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INSIDE

NOVEMBER 1998

VOL. 7, NO. 11 (pages 145-160)

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Tighten your belt: Changes coming in outpatient reimbursement

Prepare now for Medicare cuts, increase in managed care

If you're an outpatient provider, you're likely to face a whole new ballgame with your reimbursement in the near future. Consider these issues:

• The Balanced Budget Act of 1997 sets a $1,500 cap on therapy reimbursement, scheduled to go into effect Jan. 1, 1999, for Medicare patients treated at freestanding outpatient facilities. The legislation limits reimbursement to $1,500 in a calendar year for physical therapy and speech therapy services combined, with an additional $1,500 limit for occupational therapy.

• The Health Care Financing Administration (HCFA) is requiring that all outpatient providers — whether in a hospital or freestanding center — use a standard set of codes for reimbursement. Some fiscal intermediaries have not required the codes for billing in the past.

• HCFA is moving toward a fee schedule for outpatient services for providers in all settings. This means that the old days of being reimbursed on a cost basis for Medicare patients is clearly drawing to an end.

• Managed care is still on the increase, with few fee-for-service payers left in many parts of the country.

Special report: Survive changes in outpatient reimbursement

This issue of *Rehab Continuum Report* focuses on the reimbursement issues that will revamp the world of outpatient providers in coming years. You'll learn what you should do to make sure your facility stays in the black as Medicare, managed care, and workers' compensation providers shave reimbursement to the bone; how other providers are preparing for outpatient reimbursement cuts; and why you should meet with your senators and representatives to tout the benefits of outpatient rehab. Don't miss reading this critical report! ■

Executive Summary

Subject:
Upcoming changes in outpatient reimbursement

Essential points:
- ❑ Significant cuts in Medicare reimbursement are likely.
- ❑ Managed care is on the increase even for Medicare and workers' compensation payers.
- ❑ The Health Care Financing Administration is requiring new coding for outpatient reimbursement.

• Reimbursement for workers' compensation and Medicare patients is increasingly falling under managed care plans in many states.

• Non-Medicare managed care plans and other third-party payers are continuing to cut the number of treatment visits, offer capitated contracts, and force providers to shave costs to the bone.

"My view is that outpatient providers have to do spring cleaning to get ready for all of the changes that are coming in reimbursement," says **Nancy J. Beckley**, MS, MBA, president of the Bloomingdale Consulting Group, a rehab consulting firm based in Valrico, FL. "It's not just a matter of figuring out your Medicare fee schedule. You need to analyze everything about your program to succeed in the future, and now is a perfect time."

Whatever changes are made in reimbursement, whether it's through HCFA, workers' compensation, or private-pay insurers, this is the bottom line: You're likely to have to do more with less.

This change may mean you need to start providing fewer treatments per diagnosis, developing more home exercise programs, using lower-cost employees for some tasks, and keeping a close tab on your outcomes vs. cost to come up with more efficient and effective ways to treat patients.

Outpatient providers must start now to analyze their case mix, utilization, and types of reimbursement for all their patient populations to see how they will fare when reimbursement changes in the future, suggests **Malcolm Morrison**, PhD, president of Morrison Informatics, a health care information management company based in Mechanicsburg, PA.

"The most important issue is to understand what your costs and utilizations are for treating outpatients. Evaluate carefully whether the amounts are within the limits and to what degree and for which patients," Morrison says.

Managed care reimbursement declines

Some providers have taken advantage of the fact that, in the past, Medicare has reimbursed based on costs, Beckley says. Their costs were high, and their reimbursement was high. "Unless those providers have really been doing something to move costs down, they may be in deep trouble."

Medicare reimbursement isn't the only reason outpatient providers need to cut costs. Managed care reimbursement is shrinking. The number of treatments insurers will cover is shrinking. Payers in many areas are moving to capitated contracts. "If people just look at Medicare as a carve-out, they still have a moving target," she points out. "Medicare managed care is growing, and Congress wants it to do that." Workers' compensation also is switching to managed care in some areas, she adds.

Don't miss out on contracts

If your market isn't already saturated by managed care plans, it will be soon. If you don't work on forming strategic alliances and networks with acute care hospitals, rehab hospitals, and other health care providers throughout the continuum, your outpatient facility may be left out of contracts.

"The important thing to remember is that you can't start today and work all night and get a managed care contract tomorrow morning," she says. "A lot of markets are in a lockout. If you're not in a network, you are not going to get in on a

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managed care contract unless you bid the price down."

