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INSIDE

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Details of rehab PPS still sketchy

HCFA being urged to change its approach

As the clock ticks toward the Oct. 1, 2000, deadline for implementation of a Medicare prospective payment system (PPS) for rehabilitation providers, the Health Care Financing Administration (HCFA) is being urged to modify its current approach to the PPS and to implement a system that is preferred by many in the rehabilitation field.

The American Medical Rehabilitation Providers Association (AMRPA) recently picked up support for some of its recommendations to HCFA on details of the PPS. Consider the following recent events:

• The Medical Payment Assessment Commission's (MedPAC) annual report to Congress is expected to recommend that the rehab PPS utilize the Functional Independence Measure-Function Related Groups (FIM-FRGs) for patient classification, and that reimbursement be on a per-episode rather than per-diem basis.

The FIM-FRG-based classification measure would use the FIM and historical patient data in the Uniform Data System for Medical Rehabilitation's extensive database of functional outcomes information. Many in the rehab field believe the use of this instrument would more accurately reflect the specific needs of rehab patients. Rehab professionals are concerned that, with per-diem rates, inpatient providers would be inclined to keep patients until they are completely functional, rather than sending them home with outpatient or home health services. Using the current per-episode rate, inpatient providers release patients more quickly. Since there is a cap on the total amount of money HCFA can spend on rehab services, the agency argues that per-diem rates ultimately would decrease,

Executive Summary

Subject:
HCFA urged to change rehab PPS

Essential points:

- ❑ Per-episode rather than per-diem payments proposed.
- ❑ HCFA urged to use FIM-FRGs to determine classifications, weights.
- ❑ Staff time studies going forward.
- ❑ Final version of MDS-PAC patient assessment tool due March 1.

resulting in longer stays and fewer services for patients.

MedPAC, an advisory board that makes recommendations to Congress on payment, policy research, and other Medicare issues, was scheduled to publish its report March 1. (The full report is available on MedPAC's Web page at http://www.medpac.gov.)

Under MedPAC's recommendation, the FIM-FRG would not be tested on skilled nursing facility (SNF) patients who are medically complex long-term patients, only on those who go to the SNF specifically for rehabilitation, such as following a stroke or a hip replacement.

• U.S. Rep. Pete Stark (D-CA), the ranking Democrat on the House Ways and Means subcommittee on health, has asked William J. Scanlon, PhD, director of health financing and systems issues for the Government Accounting Office to evaluate some of the concerns expressed by professionals in the rehabilitation field and to discuss them with HCFA officials before final decisions are made on the PPS.

He repeated concerns of rehab providers "both individually and through associations" about the per-diem reimbursement systems and HCFA's plan to develop patient classifications and case weights from a small sample of cases.

"Rehabilitation providers feel that use of such a small sample will inevitably lead to inaccurate classification and payments. As a consequence, there will be inappropriate rewards for treating some types of patients and financial penalties for treating others," Stark said in his letter.

Specifically, the AMRPA has been recommending to HCFA:

— that payments under the PPS be based on a per-episode rate instead of a per-diem rate as proposed by HCFA;

— that patient classifications and weights be based on the methodologies using the FIM-FRGs (these were developed for HCFA by RAND Corp. in Santa Monica, CA);

— that HCFA's patient assessment system for post-acute services, the Minimum Data Set-Post Acute Care (MDS-PAC) include the FIM rating scale used by virtually all medical rehabilitation providers. (For more details, see AMRPA's Web page at http://amrpa.firminc.com.)

HCFA still leans toward a per-diem reimbursement rate based on a different classification and case-weight study, scheduled for release this spring, and a version of the MDS that encompasses some, but not all, elements of the FIM. However, the AMRPA has picked up support for its position.

Working against a deadline

Meanwhile, the organizations that have contracted with HCFA to research the proposed PPS are moving ahead with their work.

"HCFA has made it clear to us that we have a contract and that we have a timeline, and that is what we are marching to. Any policy changes will be dealt with at the HCFA level. We don't worry about it day-to-day in the trenches," says **Robert E. Burke**, PhD, vice president at Washington, DC-based Muse & Associates and principal investigator for the HCFA's patient classification system project.

