AMERICAN HEALTH CONSULTANTS®

Rehab Continuum Report™

Outcomes
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The essential monthly management advisor for rehabilitation professionals

INSIDE

JANUARY 2000

VOL. 9, NO. 1 (pages 1-12)

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Doctors need your help in caring for fibromyalgia patients

The challenge is to get payers to pick up the tab

Rheumatologists and the medical community in general are becoming increasingly willing to accept the diagnosis of fibromyalgia. However, many physicians find it frustrating to treat those patients, who typically present with pain in several parts of the body, fatigue, and difficulty carrying out activities of daily living. Because their condition is chronic and prone to frequent flare-ups, there is the constant problem of making an appropriate referral. That problem leaves an opening for rehabilitation hospitals that would like to provide a needed community service while establishing a new niche market.

"Doctors are very happy to find someone who can help them with fibromyalgia patients because they become frustrated in dealing with the long-term symptoms and ups and downs of the patients' complaints," says **John Kraus**, MD, MMM, chief medical officer at Bryn Mawr Rehab in Malvern, PA.

Rehab Continuum Report offers the following case studies of two new, formal fibromyalgia programs at St. Francis Hospital in Greenville, SC, and Bryn Mawr Rehab:

St. Francis Hospital had been treating fibromyalgia patients as part of the hospital's rehab program, but hospital officials found that most physicians in the community were not aware the hospital had a program geared toward people with that disorder, says **Amy Malcomb**, MHR, business development coordinator for St. Francis Health System.

"We didn't market it, although it was on a list of services we provided," Malcomb says.

The hospital decided to expand the fibromyalgia program and promote it among physicians, starting in August 1999. As a result, the program had about 12 patients during its first few months.

Bryn Mawr Rehab has had a chronic pain management program for

nine years. Last August, the rehab facility launched a special program for fibromyalgia patients.

Fibromyalgia patients need to be treated differently than other chronic pain patients because they often have physical setbacks after strong exertion, Kraus says. "The difficulty in treating fibromyalgia is with setting limited goals because those individuals already know they are dealing with something that is lifelong or very long term, and they know that exercise or activity sometimes will increase their symptoms," he explains.

"There's no question that many people with fibromyalgia who try to get on with their normal pace of work are burdened by pain all over," Kraus says.

Therapists have to lower their goals and expectations with fibromyalgia patients, and they should emphasize having patients pace themselves, says **William Burkett**, OTR, clinical supervisor of Bryn Mawr Rehab Works of Bryn Mawr Rehab. The freestanding rehab facility is part of the Jefferson Health System in Malvern, PA.

"The fibromyalgia group tends to fatigue very quickly," Burkett says. "Our more aggressive pain management program was too difficult for fibromyalgia patients."

That was one of the main reasons Bryn Mawr decided to start a separate program with specific goals geared toward fibromyalgia patients. The program focuses on goals that can be achieved without depleting the patients' energy.

Such a program is relatively easy and inexpensive to start, Burkett says. Here's a quick look at how Bryn Mawr Rehab and St. Francis Hospital implemented their programs, with some guidelines on how other rehab facilities can follow their example:

• **Assess need.** Many rehab providers already have treated patients with fibromyalgia, myofascial pain syndrome, or chronic fatigue syndrome. Because fibromyalgia is a subjective diagnosis, patients may have similar symptoms and treatment protocols with any of those three diagnoses.

St. Francis Hospital and Bryn Mawr Rehab already had been treating those patients, so it was easy for their administrators to see the need for a special fibromyalgia program. However, rehab facilities that have not been receiving referrals for those types of patients first might survey referring physicians to see how great the need is for a fibromyalgia program.

• **Write protocols.** St. Francis Hospital uses treatment protocols that can be individualized according to patients' needs, says **Teresa Woodard**, PT, director of rehabilitation for the 218-bed hospital, which has 19 rehab beds.

Internet has many sources on the condition

Woodard researched the Internet and other sources to learn as much as she could about fibromyalgia. The American Occupational Therapy Association Inc. in Bethesda, MD, and the Arthritis Foundation in Atlanta also have information on the condition. Woodard also attended a fibromyalgia conference in South Carolina and followed up on references provided by speakers at the conference. **(See fibromyalgia resource information, inserted in this issue.)**

"Then I pulled together a team of people, and we reviewed the literature and put together a good protocol," she says.

