9 - 12.1 to 24.0 cm^2; 10 - > 24 cm^2)

52D. Exudate amount
Admission _____ Discharge _____
0 - None; 1 - Light; 2 - Moderate; 3 - Heavy

52E. Tissue type
Admission _____ Discharge _____
0 - Closed/resurfaced: The wound is completely covered with epithelium (new skin); 1 - Epithelial tissue: For superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as islands on the ulcer surface. 2 - Granulation tissue: Pink or beefy red tissue with a shiny, moist, granular appearance. 3- Slough: Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous. 4 - Necrotic tissue (eschar): Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges.

52F. TOTAL PUSH SCORE (Sum of above three items -- C, D and E)
Admission _____ Discharge _____

SAFETY

53. Total number of falls during the rehabilitation stay — Discharge _____

	Admission	Discharge
54. Balance problem	_____	_____

(0 - No; 1 - Yes; e.g., dizziness, vertigo, or light-headedness)