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INSIDE

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PPS clouds future of skilled nursing as hospitals anticipate losing millions

Financial shortfalls could force some providers to close doors

Although the prospective payment system (PPS) won't become a reality for many rehab administrators until October 2000, skilled nursing facilities (SNFs) have been dealing with the impact of a PPS reimbursement system since July 1998. The picture they paint isn't pretty. Administrators interviewed by *Rehab Continuum Report* say they anticipate financial losses from their SNFs that run in the millions, and many question whether they will be able to remain in the SNF business.

"We're estimating that for fiscal year 1999, it [the PPS for skilled nursing] will have a $1.4 million impact," says **Chris Karam**, chief operating officer of CHRISTUS St. Michael Health System in Texarkana, TX. "If we're not successful in providing these services, the future of our skilled nursing facility would be questioned. That would be unfortunate, because there is a need in the community."

"What happens to the industry if the majority of hospital-based SNFs have to go away or severely limit their scope?"

Jim McCaslin, FACHE, director of Chestnut Hill Rehab Hospital in Wyndmoor, PA, says reimbursement for hospital-operated SNFs has dropped dramatically since the PPS was implemented. "From what I can tell, the average Resource Utilization Group [RUG] reimbursement in a typical hospital-based SNF generates about $250 per day," he says. That contrasts sharply with data from the Health Care Financing Administration (HCFA) showing that 1996 average costs for hospital-based SNFs totaled $441 per patient per day — $292 for routine costs and $149 for ancillary costs, McCaslin says.

The picture isn't as harsh for freestanding SNFs. McCaslin says HCFA figures show that average 1996 costs for the freestanding facilities were $254 per patient per day, including $129 in routine costs and $125 in ancillary costs.

Karam concurs. He says costs at St. Michael's SNF typically are higher than those at a free-standing SNF. "Because we are associated with the full continuum of care, our patients are a lot more complex. Where you might see some nursing homes with two to four nursing hours per patient day, our goal is four to six nursing hours per patient day. Community SNFs aren't taking them because they're more [medically] complex, and home health and nursing homes aren't an option. We're committed to taking care of these patients, and it's part of our mission [as a nonprofit]," he says.

It's time to look at other options

However, Karam is investigating several options because St. Michael can't afford to operate with that kind of financial loss, he says. Those options include negotiating supply contracts to increase St. Michael's efficiency and looking at improving physician utilization. "But that's a tough one, because physician habits don't change overnight," he adds.

St. Michael is working with its case management staff and with the medical directors on the system's utilization management committee to make sure the most appropriate venue for care is being used for each patient, Karam says. The system also has an 80-bed rehab hospital, a 239-bed acute care hospital, long-term care programs, day rehab programs, home health subsidiaries, and a hospice.

The hospital also is developing a request for proposal (RFP) to build a referral relationship with a local nursing home in the community, Karam says. St. Michael hopes to enter a contract relationship with a nursing home that spells out expectations for quality of care and patient satisfaction. "It might be that they could take care of [some of] these patients less expensively because their cost structure is less than ours," he explains. "And it could be a win-win for them [the nursing home] to enhance their reputation in the community."

Training billers in the new PPS coding system has been a major effort at Chestnut Hill, McCaslin says. Under the RUGS system, these facilities are operating with 40-odd RUGS codes, compared with some 440 DRG codes under which hospitals typically have operated.

At Pinecrest Rehab Hospital in Delray Beach, FL, CEO **Paul Echelard**, MS, is rapidly preparing for June 1, the date the PPS system becomes effective at his SNF. June 1 is Pinecrest's effective date because it coincides with the date the facility's Medicare cost report goes to HCFA. He has put an RFP out for every ancillary service the hospital has and plans to reduce the number of staff therapists across the board by 20%.

Echelard and other senior management team members also are talking with physicians one-on-one to educate them about changes to expect once the PPS system takes effect. The idea is to tell physicians upfront that SNF staff will have to spend less time with patients in the future due to cost constraints.

As a member of an SNF subcommittee of the American Medical Rehabilitation Providers Association, McCaslin says he and others are urging trade associations to lobby for changes in the system. "One of the concerns we all have in terms of public policy is whether or not we will be able to stay in the SNF business," he says. "Then what happens to the industry if the majority of hospital-based SNFs have to go away or severely limit their scope? Pondering these ramifications is mind-boggling." ■

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COMING IN FUTURE MONTHS

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- New coding regulations challenge rehab providers
- Prospective payment update
- OASIS launch prompts privacy concerns
- More hospitals switching to product line management

You can survive under PPS, AZ facility says

SNF impact shows sign of things to come

Like many rehab administrators in skilled nursing facilities (SNFs), **Pat Moorhead** can divide her tenure at Scottsdale (AZ) Healthcare in two: before and after the prospective payment system (PPS) was implemented. The message she gave to administrators at the 2nd annual PPS for Rehabilitation Conference in Atlanta in April was this: You can survive, but be prepared to decrease therapy costs and manage them much more aggressively.