The team included staff from the disciplines of physical therapy, occupational therapy, psychology, nutrition, and recreational therapy. They created a protocol that has two main features: an acute flare-up program and a lifestyle management program.

"The flare-up management part is traditional with physical therapy, and it's modality-based and geared toward getting the patient's pain under control," Woodard explains. "The lifestyle management part is about teaching patients what fibromyalgia is and how it's affected by sleep, stress, and diet."

Patients' progress depends on how quickly they meet treatment goals. For example, before a patient is given aerobic exercises to practice, a therapist will make sure the patient has

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performed all the active exercises without suffering from a flare-up, she explains.

The lifestyle management protocols also call for a multidisciplinary approach that helps patients manage their stress, nutrition, and exercise routines. Typically, patients with acute flare-ups are seen several times a week for two to four weeks. The lifestyle maintenance program may last 10 weeks, with patients seeing therapists twice a week.

Bryn Mawr Rehab's program consists of treatment two to three times a week for up to six weeks. Unlike the pain management program, the six-hour fibromyalgia evaluation is broken up over several days, Burkett says.

First, patients receive a 60-minute physiatric evaluation. "The doctor goes through inches of medical records to make sure all tests have been done and to confirm diagnoses," Burkett says.

Because fibromyalgia is a very subjective diagnosis, the physiatrist will make sure the referring clinician has not overlooked a symptom that could signify a different disease or disorder. Then patients have a two-hour physical / occupational therapy screening in which therapists check musculoskeletal and functional status, looking at how long patients can sit, stand, and walk, as well as determining which positions exacerbate pain and discomfort.

Psychology a major role in treatment

Next, patients meet with a clinical psychologist. The psychologist looks at family dynamics and changes in roles in employment or in the family, and then assesses how patients are adjusting to those changes. Also, the psychologist asks patients about sleep patterns and pain levels and administers patient personality and psychosocial adjustment tests.

"After the evaluation process takes place, treatment modalities are developed," Burkett says. Those may include strengthening and stretching exercises, body mechanics, pacing, aquatics, psychotherapy, biofeedback, stress management, and other treatments.

One important part of the fibromyalgia program is a focus on energy conservation. An occupational therapist works with patients to teach them about pacing and how to avoid flare-ups.

"Fibromyalgia patients have good days and bad days, and on a good day they may go out and do as much as they can that day because they don't know how much they'll be able to do the next day," Burkett explains. "Then they will overdo it and have to spend the next few days in bed."

OTs teach patients how to pace themselves and how to move in a way that conserves energy. They also show patients how to rearrange their daily tasks to make their lives much simpler.

Fibromyalgia patients also are given psychological treatment to help them develop coping skills and the ability to manage their condition.

The program next focuses on how patients can continue the exercise, diet, and stress management routines after they are discharged. "We put them on the right track and get them to think about joining a fitness program," Burkett says. Therapists encourage patients to stick with a lifelong maintenance program.

• **Market to referral sources.** St. Francis Hospital markets its fibromyalgia program directly to physicians. The hospital's marketing representative, who is a physical therapy assistant, handles all parts of the rehab / ortho / neuro product line, focusing particularly on marketing the hospital's outpatient rehab programs.

The representative visits doctors' offices and meets with physicians or their office staff to discuss the disorder and to give them new brochures that detail the program's features. The brochures are geared toward patient education and provide physicians with a list of fibromyalgia services.

Bryn Mawr Rehab markets its program to a variety of referral sources, including physicians, consumers, and a fibromyalgia support group. The facility has a nurse who markets the program to physicians. It also has a Web site that can be accessed when people type "fibromyalgia" into a search engine.

"We're marketing our fibromyalgia program to consumers more than just about any other condition," Burkett says. "We also do consumer mailings that are sent to thousands of people within the health system."

• **Convince payers to reimburse services.** Reimbursement is the largest obstacle to providing a fibromyalgia program, although Bryn Mawr Rehab and St. Francis Hospital have developed some strategies that address the problem.

At St. Francis, all of the billing so far has been therapy-based and coded that way, so reimbursement hasn't been a major problem, Woodard says. "We haven't billed anybody based on the entire program. It's all individual sessions — we don't have a package program cost." However, the program doesn't provide specialized psychology, nutritional, or recreational therapy services

that might run into reimbursement snags.