In some marketplaces, reimbursement for rehab services has dropped dramatically as providers who are left out of managed care contracts bid down prices just so they can get the business, Beckley says. "Yes, we might have gripes against managed care in general. We might not like the managed care reimbursement. But a lot of the onerous drops in reimbursement has been market-driven by providers."

The Medicare therapy cap would have the most dramatic effect on your bottom line in the near term. A coalition of rehabilitation organizations and individual providers has been working in Washington, DC, to convince lawmakers to at least delay implementation of the cap before the 105th Congress adjourns**. (For more information on the legislative initiative, see related article, p. 149.)**

'Drastic changes' may be necessary

Frank Pugliese, CHE, chief executive officer of Riverside Rehabilitation Center in Plains, PA, says, "If we are not successful in changing the cap, we will need to make drastic changes in the way we practice medicine in our type of facility." Riverside is an outpatient rehab provider with two comprehensive outpatient rehabilitation facilities (CORFs) and five other satellite clinics in rural Pennsylvania.

Pugliese has made three trips to Washington, DC, to talk to his senators and representatives about the adverse effect of the therapy cap and to urge that it be eliminated or at least postponed. "Many providers will not be able to continue to provide services to Medicare recipients with the therapy cap," he says.

For example, Riverside performed an analysis of all stroke patients at its seven outpatient centers. The patients received an average of $6,000 in outpatient therapy services a year. However, the tab for some of the older patients ran as high as $12,000 a year, he points out. And while outpatient rehab providers are coping with pending changes in reimbursement, their staff have to be trained to use a whole new set of codes for reimbursement.

Progressive Steps Rehab, which operates outpatient rehab clinics throughout the country, has compiled information on the number of visits needed for the various diagnoses and is looking at how to cut the number, says **Agnete Mansori**, national clinical director for outpatient services of the Milwaukee-based provider.

"For most diagnoses, we can manage well within the $1,500 cap. But as far as the consumer is concerned, they'd better not get sick more than once a year," Mansori says.

The HCFA Common Procedure Coding System codes, now required for reimbursement, are procedure codes, which contain the current procedural terminology codes.

If you haven't already done so, check with your software vendor to make sure the products you are using have been upgraded to deal with the new codes, Morrison says. Otherwise, you'll have to do all your coding by hand on the bills, and it will be a time-consuming task. ■

Need More Information?

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CALENDAR

- **The First National Congress on PPS for Rehab and Skilled Nursing Facilities** — Nov. 18-20, Orlando, FL. Sponsor: AIC Worldwide. Contact: AIC Worldwide, Customer Service, 29 W. 35th St., Third Floor, New York, NY 10001. Phone: (800) 409-4242. Fax: (212) 714-9815. Web: http://www.aic-usa.com.

Executive Summary

Subject:
How to make sure your program is in the black

Essential points:
- ❑ Analyze your costs, reimbursement, and case mix for each diagnosis.
- ❑ Find out what you can expect to receive as reimbursement changes.

Analyze outpatient costs, case mix, and payers

Act now to survive cuts in reimbursement

To succeed in the future, outpatient providers must know the cost of treatment, how many patients they treat for each diagnosis group, and how they are reimbursed for each patient.

By analyzing this data, providers will be able to determine how they will come out when reimbursement changes, and what steps they need to take to stay in the black.

"Some analysis of the cost of treatment per patient has to be done to make sure there is not excessive utilization that won't be reimbursed," says **Malcolm Morrison**, PhD, president of Morrison Informatics, a health care information management consulting firm in Mechanicsburg, PA. Review your outpatient caseload and the costs, he suggests. If you can't collect your costs, use your charges and compare them with your cost-to-charge ratio, he adds. Often the data exist, but you have to obtain them from your hospital's accounting department or gather them manually from copies of claims forms.

If the Medicare fee cap is too low to cover your costs, or if you negotiate a managed care contract that doesn't adequately reimburse you for treating patients, there will be dramatic consequences for your bottom line, Morrison warns.

To determine what it costs to treat your patients, do the following:

- Make a financial analysis of every patient you treated and every cost you incurred this year.
- Determine your percentage of Medicare, Medicaid, workers' compensation, and private-pay insurance reimbursement.
- If you think your client mix will remain essentially the same next year, analyze what your return will be with the new reimbursement. For example, see how many of your Medicare patients would exceed the $1,500 therapy cap.