Under their joint contract with HCFA, Muse & Associates and Aspen Systems in Rockville, MD, will begin staff time measurement studies at a sampling of rehabilitation hospitals and units this spring. Using the MDS-PAC assessment instrument, the researchers will determine a patient classification system based on resource allocation. Their final report is due to HCFA in April 2000.

(For additional information on the Aspen Systems/Muse & Associates research, see *Rehab Continuum Report*, January 1999, p. 1.)

The Research and Training Institute at Hebrew Rehabilitation Center for the Aged in Roslindale, MA, is expected to submit its final report to HCFA by March 31 on the MDS-PAC. The institute's original deadline, Feb. 1, was extended. **(For information on the Hebrew**

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- **Pauline Belleville-Taylor**, MS, RN, HCRA Research and Training Institute, 1200 Centre St., Roslindale, MA 02131.

Rehabilitation Center for the Aged research, see *RCR*, August 1998, p. 101.)

Field testing of Draft 8 of the proposed patient assessment instrument began in January at 120 sites, including long-term care hospitals, rehabilitation hospitals, freestanding SNFs and SNF units, and transitional care units in hospitals. The field test should involve more than 4,000 patient assessments, according to **Pauline Belleville-Taylor**, RN, MS, CS, project director. A smaller field test may be done as a reliability test, she says.

Trimming some items

Draft 7 of the MDS-PAC, which was pilot-tested in the fall, had more than 350 items. The final document will have fewer, Belleville-Taylor says. The number and type of items to be dropped will depend on what the field test research shows, she adds.

"It's clearly too long. Some items will be dropped. We are looking at time factors. We don't need another two-hour assessment like the MDS-RUGS [the assessment instrument used in nursing homes]," Belleville-Taylor explains.

However, she says, the HCFA contract calls for an assessment instrument that is to be used in a variety of post-acute settings, which makes it difficult to shorten. ■

Extended therapy hours maximize patient gains

Therapists work from 6:30 a.m. to 6:15 p.m.

Faced with having to squeeze a full regime of therapy into fewer days, a practice that often left patients exhausted by mid-afternoon, Genesys Regional Medical Center in Grand Blanc, MI, has extended its therapy schedule to nearly 12 hours a day.

Now therapy services start at 6:30 a.m. and continue until 6:15 p.m. The change gives patients a chance to rest during the day, makes training and educational sessions more convenient for family members, and relieves the early morning frenzy of trying to get all patients up and dressed in an hour.

When patients are admitted late in the day, they can be evaluated by the therapy staff, fitted for a wheelchair, and be ready to begin their therapy the next day.

The 32-bed rehabilitation unit has 20 therapists on staff. Before the change in staff hours, occupational therapists worked from 7 a.m. to 3 p.m., and physical therapy shifts were from 8 a.m. to 4 p.m.

Now on weekdays, there are two shifts of occupational therapists: one from 6:30 a.m. to 2:45 p.m. and one from 10 a.m. to 6:15 p.m. Physical therapists work either the 8:30 a.m. to 4:45 p.m. shift or the 10 a.m. to 6:15 p.m. shift.

The hospital's administration chose the 10 a.m. arrival time for the second shift because team

Executive Summary

Subject:
Extending therapy to nearly 12 hours a day

Provider:
Genesys Regional Medical Center, Grand Blanc, MI

Essential points:
- ❏ Two shifts of occupational and physical therapists work from 6:30 a.m. to 6:15 p.m.
- ❏ The change maximizes patient gains by giving patients midday rest periods and making family education more convenient.
- ❏ Late admissions can be evaluated and fitted for equipment on day one.
- ❏ Therapy staff rotate between shifts.

conferences start at 10 a.m., and they wanted all staff to be present, says **Daniel Swank**, MPA / CRRN, director of rehabilitation.

As the rehab center's average length of stay dropped from 17 days to a little less than 12, the staff looked at ways to maximize patient gains in the short time they were inpatients, he says. Often, this meant providing far more than the traditional three hours of therapy a day.

"We found that we were cramming all the treatment into five or six hours a day, and the patients did not have time for rest periods. They were exhausted at the end of the day," says **Joy Finkenbiner**, PT, administrative director of physical medicine.

Social workers trying to do group therapy at 3 p.m. complained that the patients were falling asleep. Family members complained the patients were too tired to visit in the evenings.