Moorhead, who recently served as manager of rehabilitation services for Scottsdale Healthcare, characterizes life under PPS in these ways:

❑ **Many patients are being shifted from the SNF to the hospital rehab unit.** In mid-November, Scottsdale Healthcare closed 30 SNF beds in the unit because of this shift. The rehab unit is now operating at 16 beds rather than the 10 for which it originally budgeted.

❑ **The unit uses more staff therapists and few, if any, contract therapists or on-call employees.** In Phoenix, a heavily capitated market with a large Medicare managed care population, the job market for therapists is tight, Moorhead says. "No one is leaving. Many places are having layoffs. There is nowhere else to go in the Phoenix area at this point, so therapists who might have left before if they weren't happy are staying." As a result, few have scoffed at working later hours — a necessity because most admissions don't arrive until at least 3 p.m., and evaluations must be done on the day of admissions to capture the minutes of care needed for reimbursement. Also, nurses and therapists are more open to working weekends, and the same therapists are working each weekend, which improves continuity of care, she says. The facility also cut its recreational therapist staff position.

❑ **Staff have had to increase efficiency.** "We used to have a standard of 22 patient care units per day, and now we have an average of 24 to 26," she says. "We also are encouraging therapists to deliver care in group settings, and those therapists are averaging 26 to 28 patient care units a day." Again, the tight job market has made therapists more willing to increase their workloads.

❑ **Time is built into some staff therapists' schedule to do MDS data entry.** Scottsdale Rehab has designated one senior therapist for the role, and time is built into that therapist's schedule for those duties.

❑ **Interaction among nurses, physicians, and other staff members has increased.** There is daily communication with nursing staff on patient progress and regular communication with case managers on discharge plans. Staff also make daily patient rounds with the physicians and use those interactions to suggest changes that might increase efficiency (such as switching antibiotics or changing dressings). Finally, staff have developed discharge criteria for each category of care.

Moorhead offers the following survival tips for providers:

— Know your rates and your payer mix. Compare these rates to your cost of care and evaluate potential new contracts carefully.

— Question every cost, beginning with supply costs. Supply costs are a great way to save money, Moorhead says. She has educated staff nurses about the expense of hospital supplies and services, and she plans to set up a display during Nurse Week that includes costs for linens, catheters, and every other supply used in a patient's room. This causes nurses to think twice before automatically doing things. Actions that can seem small on the surface — such as using towels instead of sheets in some instances — add up to large savings in the course of a year.

— Look at managing care across the continuum. Scottsdale Rehab uses weekly team meetings to evaluate where in the continuum of care a patient can be served best, Moorhead says. "If a patient still meets the criteria for the acute care unit, we'll keep them there rather than transferring them [to rehab or the SNF]." ■

Executive Summary

Subject:
Episode-of-care reimbursement concept

Essential points:
- ❑ Rehabs are beginning to embrace the concept, in which prices for specific cases such as surgical costs, follow-up outpatient care, and durable medical equipment are bundled into one price.
- ❑ Shepherd Spinal Center of Atlanta is offering bundled pricing for multiple sclerosis patients and pursuing episode-of-care contracts with managed care companies for three types of spinal patients.
- ❑ Keys to success include knowing the costs, selecting high-volume procedures, and forging effective alliances with providers outside the hospital.

Willing to assume risk? Try bundled arrangements

Volume pricing by procedure can work for rehab

If you can't beat 'em, join 'em. That's the approach a few rehab providers have chosen by trying the new cutting-edge reimbursement trend, bundled pricing. Also known as the episode-of-care approach, bundled pricing allows a hospital to charge one sticker price to cover all elements related to the continuum of care for specific types of cases.

The price might include surgical fees, operating room costs, and other associated hospital costs, as well as expenses incurred outside the hospital realm relating to patient treatment, such as follow-up medical visits to specialists outside the hospital, durable medical equipment, or outpatient physical therapy.

Going a step beyond global pricing

Shepherd Center in Atlanta, for example, has benefited from global pricing arrangements that assume risk for all procedures performed on a specific type of patient during the hospital stays. Shepherd is taking risk assumption one step further by pursuing episode-of-care deals for patients with multiple sclerosis and three categories of spinal injury patients: high-level quadriplegics, low-level quadriplegics, and paraplegics.

"Because we're also an acute care hospital, that gives us the capability to package price that very few other rehab centers would be able to do," says **Mitch Fillhaber**, Shepherd's vice president of marketing and managed care.