You may expect that some of your workers' compensation patients will be covered under a managed care arrangement next year and that at least some of your managed care contractors will negotiate a lower reimbursement rate.

Here are some of the items you need to analyze for each diagnosis group:

- average number of visits per diagnosis;
- modalities used for each diagnosis;
- cost of the modalities;
- cost of other products, such as splints, that may be used;
- cost of the therapists' time.

"Providers should remember that every time someone does something to a patient, somebody is going to have to pay for it," he says. "If you're not reimbursed for it, your facility will have to bear the costs." ■

Marketing, outcomes analysis keys to success

Payers demanding data from outpatient providers

With Medicare reimbursement taking a nosedive, rehab providers must have a strategy for developing new business. That's where marketing comes in.

"Marketing got a bad name in the 1980s when it meant advertising agencies got a lot of money," says **Nancy J. Beckley**, MS, MBA, president of Bloomingdale Consulting Group, a rehab consulting firm in Valrico, FL. "Providers thought if they paid for advertising, they'd get a lot of business."

But now, marketing is an essential part of business development, and providers must have a

Executive Summary

Subject:
Analyzing and marketing your outcomes

Essential points:
- ❑ To survive reimbursement cuts, providers need a business development plan that includes marketing.
- ❑ Outcomes data should be a key part of a marketing plan.
- ❑ Payers want to know your track record and what you can do for their patients.

business development plan to survive, Beckley says. Your own outcomes data are your best marketing tools, she maintains. If you're an outpatient provider and aren't already doing it, start compiling data on your outcomes.

In the inpatient setting, most providers collect outpatient data based on the Functional Independence Measure (FIM, administered by Uniform Data Services for Medical Rehabilitation in Buffalo, NY) that collects and reports functional gain.

However, there are no generic, universal outcomes measures available for outpatient programs, at least in part because the types of patients and the patient mix among facilities are so varied. For example, some facilities deal primarily with sports injuries and treat only one body part, such as a neck or knee, at a time. Others may focus on stroke patients with multiple physical and cognitive deficits.

Even though there isn't a universally defined set of outcomes measures available, your facility can track its outpatient outcomes and show providers your treatment makes a difference. **(For details on how one provider tracks outcomes for its outpatient programs, see *Rehabilitation Outcomes Review*, p. 151.)**

For example, if your population is largely orthopedic, you can choose from a number of orthopedic outcomes measures available, most of which deal with one body part or another. Or, if you have a pain clinic, you can track the number of patients who report that their pain was less when they finished the program than when they started. Include patient satisfaction measures in the data you give to payers.

If most of your patients are workers' compensation patients, track how many in each diagnosis return to work in what length of time. Develop a meaningful outcomes analysis you can use when talking to managed care companies or other referral sources, she suggests. "The insurance company doesn't care what happened 10 years ago or even what happened last week in another city. They want to know what you can do for them today."

Take your own data, and let those data tell the story of what your facility can do for patients, Beckley advises.

[Editor's note: For more on outpatient outcomes measures, see: Rehab Continuum Report, *July 1998, p. 85, and March 1997, p. 35. For an overview of widely used outpatient outcomes measures, see* Hospital Rehab *(now* Rehab Continuum Report*), September 1994, p. 119.]* ■

Therapy cap could affect your bottom line

Congress may repeal $1,500 limit

The proposed $1,500 cap on Medicare reimbursement for outpatient therapy services could have dire effects on the elderly rehab population and force rehab providers to change the way they practice, outpatient providers say.

Unless it's postponed or repealed by Congress, the proposal, part of the Balanced Budget Act of 1997, is scheduled to go into effect Jan. 1, 1999. It sets a $1,500 annual limit per patient on reimbursement for physical therapy and speech therapy combined and an additional $1,500 limit on occupational therapy services provided at freestanding outpatient clinics and comprehensive outpatient rehabilitation facilities (CORFs). Outpatient clinics within rehab or acute care hospitals are not affected by the limits.

If the therapy caps go into effect, there could be dire results for elderly patients in the rural Pennsylvania areas served by Riverside Rehabilitation Center in Plains, PA, says **Frank Pugliese**, CHE, chief executive officer. Riverside is an outpatient provider that treats primarily elderly patients at two CORFs and five satellite clinics.