"If patients weren't in therapy, they were either eating or doing other personal activities. Our new schedule allows them to rest during the day and have time for socialization with their families or go to support groups in the evenings," Swank says.

The change benefits families

The change has allowed the therapy staff to do family training activities in the late afternoon and be on hand to answer any questions families may have, Finkenbiner says. In the past, families would have to leave work to learn how to care for the patients after discharge, or the therapy staff would volunteer to stay late. "Our family reaching and training program is much more effective now," she says.

The change also has alleviated insurers' complaints about the limited amount of therapy provided to late admissions, Swank says. "Extending the therapy hours to 6:15 p.m. ensures that initial assessments can be completed by the therapists," he says. For example, a recent patient was admitted late Friday afternoon, evaluated by physical therapy and occupational therapy before the shift ended at 6:15 p.m., and started on a full therapy treatment during the weekend. **(For more information on the weekend staffing at Genesys, see story at right.)** "Insurance companies and physicians really wanted it. It came down to staff availability," Swank says.

(Continued on page 37)

Patients receive individual therapy on weekends

Insurers pushed for weekend treatment

At Genesys Regional Medical Center in Grand Blanc, MI, all patients in the rehab center receive therapy seven days a week.

Two members of the physical therapy staff and two members of the occupational therapy staff work eight-hour shifts on Saturdays and Sundays.

"If patients are on the rehab unit for only seven to 10 days, you can't let them be idle on the weekends," says **Daniel Swank**, MPA/CRRN, director of rehabilitation.

The hospital started with only a half day of therapy on Saturdays. About a year ago, half-day Sunday staffing was added. "We could accommodate all the new admits and those who really needed therapy on weekends," Swank explains.

However, as the payer mix increased to more health maintenance organization patients, insurers began requesting full therapy treatment on weekends. Insurers were pushing the acute care hospitals to release patients on Fridays, Saturdays, and Sundays if they were ready, but they didn't want patients transferred to the rehab unit if they weren't going to be treated.

"We tell them that they will be seen and have a full complement of therapies on the weekend," Swank says.

Rotating weekend duty

The hospital did not add additional staff for the weekend rotation. Instead, the administration looked at the therapy staff throughout the system, including its outpatient treatment centers, and moved therapists around to provide coverage.

More group activities take place on weekends than during the week, but enough therapists work so they can provide one-on-one treatment when indicated.

"The amount of therapy depends on the patient's individual needs and tolerance level, but it generally ranges from one to three hours of therapy per patient, on both Saturday and Sunday," says **Joy Finkenbiner**, PT, administrative director of physical medicine.

Therapists who work on weekends get days off during the week. All therapy staffers participate in the weekend rotation. ■

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Having staff come in earlier in the mornings allows them to help the patients get up and dress themselves, rather than having staff doing it for them.

"The whole emphasis of this program is to get patients to be as functional as possible, but when you have to get a lot of patients up and ready at the same time, it's often easier to transfer them or button their clothes for them, rather than letting them do it themselves," Finkenbiner says.

Small changes in schedules

Now that some of the occupational therapists are coming in at 6:30 a.m., they can see more patients and provide them with the assistance they need in getting up. Patients who want to get up earlier can do so.

"What it means is that we have a ratio of two to three patients to one staff member for the 6:30 to 8 a.m. time period. It's very manageable and allows the patients to practice their dressing and transferring skills," Swank says.

The dinner hour was changed from 5 to 6 p.m. This allows patients to rest in the afternoons and have their therapy before dinner.

Genesys started the new therapy hours in early October 1998. The administration gave the staff a month's notice about the new shift changes so the therapists could arrange family schedules. At present, staff rotate shifts every three months.

The biggest complaints have been from staff who do not want the later shift because they have to find a baby-sitter for their children after school, Swank reports. "We have emphasized that it's not just something management decided to do. It was a problem identified by the patients themselves," he says. ■

Cardiac rehab focuses on prevention, home exercise

Regime is customized for each patient

Faced with sending its cardiac patients across town for rehabilitation, a network of providers opened its own cardiac rehabilitation center with services emphasizing prevention and exercises that can be done easily at home.

The Einstein Cardiac Rehab and Fitness Center is a combined effort of MossRehab, Albert Einstein Heart Center, and Germantown Hospital and Community Health Services, all part of the Albert Einstein Healthcare Network in Philadelphia.