Specifically, the concept works like this:

A provider identifies a high-volume, high-cost procedure that has strong potential to be performed efficiently without sacrificing quality of care. For example, Medicare demonstration projects in bundled care have been conducted for total joint replacements and coronary artery bypass procedures.

The rehab unit of a hospital, either independently or through the hospital's managed care department, aligns with other health care providers involved in the procedure. This typically involves a vendor and a physician practice.

The team works together to develop a critical pathway for the procedure, developing "best practice" methods that follow patient care from the moment the decision is made to perform the surgery through preadmission checkups and tests, the actual surgical procedure, and any needed follow-up care, such as rehab or physician visits. Costs and medical outcomes are monitored to ensure goals for efficiencies, functional outcomes, and quality of care are met.

Shepherd's global pricing arrangement with United Healthcare, a Minneapolis-based HMO that charges United-defined case rates for all care delivered at Shepherd to the three categories of patients, Fillhaber says. Shepherd has benefited from the arrangement in several ways:

- **The insurer is less involved in day-to-day care decisions.** "There's a certain degree of micro-management [from an insurer] that every facility has to cope with. We felt that if we could develop a comprehensive global rate, . . . it would minimize their need to be aggressively involved in administration [of patient care]," he says.
- **Shepherd enjoys more latitude in patient care.** As the patient moves along the continuum of care, goals and needs may change. By charging one case rate for all care delivered, there no longer is a concern about whether a method of suggested care is a noncovered benefit.
- **Good results are easier to demonstrate.** As a spinal cord injury center, Shepherd typically treats patients with higher acuity levels, which often means higher costs. "Contracting on a per-diem level invites comparisons between Shepherd and other hospitals. It's too convenient for a health plan to perceive us as costly and deny an admission that we've been referred by a regional hospital or trauma center," Fillhaber says. By being able to produce care at or under a set budget, Shepherd can demonstrate it has the ability to be efficient.

Under the global case rate structure, Shepherd assumes all the risks for care within a defined range of ICD-9 codes. If care for a patient totals less than the agreed-upon price, Shepherd keeps the profits. But if care exceeds that amount, Shepherd eats the loss.

Shepherd's experience with global case rates has worked so well that the hospital is pursuing episode-of-care contracts with managed care companies for multiple sclerosis patients and for the three types of spinal cord injury patients involved in the current global pricing deal. The hospital is actively pursuing contractual arrangements with other payers, as well.

The multiple sclerosis arrangement is part of a disease state management program Shepherd

Using the episode-of-care approach to billing

Tom Pedersen, a consultant with Phoenix HealthCare in Redondo Beach, CA, and **Mitch Fillhaber**, vice president of marketing and managed care at the Shepherd Center in Atlanta, offer these tips for rehab units interested in the episode-of-care approach:

• **Know your costs and your experience in the area in question.** "Know your business inside and out, including what it costs to perform each procedure, what ancillary support or procedures are typically required, and what your rehab time and costs are," Pedersen says. This can be determined by looking at historical information your hospital has that lists every service provided for a particular procedure, and what each procedure costs.

• **Ensure you have a quality information system to track costs and performance.** This should include a relational database which will be able, with appropriately trained staff, to generate accurate and meaningful reports showing utilization of services, costs, and net income, Pedersen says.

• **Choose high-volume diagnoses for these types of agreements.** "If you're a general rehab hospital, you probably wouldn't want to do (episode of care) for a patient population if it's less than 10% of admissions. Pick high-frequency diagnoses that you've mastered care paths for and have a clear understanding of costs," Fillhaber says. If your community has several hospitals with strong rehab units, your hospital can gain a competitive advantage by offering a different type of pricing structure, he adds.

• **Pick your partners carefully.** It's necessary to have a strong contractual relationship with either a multi-specialty independent practice association or a hospital PHO in order to get a good handle on costs of care delivered outside the hospital, Fillhaber says. "Identify physicians who have practice patterns that meet the financial viability of your model. It's really no different from what a hospital would do to profile its medical staff and get costs under control."

• **Have a strong case management component, preferably in-house.** Good case managers track any variances from a standard care plan or costs, and inform the administrator or other accountable parties if there are deviations. ■

developed that sets a price based on a 12-month period of care, Fillhaber says. Based on eight years worth of data Shepherd has collected from more than 2,000 multiple sclerosis patients, the hospital developed three pricing structures based on a patient's level of drug regimen.

Patients are grouped into one of three categories: an ambulatory group, an immunosuppressant group, and a steroid group. Or payers can contract with Shepherd based on a composite rate for all their enrollees with multiple sclerosis, which is somewhere between the highest rate of reimbursement (the steroid group) and the lowest rate of reimbursement (the ambulatory group).