Many rehab patients in rural areas are served by freestanding outpatient providers in their communities and would be subject to the $1,500 cap. To continue to receive treatment when they reach the cap, residents of the rural areas would have to travel long distances to hospital outpatient departments. For example, Riverside Rehabilitation Hospital now provides outpatient services in rural Monroe County. If those patients exceed the $1,500 cap, they will have to make an 80-mile round-trip to the nearest acute rehab center for therapy.

Executive Summary

Subject:
Effects of the $1,500 Medicare therapy cap

Essential points:
- ❑ Elderly, rural patients are most likely to be affected.
- ❑ Providers must expand services to include patients not covered by Medicare.
- ❑ Fewer visits and more home exercise programs may be necessary.

Keep your eye on DC for latest on therapy cap

At the time this issue of *Rehab Continuum Report* went to press, several measures were pending before Congress that would repeal or delay the $1,500 cap on outpatient therapy services for Medicare patients.

The American Medical Rehabilitation Providers Association in Washington, DC, the American Physical Therapy Association in Alexandria, VA, the American Occupational Therapy Association in Bethesda, MD, and a number of other national and state professional organizations have been urging Congressional leaders to delay the measure.

If the 105th Congress does not take action before adjournment, the issue will be pending before the 106th Congress when it convenes in January. In the meantime, here's what you can do:

❑ Keep in touch with your professional rehab associations to find out what is going on in Washington.

❑ Use the time between the general election in November and the Congressional session that begins in January to get to know your U.S. representatives and senators.

❑ Schedule a meeting with them, or invite them to your facility to show them firsthand the benefits of rehabilitation services.

❑ If the therapy cap is still in effect, urge them to support the repeal when Congress convenes in January. ■

"The choices of rural patients are going to be extremely limited," Pugliese says. "The quality of care will be affected in many areas just by the logistics for treatment patients and the coordination of benefits."

When patients shift to another outpatient treatment center in an acute rehab hospital, staff are likely to do their own assessments and evaluations before beginning treatment, which will add to the total cost of rehab, he points out.

To make adjustments, Riverside will change its focus from Medicare patients to those whose care is reimbursed by other payers, such as workers' compensation and managed care plans. Pugliese is considering sports medicine, chronic pain, pediatric, and work-hardening programs to make up for the loss in Medicare patients.

As the number of visits become limited, outpatient providers will focus on teaching home exercise programs and helping patients learn what equipment they can use in fitness centers to continue with their rehabilitation after their benefits run out, predicts **Agnete Mansori**, national clinical director for outpatient services at Progressive Steps Rehab in Milwaukee.

"In the past, we provided treatment and made patients dependent on us in outpatient services," Mansori says. "Part of my job is teaching clinicians to let go of patients, to teach them to be independent, and to rely on patients and caregivers to learn what to do away from the clinic."

Outpatient providers must embrace the concept of educating patients to take care of themselves and handle their impairments, she says. At Progressive Steps, staff are looking at ways to make each session of therapy more intensive. A therapy session eventually may serve as a teaching session to help patients learn what to do at home to make a difference in the long run.

"Once they get over the acute stage, most people should be able to continue on their own with a monthly or biweekly checkup with the therapist, rather than coming in three times a week," she says. ■

Menu-type day program is a hit with payers

Days, hours, LOS vary with each patient

Day treatment patients at Columbia St. David's Medical Center Austin, TX, may spend as much as five hours a day, five days a week for a full regime of therapy at the rehab center, or they may spend as little as an hour a week for treatment by just one discipline. It all depends on how much and what kind of treatment they need.

"A day program is a unique treatment modality," says **Laura Hamilton**, PhD, day program supervisor. "It's less expensive than inpatient, and our focus is on the most efficient and effective treatment to return people to the highest level of functioning as quickly as possible."

Juggling staff and patient schedules to create an individual program for each day treatment patient takes a lot of time, but the concept has paid off, says case manager **Shaley vonDoenhoff**, LMSW.

"Some payers don't include day treatment in their benefits package, but they'll work to come up

(Continued on page 155)

Executive Summary

Subject:
Menu-type day treatment programs

Provider:
Columbia St. David's Medical Center, Austin, TX

Essential points:

- ❑ The number of days, number of hours, and treatment depend on each individual patient's needs.
- ❑ Patients are discharged from individual disciplines as soon as they meet their goals and taper off their participation in the program.
- ❑ Patients may take advantage of hospital-based programs such as cardiac rehab or chronic pain therapy.
- ❑ Payers like the program because it's not "one size fits all," and they pay only for the modalities and therapies the patients need.