The center was opened in the summer of 1998 to serve patients recovering from heart-valve surgery, angioplasty, heart attacks, coronary artery bypass, heart failure, stable angina, and other heart conditions and procedures.

Instead of a structured exercise program using resistance machines, the Einstein Cardiac Rehab and Fitness Center focuses on preventing future heart problems.

"With shared-risk contracts, everybody has a stake in preventing second heart attacks through long-term management of risk factors such as smoking, diabetes, and cholesterol management," says **Lance Crosby**, RN, MA, director of the Einstein Cardiac Rehab and Fitness Center.

The cardiac rehab services include an individualized exercise and education program for each patient. "We try to make it a unique experience for them based on their own rehabilitation and education needs," Crosby says.

Treadmill walking is the primary exercise modality used at the Einstein center because it

Executive Summary

Subject:
Outpatient cardiac rehab services

Provider:
Albert Einstein Healthcare Network, Philadelphia

Essential points:
- ❑ Focus is on prevention of heart problems.
- ❑ Each patient undergoes an individualized program.
- ❑ Exercise regime is easy to transfer to home.

gives the patients a form of exercise they can do at home without purchasing a machine, he says. "Bikes, rowing machines, and other exercise machines do the job, but humans are primarily a walking machine. I want my patients to be able to leave here and do regular walking as their principal source of exercise."

For the same reason, Crosby uses dumbbells for resistance training rather than machine weights. "My patients can go out for a walk every day and put weights in their bedroom and do exercises with them twice a week. We try to accentuate transference to home activities," he says.

Nutrition, diabetic education

Patients at the Einstein Center go through a one-on-one education program based on nutrition and diet modification, with the objective of getting them down to a diet that includes about 15% of calories from fat.

Patients are asked for a diet history, what foods they normally eat, and whether they eat out or cook at home. Staff help them learn to adapt their current eating methods for a diet. "If they love meatloaf, we help them find a way to change the meatloaf. With the ethnically diverse population we serve, it doesn't make sense to hand out standard diets," Crosby says.

The program is staffed by Crosby, who is a registered nurse and an exercise physiologist, along with another nurse and a certified diabetic educator.

"Other than nutritional education, diabetic education is the most formalized education our patients receive. Both require a significant amount of discipline," he says.

Working with insurers

When a patient is referred to the program, Crosby conducts an initial evaluation free of charge and recommends a treatment plan. He then contacts the patient's insurer to find out if the services will be covered and to what extent. "As a service to the payers, we try to minimize the amount of insurance utilization so we provide value to the insurance company," he says.

For instance, if an insurer agrees for the patient to attend 36 sessions and Crosby feels the patient has accomplished his or her goals in 20 sessions, the center discharges the patient. "We don't try to

Cardiac rehab adds value to your rehab continuum

Program allows patients to stay in network

Your facility should consider cardiac rehabilitation if it handles cardiac patients but refers them to other facilities for rehabilitation**, Lance Crosby**, RN, MA, says. Crosby is director of the Einstein Cardiac Rehab and Fitness Center, part of the Albert Einstein Healthcare Network in Philadelphia.

"A lot of networks see rehab as a value-added service, not a profit center. The reimbursement is good enough so it can be profitable, but it's more a value-added service so you can manage all aspects of cardiac patients within your own network," he says.

How to get started

If you're thinking of adding cardiac rehab services to your continuum of care, consider these tips from Crosby:

- Assess whether physicians within your system are demanding to have this service for their patients.
- Determine how many potential patients your cardiac rehab program might expect. Crosby estimates about 20% to 30% of patients treated for myocardial infarction or receiving bypass surgery are potential candidates for outpatient cardiac rehab services. Providers can get this information from referring hospitals in their areas, he says.
- Look at how much space you have available and how many patients you can expect your program to treat before deciding on staffing.
- Remember that when a patient participates in an HMO, the primary care physician has to take an initiative on behalf of the patient. "The doctors have to write a letter recommending your cardiac rehab services for the patient in order for you to get paid. If you've got physician commitment, you can have a successful rehab service," he says.
- Make sure your key referring physicians have a lot of patients. You need volume to make your cardiac rehab program succeed.
- Educate local cardiologists and primary care physicians about the benefits of cardiac rehab. "If the patient avoids a future episode, everybody wins. The patient wins. The doctor wins. It's good for the rehab facility and good for the payer," Crosby says. ■

Need More Information?