The costs of care contracted under these arrangements include those for medications, durable medical equipment, home health care, and any primary and specialty care related to management of the disease, such as doctor's visits, Fillhaber says. Also, the contract lists exclusions for specific types of care identified by ICD-9 codes and has a stop-loss provision when costs exceed 2.5 times the case rate in use. Once charges exceed that rate, reimbursement reverts to a fee of 80% of actual charges. This situation might occur if complications develop from a patient treatment or if other extreme events occur.

The episode-of-care arrangements Shepherd is pursuing for a select group of spinal patients includes all medical and surgical costs incurred at Shepherd as well as any continued therapy, such as preventive care visits or telemedicine outreach needed, Fillhaber says.

Why haven't more providers entered these kinds of arrangements? Some say managed care companies in some markets are reluctant to pass on the risks — and possible gains — to providers, while others say rehab can be a difficult area in which to implement the concept.

Robert Westergan, MD, medical director of the Jewett Orthopaedic Clinic in Winter Park, FL, says his practice has approached local payers about participating in an episode-of-care arrangement for joint replacement patients — to no avail.

Tom Pedersen, a consultant with Phoenix HealthCare in Redondo Beach, CA, says physical therapy and orthotics services can be tricky. Both represent areas in which care isn't always delivered "off the shelf" due to patient complications and differences in patient mix. Pedersen says it is hard to apply a set concept to treating a particular class of patients because each patient is different, and it is hard to predict how many therapy visits a patient will need. In the case of durable medical equipment, it could take several fittings for a customer to be satisfied with a prosthetic device. ■

Rehab hospital develops global pricing program

Moss offers package billing for foreign payers

Talk about a market niche. Moss Rehab in Philadelphia has found an interesting one: providing packaged pricing for services provided to amputees, brain injury patients, and those with neuromuscular disorders. The payers in these cases are foreign governments.

In 1999, the hospital expects to see 25 to 50 patients whose care is financed under global billing arrangements with foreign governments, says **Bob Meighan**, program manager at Moss Rehab. The hospital has provided these services for the past five years based on word-of-mouth referrals and the reputations of three well-known Moss Rehab physicians: Mary Ann Keenan, MD, director of neuromuscular surgery; Nathaniel Mayer, MD, director of the brain injury center; and Alberto Esquenazi, MD, director of the Moss Rehab Regional Amputee Center. "These three got together and realized that the sum of their expertise was greater than what they had individually, and they began publishing," Meighan says. "We started small with a couple of patients by accident. The physicians and administrators said, 'Let's learn while we go.' And we built this into something more than we thought it would be."

The three physicians developed their own program, known as the Institute for Mobility Examination and Treatment, Meighan says. Then they calculated costs for the typical patient for specific types of cases and came up with a set price that includes fees for surgery, operating room costs, anesthesia, X-rays, durable medical equipment, and rehabilitation.

Executive Summary

Essential points:

- ❑ Moss Rehab Hospital in Philadelphia has developed a global pricing program for billing foreign governments for specific types of surgical procedures.
- ❑ The hospital operates the service as a nonprofit gesture. If costs come in under the agreed-upon rate, Moss gives the difference back to the payer.
- ❑ The service is marketed primarily by word of mouth. Plans are under way to work with foreign embassies that traditionally have sent patients to Moss Rehab.

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- **Mitch Fillhaber**, Vice President of Marketing and Managed Care, Shepherd Spinal Center, Atlanta. Phone: (404) 350-7313.

"The original idea was to limit this to areas where we could get a handle on our costs. We wanted to make sure we accounted for outliers, so we set a price range in which 90% of patients fall," he says. Contracts with the governments include language protecting the hospital "against extraordinary events," he says. For example, a patient might suffer from another illness, such as a heart attack, while in the hospital. Providing services for that illness obviously would create more costs.

Developing cultural sensitivity among hospital staff has been key, he adds. "Any time you're working with foreign patients, you have to go to another level. Our staff has really jumped on that in an exciting way. For example, when we first began getting United Arab patients, we had a Muslim member of our staff teach cultural sensitivity for this patient population. If you go into one of our rooms for these patients now, you'll see arrows on the wall that point to Mecca. We even leave a compass in the room so they can find which way to pray toward Mecca in case they want to check whether we've done it correctly." ■

HCFA still weighing PPS methodology

Decision to come within the next few weeks

Whether you're planning a vacation or navigating a drive from your home to your office, you know there is more than one way to reach a destination. The question is, which route will lead to less frustration and save time?

The Health Care Financing Administration (HCFA) faces a similar challenge in setting up a reimbursement mechanism for the prospective payment system (PPS) that takes effect Oct. 1, 2000, for the hospital rehab industry. HCFA is expected to make a decision by May as to whether reimbursement will be based on a per-diem or a

per-discharge methodology, a HCFA project leader announced during the 2nd Annual National Forum on PPS for Rehabilitation, held in April in Atlanta.