(Continued from page 150)

with ways to fund our program. They trust us because we don't keep the patients any longer than we need to or give them therapy unless they absolutely need it," vonDoenhoff adds. **(For details on how St. David's has gained payer approval, see p. 157.)**

The majority of patients are being treated for strokes and head injuries. "They come here to solidify their skills that will allow them to remain independent and to improve their level of independence in the home and the community," says **Barbara Lasiter**, MOT, OTR, director of the rehabilitation center.

The Columbia St. David's program is personalized for each patient, Hamilton says. "We develop a treatment plan that depends on each patient's areas of strength and weaknesses, based on their input, the doctor's prescription, and the evaluation from each discipline." One patient may come five days a week from 9 a.m. to 3 p.m. and receive physical therapy, occupational therapy, speech therapy, recreation therapy, counseling, and vocational rehabilitation. Another may come just three days a week for half a day to work on cognitive issues. **(For more on how staff set the schedule, see p. 156.)**

Patients who need it can take advantage of other hospital programs. For example, one patient attends the day treatment program in the mornings and a cardiac rehab program in the afternoons. Others have been seen a physical therapist from the hospital pain management program.

Patients may choose to participate in recreational activities or group sessions geared to meet the needs of a variety of patient needs**. (For details on recreational and group activities, see p. 156.)**

As soon as patients make progress and meet their goals, they are discharged from the individual discipline. For example, a patient may start out coming five days a week and receiving treatment from five disciplines. After a period of time, treatment may taper to just one day a week for speech therapy. Some patients are in the program for six weeks; others may come to day treatment for as long as a year.

Day treatment includes the Quest program for younger people, some as young as 10, and the Bridges program for retirement-age people or older. Programs are tailored for the age groups. For example, the younger people participate in more strenuous recreational activities, and retirees don't receive vocational rehab services.

The program has about 20 professional staff, some of whom work on a PRN basis. "The PRN staff know the patients and the program and come in to provide continuity if the census increases," Hamilton says. The patient census is usually about 30, but it can reach 37. Each discipline tracks patient improvements over time, such as how far a person could walk, how much time was needed to transfer from a wheelchair to a mat, and how much assistance was needed at the beginning of treatment vs. the end.

Each patient undergoes neuropsychological testing at the beginning and at the end of the program to measure what kind of progress they have made. Patients also are evaluated on their ability to meet a specific goal, which is set after their evaluations. A goal might be the ability to recall auditory information with 80% accuracy.

When goals are met, the staff decide if there is a next step or if the patient may be ready for discharge from that part of the program. ■

Need More Information?

For more on Columbia St. David's treatment program, contact:

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Day treatment scheduling is time-consuming

Slots are filled on a case-by-case basis

Setting up the schedule for the flexible day treament program at Columbia St. David's Medical Center in Austin, TX, is similar to fitting a puzzle together, says **Laura Hamilton**, PhD, day program supervisor.

"We set the schedules on a case-by-case basis," Hamilton says. "Each schedule matters so much to each patient that it's very satisfying to work it all out."

Each Tuesday afternoon the treatment team meets to set the schedule for the following week. Representatives from each discipline discuss the patients' needs and preferences and acts as an advocate for each patient's slot on the schedule. For example, a family member's schedule may make it necessary for the patient to come in at 10 a.m. instead of 9 a.m. If so, the patient isn't scheduled for a 9 a.m. treatment.

Juggling the time slots

Some patients may prefer an afternoon time slot for their thrice-weekly speech therapy, or they may be too tired after lunch every day for physical therapy. Others may come just two mornings or three afternoons a week. In addition, there are group treatments and community outings to consider.

The staff take all that into account as they juggle the time slots, patient preferences, and staff time. "It's a big investment of time to get it just right," Hamilton says. The schedules are entered on a transparency so they can be changed easily.

Once the treatment team sets the schedule, a staff member cross-checks to make sure everything on the patient and staff schedule is the same. Another staff person checks again to make sure the schedules will work. The schedules are printed, distributed to patients and staff, and posted on the weekly therapy board.