Bryn Mawr Rehab's fibromyalgia program has encountered some reimbursement problems, Kraus says. "The biggest stumbling block is insurance carriers because it's a chronic problem, and they're much more cautious about approving treatment. So we have to focus on very specific goals and what we want to accomplish with a patient within a specified time frame."

For example, the program won't propose ultrasound treatment three times a week for six months. Instead, it focuses on teaching patients about their condition and how to control their pain. "Hopefully, the insurer will recognize the goals the patient's achieving and will see how it helps the patient reduce the need to return to doctors frequently and rely on medication, which will ultimately reduce the cost," Kraus says.

The other problem is that insurers frequently balk at paying for the psychological treatment. "They say if it's emotionally related they won't pay for that," he explains. "They say they'll pay for the physical treatment."

Bryn Mawr deals with those funding issues by seeking other sources to pay for the psychological and stress management services. For instance, a local office of vocational rehabilitation might kick in some funding if a patient is looking for work and might be able to return to work, Burkett says.

Workers' comp not yet convinced

A fibromyalgia program also is a tough sell to workers' compensation plans, which are not comfortable with paying for a condition that might not have been triggered by a patient's work-related injury. Bryn Mawr has received some workers' compensation cases after a person's low-back or other injury isn't resolved and escalates into a sleeping disorder and chronic pain, and the worker still can't return to the job.

"The workers' compensation arena feels like they're responsible for your low-back injury and only what relates to the injury site," Burkett says. "They won't pay for the psychology stuff or medications to help you sleep."

Rehabilitation facilities will have to work with payers and modify their fibromyalgia programs to increase insurance coverage, Kraus suggests. Providers have to give patients their best treatment within the parameters of what they can provide and what's reimbursed, he adds. ■

Details on fibromyalgia

An estimated 2% of the population suffers from the chronic pain syndrome called fibromyalgia.[1] And 17% of Gulf War veterans with soft tissue syndromes had fibromyalgia.[2] The disease also is associated with people who have had a car accident, a viral or bacterial infection, or who have lupus, hypothyroidism, or rheumatoid arthritis.

Patients experience relentless musculoskeletal pain, fatigue, sleep disturbance, abdominal problems, tension, migraine headaches, and a variety of other symptoms. Some people describe it as similar to the flu. The associated sleep disorder is called the alpha-EEG anomaly, in which fibromyalgia patients' deep sleep is constantly interrupted by brain activity, leaving them feeling unrested when they awaken.

Some fibromyalgia patients also have temporomandibular joint dysfunction syndrome, which causes face and head pain or tenderness. Those patients also might be sensitive to odors, noise, bright lights, chemicals, medications, and certain foods. Environmental changes, hormonal changes, stress, and anxiety can lead to symptom flare-ups.

While fibromyalgia has no known cure, patients can learn to adjust and limit flare-ups and symptoms through rehabilitation treatment.

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Need More Information?

- **William Burkett**, OTR, Clinical Supervisor of BMR Works, Bryn Mawr Rehab, 414 Paoly Pike, Malvern, PA 19355. Phone: (610) 251-5681.
- **John Kraus**, MD, MMM, Chief Medical Officer, Bryn Mawr Rehab, 414 Paoly Pike, Malvern, PA 19355. Phone: (610) 640-3935.
- **Amy Malcomb**, MHR, Business Development Coordinator, St. Francis Health System, One St. Francis Drive, Greenville, SC 29601. Phone: (864) 255-1757.
- **Teresa Woodard**, PT, Director of Rehabilitation, St. Francis Hospital, One St. Francis Drive, Greenville, SC 29601. Phone: (864) 255-1428.

REHABILITATION
OUTCOMES REVIEW™

Meet market demand with new services for seniors

By **John Whitman**
Chairman and Chief Executive Officer
The Whitman Group
Huntingdon Valley, PA

No matter what anybody says about the health care industry, one basic fact cannot be denied: Form follows finance.

As reimbursement changes are introduced by the Health Care Financing Administration, a direct and often profound change follows in the provision, location, and target market being served by providers. As a result, administrators of rehabilitation facilities must constantly think strategically about serving new and different market cohorts within their service areas.