"We will decide in the very near future which method to use," says **Lawrence Wilson**, director of inpatient post-acute care at HCFA. Many industry leaders contend HCFA officials made up their minds in the beginning that a per-diem charge system is the way to go, but Wilson says that is not the case. "I can assure you very serious consideration is being given to both sides of this issue," he says. One option being studied is a hybrid approach that incorporates elements of both systems. Wilson did not say how that might work.

Whichever methodology is chosen, the MDS-PAC assessment instrument developed by The Research and Training Institute at Hebrew Rehabilitation Center in Boston will be used, he says. (**For details on this instrument, see the April 12 fax bulletin issued by *Rehab Continuum Report.*** For a copy of the bulletin, call [800] 688-2421. The latest draft can be accessed at http://www.hcfa.gov/medicare/hsqb/mds20/pacte.htm.)

Study sample size may be too small

Work is beginning on the staff time measurement studies being conducted by an Aspen Systems/Muse & Associates team, Wilson says. Aspen Systems is in Rockville, MD; Muse & Associates is in Washington, DC. These studies will develop groups of classification systems that will place types of patients into groups with an assigned reimbursement factor.

The April 15 *Federal Register* contains a summary of the proposed collection process for the patient classification system the team will develop. HCFA has dubbed the classification system the Rehabilitation Resources Groups, Version 2000.

Following industry criticism of the Aspen/Muse study's sample size, HCFA has doubled the sample size to include 100 facilities and 4,000 patients.

The Washington, DC-based American Medical Rehabilitation Providers Association (AMRPA) continues to express its concerns to HCFA regarding the shortcomings of a payment system designed on a per-diem basis, AMRPA executive director **Carolyn Zollar**, JD, said during the presentation at the PPS conference. "There are serious budgetary implications of a per-diem approach. Over time, the length of stay will float up. Medicare will have to pay more money out, and [eventually] they will have to ratchet down daily per-diem rates. If costs are cut to hospitals, they'll have to reduce staff," and quality of care will be reduced, Zollar says.

However, Zollar says AMRPA is pleased that the Aspen/Muse staff time measurement studies now will consider nontherapy ancillary costs. And even though the sample size has been increased, she says AMRPA is concerned it still is too small. A sample of 100 facilities using 4,000 patients is small when there are 1,100 total rehabilitation facilities or hospital units, with a total of 325,000 annual cases, she says. "For low-incidence/high-cost cases, these may be undersampled, and the weights may be artificially low." ■

GAO report discovers nursing home shortfalls

Agency asks HCFA for greater oversight

Despite increased efforts by the Health Care Financing Administration (HCFA) to improve oversight of nursing home care, 25% of the nation's more than 17,000 nursing homes have deficiencies that "caused actual harm to residents or placed them at risk of death or serious injury," according to a report released by the General Accounting Office (GAO) in Washington, DC.

The most frequent violations causing "actual harm" included inadequate prevention of pressure sores, failure to prevent accidents, and failure to assess residents' needs to provide appropriate care, the report states. The report points out, however, that the survey, conducted between December 1997 and March 1999, focused on homes that had been referred to HCFA for enforcement action.

HCFA's sanctions against noncompliant nursing homes have little impact, the GAO report states. "The threat of sanctions appeared to have little effect on deterring homes from falling out of compliance again because homes could continue to avoid the sanctions' effect as long as they kept correcting their deficiencies. HCFA has some tools to address this cycle of repeated noncompliance, but has not used them effectively."

Issues that remain to be addressed, according to the GAO report, include the following:

• strengthening the use of civil monetary penalties;

• improving the referral process for sanctions;
• increasing the deterrent effect of terminating homes from the Medicare and Medicaid programs.

HCFA representatives did not return phone calls from *Rehab Continuum Report* about the report.

At least one industry group has expressed concerns about the report. The American Occupational Therapy Association (AOTA) in Bethesda, MD, has called for an additional study of clinical issues that may be indicators of poor care given the constraints imposed by the prospective payment system. "Our members are reporting to their professional association their experiences of being laid off and having their hours cut substantially," said Jeanette Blair, executive director, in an AOTA statement. Blair added that AOTA members working in nursing homes are "seriously concerned that their removal from treatment plans is jeopardizing patient care." ■

Wound program can boost revenue, patient care

More rehab programs embracing the concept

The old saying, "When one door closes, another opens," might apply to the use of wound management programs by rehabilitation departments. The same rehab departments that are stretched thin in terms of commercial and Medicare reimbursement are building revenue and improving patient outcomes through wound care and wound management.

Adding wound management services can generate between $200,000 to $457,000 in revenue per year for a hospital, depending on the size of the institution, says **Pam Unger**, PT, partner and clinical director of The Center for Advanced Wound Care in Wyomissing, PA.