"We can't always accommodate everyone," Hamilton says. "Sometimes a patient gets a good match, and sometimes he or she has to make the best of things." ■

Recreation, group therapy integral to day program

Goal is to regain quality of life

The philosophy of the day treament program at Columbia St. David's Medical Center is to help people regain their quality of life and participate as much as possible in the activities they enjoyed before their illness or injury. "We want to help them get back to work and make the best possible use of their time instead of sitting around and being sad," says **Laura Hamilton**, PhD, day program supervisor at the Austin, TX, medical center.

If a patient enjoyed outdoor activities, the recreation therapy staff help create modified ways of resuming them. For example, if a patient wants to fish and doesn't have the flexibility, they can suggest adaptive poles with bigger grips.

The recreation therapist works closely with each discipline to plan activities patients enjoy and help them meet their therapeutic goals. For example, if patients need to practice ambulation or transferring, they can do so while playing golf or learning to do a salsa dance. One man's goal was to be able to walk his daughter down the aisle at her wedding. Recreation therapy is recommended for each patient, but some aren't interested.

The day treatment program also includes group sessions on a variety of topics:

❑ A brain injury education group for patients and family members provides information on the types of injuries, what kinds deficits they cause, and which areas of the brain may not be affected. "We give them as much information about themselves as possible so they can be in charge of their lives," Hamilton says.

❑ A memory group does problem-solving and memory-increasing tasks. Patients in a group setting often reinforce learning for each other.

❑ A newsletter group produces a newsletter with stories and pictures. They plan themes, write articles, and edit their own and their colleagues' work.

❑ A discovery group, led by a counselor, talks about coming to terms with the losses associated with brain injury or stroke.

❑ A community group plans activities to help patients with therapy. For example, if they're working on ambulation, they might plan a trip to the zoo. If they're working on social skills, they might go to a restaurant. ■

Education helps payers accept day program

Case managers are sold on the results

Convincing payers to reimburse for the day treatment program at Columbia St. David's Medical Center takes a lot of education, but once case managers see the results, they're usually sold on the program, says case manager **Shaley vonDoenhoff**, LMSW.

"We do so many things that are not traditional that it requires a lot of education. But once the external case managers see that our clients make gains quicker than in other programs, they realize our innovations are very therapeutic," she says.

When a patient is referred to the St. David's day program, vonDoenhoff sends the payer an initial explanation of the program, including details about the facility and the purpose of the therapy. The program is covered by Medicare Part B.

Some of the questions she tries to answer ahead of time include the following:

❑ **Why are some occupational therapy tasks, such as cooking, therapeutic?** She points out that the occupational therapist may be working to help the stroke patient regain use of an arm and practice speech and cognitive exercises at the same time.

❑ **What is therapeutic recreation, and why is playing games therapeutic?** For example, she shows that playing golf increases ambulation and balance and helps patients regain the use of their muscles.

❑ **Why is hippotherapy (therapeutic horseback riding) beneficial?**

"Once the outside case managers learn our program and see how the clients benefit, they fight for their clients to come here. It takes work to get them to that point, however," she says.

After a patient is accepted into the program, vonDoenhoff compiles a summary from the biweekly team conference and sends it to the insurance case manager, the referring physician, and the family.

Executive Summary

Subject:
Case managers must be educated on nontraditional day treatment program

Provider:
Columbia St. David's Medical Center, Austin, TX

Essential points:
- ❑ After referral, the hospital sends external case managers material that explains the program in detail and answers questions in advance.
- ❑ Payers receive detailed biweekly reports on patient progress.
- ❑ Families and physicians are encouraged to get involved if coverage is denied.
- ❑ Once convinced of its benefits, case managers push for their patients to be admitted to the program.

Going out of contract

Day treatment is rarely covered benefit by some insurance companies, but St. David's has been able to persuade some companies to go out of contract and provide the service.

"When you're dealing with smart people, they see that it's going to save them money in the long run," she says.

If it looks like the insurer won't fund the treatment program or if a patient has limited benefits, she always asks for a case manager to be assigned. "Once case managers are educated, they will advocate for their clients."

If an insurance company initially refuses pay for the program, she also tries get the family and physicians involved in getting approval. "If the family and doctors get involved, it's amazing how much more you can get from an insurance company. Letters of medical necessity have a lot of pull since the [Texas] Legislature passed a consumer protection law that allows patients to sue if an HMO refuses to reimburse for a procedure that is deemed a medical necessity," vonDoenhoff says. "That has made a night and day difference in approvals."

The type of billing depends on what the insurance company will pay. For example, the payer may want to be billed for a certain type of therapy a certain number of times a week. Others will pay for all the services but want a flat per diem rate.