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maximize insurance utilization. There is a price to pay for that in the long run," he says.

Patients generally come to the program for a one-hour session three times a week. Crosby uses the first few sessions to get to know the patients and teach them how to operate the equipment. Spouses often attend the early sessions. The number of sessions varies depending on the patient, with the average being 18.

Crosby is evaluating outcomes measures to decide which ones meet the objectives of his program. **(For more information on cardiac rehab outcomes measures, see *Rehabilitation Outcomes Review*, p. 33.)** ■

Training video saves time, reinforces teaching

Crutch-training film produced in therapy gym

The physical therapy staff at Crozer Chester Medical Center in Upland, PA, save an average of 10 to 15 minutes per patient by using a crutch training video to reinforce one-on-one training.

"We were looking at ways to save time and found that our therapists were spending a tremendous amount of time in crutch training. My philosophy is to spend money upfront to save money in the long run," says **Bonnie Breit**, administrative director of rehabilitation services for Crozer Keystone Health System.

Watching the video doesn't replace crutch training by the physical therapy staff. Instead, patients may watch the video before seeing a therapist to get an idea of what they will be working on, or they may watch it as a reinforcement tool when they are leaving."It's not meant to eliminate the need for physical therapy. It's used for pre-education, for reinforcement of crutch training, and for patients with cognitive issues who can watch it over and over," she adds.

Initially, the hospital planned to buy a video, but an Internet literature search and calls to professional organizations such as the American Physical Therapy Association located only written resources. Hospital officials decided to make their own.

$4,000 cost

"We thought that having a video would empower patients and help us educate patients more effectively. The video saves staffing time and gives patients an action to watch, rather than trying to learn from a piece of paper," says **Patti Wardius**, PT, clinical manager for physical therapy at Crozer Keystone Health System. The hospital paid a professional filmmaking firm $4,000 to produce the video.

The legal department advised rehab staff that as long as the information in the video is correct, the hospital has no liability if a patient falls after seeing it. As an additional precaution, the video instructs patients to check with their physician or physical therapist if they have questions about using crutches.

Also, the video is never used as a stand-alone tool. A staff member always works with patients on crutches.

Having the video doesn't eliminate staff contact with patients, but it does help when therapists have to treat several patients at a time in the emergency room or outpatient setting, Wardius says. The hospital also has a loaner program for the video so patients can take it home.

Executive Summary

Subject:
Crutch-training video saves therapy staff time

Provider:
Crozer Keystone Health System, Upland, PA

Essential points:
- ❑ Video reinforces individual training by physical therapists.
- ❑ Patients may watch it repeatedly and borrow a copy to take home.
- ❑ Staff use the video in the emergency room and short-procedure area.

Need More Information?

Crozer-Keystone Health System's crutch-training video can be customized for your hospital's program. For details, contact:

- **Bonnie Breit**, Physical Therapy Department, Crozer Chester Medical Center, One Medical Center Blvd., Upland, PA 19013. Telephone: (610) 447-2429. Fax: (620) 447-2946.

Here are three of the ways the hospital uses the crutch-training video:

1. Pre-admission testing.

Patients who are expected to ambulate with crutches after surgery are fit with them during the pre-admission testing and sent home to practice instead of having to undergo training after surgery, says **Larry Flenner**, PT, senior physical therapist for acute care at Crozer Chester Hospital.

"Normally, when someone comes in for surgery, they have no idea what is involved in using crutches. We use the video in pre-admission testing to get a jump-start on what will happen after their surgery," he says.

Patients who still feel uncomfortable on crutches can borrow a copy of the video and use it to practice at home, he adds.

2. The emergency room.

The emergency room techs usually provide crutch training for patients with sprains or broken bones who are to be discharged to home, but occasionally, when the patient load is heavy, a technician may not be available.

"Sometimes a nurse who wasn't familiar with crutch training would have to do it. The video gives them an educational tool that helps ensure consistent training," Flenner says.

3. Late-afternoon surgical patients.

Patients who don't undergo pre-admission testing, experience complications from surgery, or have their surgery late in the day may need crutch training when the therapy staff have gone for the day.

Now, the nurses in the short-procedure surgical unit have a tool to use to train the patients before they go home. ■

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