"After our first eight months [of operation], we've been a moneymaker," she says. "This is an area that's booming across the entire country. There's still reimbursement for it. It [wound care] has been identified as something that exists and needs to be treated. [Rehab departments should] try to intervene with a service that's revenue-generating but also produces a positive outcome."

Although not a new concept, the area is rapidly being embraced by therapists. More than 20% of physical therapists responding to a survey sponsored by Alexandria-VA-based American Physical Therapy Association (APTA), the wound management special interest group, say wound care management should become a recognized specialty in the physical therapy field, says **Carrie Sussman**, PT, president of Sussman Physical Therapy Inc. and Wound Care Management Services in Torrance, CA.

"More than 1,100 respondents felt it should be a part of the practice of physical therapy. Eight hundred specifically said that it is part of their practice," says Sussman, a frequent consultant on wound management in physical therapy.

"Historically, therapists got into wound care via hydrotherapy, such as Hubbard tanks. But today, it has evolved to where therapists are doing open wound care. We've taken it to a more defined role," says **Cordell Atkins**, PT, a certified wound specialist who is a senior therapist and crew leader at Intermountain Health Care in Salt Lake City. Atkins also serves as chairman of APTA's wound management special interest section. "But in our physical therapy role, we have to demonstrate a functional outcome purpose. If we're working with pressure ulcers, we also have mobility activities or positioning activities, for example. If I look at diabetic wounds, I may look at gait activities, pressure reduction, total contact casting, or [shoe] insoles or inserts."

The common denominator among hospital rehab programs that have implemented wound management techniques seems to be the presence of a therapist interested in this area. Take Unger, for example. She entered the wound management area in 1981 when working in a nursing home. "Every time I had a patient with a wound, the wound got in the way of rehab. A patient wouldn't be able to do his exercises or ambulate because he had a wound in his heel, for example," she says.

Executive Summary

Essential points:

- ❏ Wound care programs can boost revenues and enhance outcomes for rehab departments.
- ❏ A collaborative approach in which therapists work with nurse managers and other clinicians is essential to assess patient needs for wound treatments as early as possible and to assign tasks/accountabilities.
- ❏ Use numbers and results to sell your hospital administrators on the need for a program.
- ❏ Costs for starting a program can be fairly minimal.

So Unger started researching what was out there. After doing some digging, she determined that rehab professionals could contribute to the area of wound management. She initiated a wound care program in the physical therapy department of a skilled nursing facility. She later established a wound care program for an 800-bed facility, then worked as a regional director for a Pennsylvania rehab agency, and, in 1991, decided to establish a wound care center at Community General Hospital in Reading, PA.

After doing some research and attending continuing education courses on wound management, Unger decided to develop a PT-directed wound care center, operating first out of the hospital's inpatient therapy department and eventually as a wound clinic within the hospital. Initially, she worked as a consultant three days a week, helping the department beef up its wound management program and dealing with patients who had specific wound management needs.

Growth occurred gradually

It didn't take long to establish a patient base. Because the hospital rotated therapists among inpatient care, acute care, and other rehab settings, Unger developed a good referral base between staff therapists and hospital physicians. "I took orders that came down from the physician, assessed the patient, and called the physician to discuss a care plan. The only outlay [to the hospital] was the cost of using me as a consultant." Unger billed a consultant's fee by the hour to the hospital.

Eventually, Unger's patient load grew enough for her to establish an on-site wound management department with ancillary clinical services at the hospital. "Initially, it was just me and a receptionist, and later we added a physical therapy assistant," she says. As patient volume increased over the years, The Center for Advanced Wound Care gradually grew to its current staff of nine. The center also added a satellite office with a staff of four.

"Don't think you need to do it all on day one," advises Unger, who consults with hospital rehab units hoping to start a wound management program. "We have our best success with clinics when we start small and progress and grow."

Atkins' involvement in wound management has led to the development of a physical therapy team specializing in wound management at Intermountain. Atkins and a partner, another physical therapist, work a seven days on / seven days off 10-hours-per-day schedule. The physical therapy team receives referrals from hospital and outpatient physicians — including plastic surgeons, general surgeons, orthopedists, endocrinologists, internists, family practitioners and podiatrists — as well as hospital-based nurse practitioners and physician assistants. The physical therapy team is able to treat the patients in their rooms or in the hospital physical therapy department, depending on the patients' needs.

Hospitals shouldn't expect to see this kind of patient volume immediately, however. Atkins has been providing wound management services for more than 17 years.

At the Veterans Administration Medical Center in west Los Angeles, the rehab department has seen subtle rather than dramatic changes since it began offering wound management treatment two years ago, says **Randi Woodrow**, PT, manager of physical therapy at the hospital.