Sometimes the team recommends more treatment than the insurance company is willing to pay. Then St. David's staff work with the family to come up with a solution: Some families pay for part of the therapy, for instance, or seek other funding such as help from the Austin office of the Texas Rehabilitation Commission. ■

Outcomes, practice pattern used to set benchmarks

Aim is to identify the best practices

By tracking the practice patterns of its treatment teams and comparing costs and patient outcomes among the teams, staff at the Shepherd Center in Atlanta are working to identify practices and procedures that produce the best patient outcomes for the best costs.

"We're not trying to find cost savings by cutting people and services, but by identifying ways that we can become more efficient," says **Gary Ulicny**, PhD, chief executive officer of the hospital. Shepherd specializes in patients with spinal cord injury, acquired brain injury, multiple sclerosis and other neuromuscular disorders, and urological problems.

A hospital committee appointed to conduct the benchmarking project is in the initial stages of collecting data. Those data will be used to compare the treatment practices, procedures, and outcomes from each treatment team within a particular diagnosis with those of other teams and compare how they stack up in terms of cost and outcomes.

Each patient at Shepherd is on a critical pathway and is assigned to a treatment team, led by a physician and a case manager. Shepherd is reimbursed on a per diem basis for about 70% of its patients. Most of the rest are Medicare or Medicaid patients for whom Shepherd receives a case rate.

Executive Summary

Subject:
A project to identify the most effective and efficient practices and procedures among treatment teams

Provider:
Shepherd Center, Atlanta

Essential points:
- ❑ Benchmarking project will compare practices, procedures, costs, and outcomes among teams treating similar diagnoses.
- ❑ Variances from the critical pathways, cost per day of treatment, drugs, modalities, and supplies will be compared.
- ❑ The goal is to cut costs without cutting people and services.

"We very rarely see fee-for-service or discounted fee-for-service patients," Ulicny says. "It's definitely in our interest to identify all opportunities to utilize resources more efficiently."

Shepherd treats many of its patients from the intensive care unit through the acute rehab stay and outpatient therapy. "When you look at global pricing, you need to know what the cost is to provide care from day one," he says.

However, Shepherd's efforts are not exclusively designed to cut costs, he emphasizes. "There are opportunities for savings, but they are by managing care and not cost. If you focus on cost savings, you compromise the quality of care," he says.

The benchmarking process will evaluate practice patterns to examine what practices, procedures, drugs, and equipment various treatment teams use and determine if they have an effect on outcomes.

Best costs, best outcomes

The committee will analyze the practices of the team with the best cost and best outcomes and determine what it is doing compared with what other teams are doing for the same patients. "Our goal is to identify the best practices and to set benchmarks on cost per day. Along with this, we are monitoring outcomes to make sure they don't have any negative effect on quality," Ulicny says.

The benchmarking project will include an analysis of each treatment team's variances from the hospital's critical pathways, a cost-per-day analysis for each treatment team, and an examination of the outcomes for each patient treated by the team.

At Shepherd, the critical pathway is a part of the patient chart. Staff chart by exception; in other words, they check off pathway items or chart the variances. "The examination of the critical pathways should tell us what the differences are among the teams in terms of practice patterns," he says.

In examining data for the benchmarking project, the committee will use Shepherd's cost accounting system to compare daily costs for teams treating the same type of patients. For example, it will compare cost per day for team A treating paraplegics and team B treating paraplegics, analyze why costs differ, and determine what the teams are doing to affect the costs.

It took staff at Shepherd about a year to set up a cost accounting system in which actual costs are

automatically entered into the system along with the charges. The system factors in overhead and actual costs and is adjusted periodically. It produces daily reports on cost per day for each patient.

The types of medication being prescribed may be among the factors that affect the cost of care, Ulicny says. Some physicians may prescribe a certain medication because they've always used it. "We're looking at coming up with new guidelines that may make the medication less costly to patients. This is particularly important when you have bundled pricing because the cost of medication comes out of the per diem rate."

The hospital already makes the data available to physicians and case managers so they can manage the cost of care by looking at the daily cost of treatment, Ulicny says.

Identifying benchmarks

The next step will be to identify the best practices and to set target benchmarks, possibly changing practice patterns. For example, every patient who comes into Shepherd receives X-rays on the first day. The committee may meet with treating physicians and determine that if patients have had an X-ray within three days of admission, they don't need to receive another.