"We're using staff time in a better way, and the costs have been minimal," she says, adding that the hospital has not totalled the costs of adding the program because funds were drawn from the department's continuing education budget.

Sussman instituted a wound management program for a skilled nursing facility to treat patients with severe mobility impairments who had developed pressure ulcers, and she found that the treatment improved patient recovery time and became an additional source of revenue for the facility. She since has branched out into a specialty in wound-management consulting for physical therapists and has co-written a book, *Wound Care: A Collaborative Manual for Physical Therapists and Nurses.*

Staff therapists educated physicians

VAMC's decision to enhance its wound care program was driven by the physical therapy department, Woodrow says. "We had a physical therapist who came to us with wound care experience," she recalls. "We didn't know what we were missing. She shared current information and education with us. It was really through her pushing that we identified that our knowledge wasn't as current as it could be."

The hospital used Sussman to train some of the staff therapists as well as educate its attending physicians and residents, who primarily are physiatrists, Woodrow explains. After the

presentation, the hospital's staff therapists invested time in educating physicians one-on-one.

"It was really very time-consuming. Traditionally, physicians would order a whirlpool treatment [for a patient with a wound infection] followed by betadine. Our message was that there are methods that are less invasive and more cost-effective" such as collagenase or hydrophilic dressings, she explains. "It was a process. It wasn't like we decided to do it one day and had approval the next. The entire process [of educating physicians] probably took a year."

Sussman agrees that physician buy-in is essential to starting a wound-management program. "Pitch it as another revenue-generating center," she suggests. "It's almost like taking your car in to be repaired. Your first two questions to the mechanic are, 'When can I get my car back?' and 'How much [will it cost]?' Similarly, physicians want to know when [you plan to implement the program] and what are the expected results. And what research do you have to back it up?" **(See story at right for resources that may provide that information and additional suggestions from Sussman.)**

Saving time and money

Woodrow says that although her department has not documented the cost and outcomes of wound management treatments vs. the whirlpool treatments typically recommended by the physicians, she has no doubt that the wound care techniques are saving time and money.

"Traditionally, when a physician would order the patient to be put in a whirlpool for 20 minutes, we needed staff time to clean the whirlpool, to sit with the patients for the 20 minutes [during treatment], and to then clean and drain the pool," she points out. "That was very time-intensive. Now, with things like electrical stimulation and dressing changes, we deal only with the involved part of the body with the wound."

Physician support is just part of the multidisciplinary team effort needed for a successful wound management program, say Sussman and Unger. "I pretty much did it all on my own initially when I started this in 1981, but you just can't do that [today]," Unger asserts. "You're not with a patient 24 hours a day. You need nurses, dietitians, and specialists like podiatrists or plastic surgeons." ■

Wound care program improves with teamwork

Management needs multidisciplinary approach

If you think of the traditional wound management program as changing dressings that contain high-tech medications, you're missing the boat. A strong wound care effort involves collaboration between therapists and other staff clinicians as well as frequent monitoring of patient outcomes, according to therapists with experience in wound care.

If your rehab department is considering adding a wound care program, these pointers may help:

1. **Wound management takes a multidisciplinary approach.** "It's very obvious that we [therapists] don't have all the answers," says **Carrie Sussman**, MS, PT, president of Torrance, CA-based Sussman Physical Therapy and Wound Care Management Services. Sussman recommends working very closely with nurses, who frequently are the referral sources for wound healing treatments by physical therapists. Both parties need to explain the treatment each is providing to the patient and the expected outcomes and should make certain they are compatible.

The Center for Advanced Wound Care in Wyomissing, PA, was created with a team concept in mind, says **Pam Unger**, PT, partner and clinical director for the center. Unger serves as clinical director, and a physician serves as medical director. The center also includes a wound care department and a wound management department. The latter includes diabetic educators, vascular services, and podiatrists, who serve as consultants.

2. **Approach the patient when developing outcomes.** Patients should be a key part of the outcomes goal-setting process, Sussman says. "It's not always as obvious as one might think. I once saw a patient who came in with a very heavily draining wound that had a lot of pus and odor. It was keeping her confined to home. What she wanted was to be able to control the odor so that she could get out of her house and go to church on Sundays and to see her family. That was her desired outcome."

3. **Distinguish between wound care and wound management to receive proper reimbursement.** "Wound care, including wound cleansing, administration of topical pharmaceuticals, and dressing changes, is typically considered a nursing service," Sussman says. "To distinguish the services of the nurse from those of a physical therapist, think of the physical therapist performing wound management, which incorporates the evaluation process of the physical therapist and the selection of interventions. It may also include the administration of these interventions or instruction, along with the wound care.

"In order to be considered a [reimbursable] PT service, it must include a service that is unique and that specifically requires the skills of a physical therapist. Examples might be: selecting electrical stimulation protocols, or sharp wound debridement accompanied by another service, such as whirlpool or pulsatile lavage with suction. Also, rehab may be a part of the wound service such as treatment of an amputee who is undergoing gait rehabilitation," she says.

4. **Develop a protocol for your wound care program.** For a sample pathway:

- Include wound assessment as part of the initial evaluation done by the physical therapist.
- Determine if any interventions are needed to heal a wound or prevent a future wound from developing.
- Determine the type of intervention needed.
- Communicate the information to the attending physician or other appropriate parties.
- Determine who does what tasks. For example, who changes the dressing? It isn't always the nurse. "Therapists are qualified to put on a dressing and topical agents, if they're doing it in the course of providing therapy," Sussman says.

At the Veterans Administration Hospital of West Los Angeles, the protocol involves team rounds of all patients who are at risk for wound problems, says **Randi Woodrow**, PT, physical therapy manager. If team members see a patient at risk for developing wound problems, they will add recommendations to the patient's chart, whether it involves a dressing change or a treatment in the physical therapy gym.

At The Center for Advanced Wound Care, patients are classified into a specific category based on the type of treatment needed, following an initial 2.5-hour visit that includes an assessment by a physical therapist and a physician and patient history data provided by a registered nurse. Patients are classified as post-surgical, traumatic, or burn patients.

The center also might use basic admitting and treatment protocols that go with each category — at least as a starting point. "The physical therapist writes a plan of care [based on these protocols] with input from team members," Unger says.

"Based on the type of case, it might include ultrasound, pulse electromagnetic induction, dressing changes, total contact casting, and exercise programs from the therapist's perspective. It also might include antibiotics or nutritional education. But the plan of care may change as things happen with the patient," she says. Once a week, the clinic has all professionals involved in the care — from surgeons to nurses to other providers —- meet to review the patients' progress.

5. **Don't forget about prevention.** Spinal cord injury patients and stroke patients are among those who frequently are at risk for wound problems, Sussman says. Prevention planning could be part of an initial evaluation as well as ongoing patient assessments.

6. **Remember: There is strength in numbers.** The American Physical Therapy Association has a wound management special interest group that is part of its section on clinical electrophysiology. Contact the association at (703) 684-2782 or on the World Wide Web at www.apta.org.

In addition to acting as a resource, the group has gotten involved in reimbursement issues affecting wound management in rehab settings. For example, APTA filed a class action suit against the Health Care Financing Administration protesting HCFA's refusal to cover electrical stimulation by therapists for wound management purposes. The suit led to a court ruling that required HCFA to consider reimbursement for these services on a case-by-case basis.

7. **Research costs and desired outcomes when beginning a program.** Potential sources include the National Pressure Ulcer Advisory Panel, which holds regular conferences and is planning a conference for Oct. 6 in New York City. Contact the organization at (314) 909-6815. Also, Sussman has co-written a book, *Wound Care: A Collaborative Manual for PTs and Nurses*, with Barbara Bates Jensen, RN. The book is available from Aspen Publishing Co. for $85. ■

Combined form saves time for staff, patients

Streamlined intake reduces patient irritation

Think back to your last visit to the doctor. Were you asked the same questions about your symptoms or reason for visiting every time a different staff member entered the room?

Eliminating patient irritation with answering the same questions repeatedly and cutting staff time spent evaluating a patient were the goals of a combined rehabilitation services intake form developed by the William P. Clough Center in New London, NH, a nursing home affiliated with New London Hospital. The center also was spurred on by a recent state mandate by the state Medicare coordinator that providers be more efficient in the area of Medicare patient evaluations.

The form has worked well since the center began using it about a month ago, says **Andy Macdonald**, PT, director of rehab services at New London Hospital. "The therapists have been happy and sad about the form. It takes less time for them, but at the same time, they're concerned that they can't put as much detail on the form," he says.

The system consists of a combined intake form filled out by the first clinical staff member to see the patient for an initial evaluation. Information included on the form consists of presenting complaints, past medical history, and other information relevant to the patient's medical condition. In addition, discipline-specific forms allow a physical therapist or occupational therapist to evaluate the patient based on standard evaluation criteria, such as range of motion or the ability to perform activities of daily living like dressing or bathing. **(See insert for a copy of these forms.)**

The information in the discipline-specific forms also conforms with criteria used by the MDS patient assessment instrument nursing homes are required to use, Macdonald says. "Our nurse who coordinates our MDS activities had trouble translating the therapist's notes, so we started using MDS terms." For example, therapists now evaluate a patient's range of motion on a scale of 0 to 2, consistent with MDS terminology, rather than listing range of motion by specific degrees.

So far, New London Hospital has used the form only in its nursing home but is considering trying it in other areas of its delivery system, Macdonald says. ■

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