At the same time, the committee will compare outcomes from Shepherd's extensive database and determine which procedure provides the best outcomes.

When cost cutting or efficiency measures are identified, Shepherd will continue to monitor the outcomes to make sure cost cutting doesn't have a negative effect, Ulicny says.

"Cost and its relationship to quality can't be separated," Ulicny says. "We have a foundation to measure both accurately, and now we are going to analyze what the relationship is and try to identify potential savings." ■

Need More Information?

For more on the Shepherd Center's benchmarking project, contact:

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Rehab Continuum Report , including **Rehabilitation Outcomes Review** , (ISSN# 1094-558X) is published monthly by American Health Consultants® , 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Rehab Continuum Report** , P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (custserv @ahcpub.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $395. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $197 per year; 10 or more additional copies, $118 per year. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $36 each. (GST registration number R128870672.)

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UNITED STATES POSTAL SERVICE

Statement of Ownership, Management, and Circulation
(Required by 39 U.S.C. 3685)

1. Publication Title	2. Publication No.	3. Filing Date
Rehab Continuum Report	1 0 6 8 - 5 2 9 4	9/25/98
4. Issue Frequency	5. No. of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$395.00

7. Complete Mailing Address of Known Office of Publication *(Street, City, County, State, and ZIP+4) (Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305
Contact Name: Willie Redmond

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*
3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305
Telephone Number: 404/262-5448

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*
Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*
Mary Booth Thomas, same as above

Managing Editor *(Name and Complete Mailing Address)*
Joy Dickinson, same as above

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Full Name	Complete Mailing Address
American Health Consultants	3525 Piedmont Road, Bldg. 6, Ste. 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check here. ☐ None

Full Name	Complete Mailing Address
Medical Economics Data, Inc.	Five Paragon Drive
	Montvale, NJ 07645

12. For completion by nonprofit organizations authorized to mail at special rates. The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes: *(Check one)*
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months
(If changed, publisher must submit explanation of change with this statement)

PS Form **3526**, July 1995 *(See Instructions on Reverse)*

13. Publication Name	14. Issue Date for Circulation Data Below
Rehab Continuum Report	87

15. Extent and Nature of Circulation	Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*	672	732
b. Paid and/or Requested Circulation (1) Sales Through Dealers and Carriers, Street Vendors, and Counter Sales *(Not Mailed)*	0	9
(2) Paid or Requested Mail Subscriptions *(Include Advertisers' Proof Copies/Exchange Copies)*	496	0
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*	496	507
d. Free Distribution by Mail *(Samples, Complimentary, and Other Free)*	23	23
e. Free Distribution Outside the Mail *(Carriers or Other Means)*	0	0
f. Total Free Distribution *(Sum of 15d and 15e)*	23	23
g. Total Distribution *(Sum of 15c and 15f)*	519	530
h. Copies Not Distributed (1) Office Use, Leftovers, Spoiled	153	202
(2) Return from News Agents	0	0
i. Total *(Sum of 15g, 15h(1), and 15h(2)*	672	732
Percent Paid and/or Requested Circulation *(15c / 15g × 100)*	95	95

16. This Statement of Ownership will be printed in the November issue of this publication. ☐ Check box if not required to publish.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Brenda L. Mooney, Publisher — Date: 9/25/98

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PS Form **3526**, July 1995

CARF appoints director of medical rehabilitation

Peggy S. Neal, MA, MBA, has been named to the position of national director of medical rehabilitation at CARF...The Rehabilitation Accreditation Commission. Neal began her responsibilities Oct. 5 at the Tucson, AZ-based accreditation organization.

Neal has been assistant vice president in the General Reinsurance Corp.'s Rehabilitation Advisory Service unit, where she coordinated rehab services for people with disabilities. Her work involved case management, educational seminars, marketing presentations, and public speaking.

Neal joins Chris MacDonell, who has served as CARF's national director of medical rehabilitation for the past eight years. In the future, MacDonell will focus on CARF's role in the international market of medical rehabilitation and will lead CARF's new Adult Day Services Division.

[Editor's note: For additional information on CARF and its programs, contact: CARF...The Rehabilitation Commission, 4891 E. Grant Road, Tucson, AZ 85712. Phone: (520) 325-1044, Medical Rehabilitation Division, ext. 107; Adult Day Services Division, ext. 171. Fax: (520) 318-1129. Web: http://www.carf.org.] ■