For many organizations, the senior market traditionally has represented a significant portion of their patient population and overall business. A strategic look into the future, however, with the rapidly approaching prospective payment system for acute rehabilitation, strongly suggests that now is the time to reevaluate this special population to identify new areas of need that represent service and financial opportunities for your facility.

Time and time again over the last four decades, we have seen example after example of major, sometimes sweeping changes brought on by nothing more than a modification of reimbursement. Look at the introduction of the Medicare and Medicaid programs in the 1960s, the prospective payment system for acute care in the 1980s, managed care in the 1990s, and now the prospective payment system for Medicare skilled rehab care. Let's not forget some of the other "minor" changes such as "caps" on physical therapy (PT), occupational therapy (OT), and speech therapy and limitations on home health care.

While many are viewing those more recent changes as very close to being "the straw that broke the camel's back," others are taking a more realistic view and asking themselves two important questions: What can I do now to best serve my patients, yet still make money for my facility? How can I change my services to prepare for the future?

To these positive thinkers and doers, I tip my hat! They have the attributes we need in health care today. Individuals who know the system is flawed know change must take place, and they work toward that change while never losing sight of their primary objective — to serve their patients well. It will be these forward thinkers who first begin to meet market demands for senior services.

Senior market a strong niche

While markets can change dramatically from one area of the country to another, the rapidly growing senior market is one constant everywhere in the United States. The growing volume of seniors is in itself worthy of concern. As health care continues to improve and people are living longer, it becomes easier to see the potential issues and opportunity.

Is your facility responding to this opportunity? It's more than just offering PT and OT for hips and joints. It's not simply providing outpatient service to follow up hospital discharges. Those services are truly important, but rehab facilities have been providing them for years.

If your facility is really interested in serving this ever-expanding market cohort, it's time to take a big step back. It's time to commit the resources to understand the needs of your senior

market. It's time to go outside the traditional lines and develop responses to meet those needs while maintaining and contributing to the financial integrity of your organization.

How do you do this? Well, first you need to understand, truly understand, the senior market in your community. This can only be done through basic research. You must construct a true and accurate picture of your market and the seniors you want to serve. You must understand that "the senior market" represents multiple subsets each with their own set of needs and required services. The "purchaser" of services could be the patient, but more likely it will be their children or Medicare of managed care programs.

The best way to truly understand the senior market is to go back to basics. Look at these specific demographic characteristics:

- age cohorts — in 10-year cohorts;
- gender;
- living status;
- health status;
- income levels.

Second, look at what senior services are currently being offered in your market by competitors and noncompetitors, including the local area office for the aging and the county office for the aging. Knowing what is being offered helps to identify gaps or needs not being meet.

Ask seniors what they want and need

Third, listen to those who know. That includes not only local professionals involved in health care services for seniors, but also the clergy, hospital discharge staff, and health maintenance organizations, which usually do have good statistics on senior services. Perhaps most importantly of all, you should listen to the seniors themselves. Hold focus groups with eight to 12 seniors, grouped within the same age cohorts if possible, and you will quickly identify what is being done well in your market and where needs still go unmet. Your senior volunteers perhaps offer you the greatest opportunity for frank commentary on what they and their friends see as needs in your market. Seniors are a great source of information but are too often overlooked. As professionals, we tend to assume we know what their needs are and how to meet them. That kind of attitude has resulted in disastrous financial consequences for more then one health care organization in the recent past.

Also, don't forget to talk to the adult children of your seniors. After all, they are more often the purchasers of services than the seniors are. Conduct several focus groups with those adult children, again trying to group them in cohorts by the age of their parents.

Another group that often has incredible insights into the needs of the elderly is your local clergy. Convene several focus groups with representatives of your local clergy and discuss the needs they see among their seniors. Be careful to structure the discussions to properly assign the needs they identify to the right age cohort within the senior population.

While some of the programs you might identify have third-party reimbursement available, others will not. In the past, some providers have steered away from other-than-basic services for seniors, due to the lack of reimbursement or fear of financial losses. While it is true that many of the service needs you will identify in your market analysis do not have traditional reimbursement available for them, you must think creatively. In many markets, the seniors themselves have significant resources, and paying out of pocket is a very appropriate option.

Other options exist as well. Rehab facilities can become catalysts in their communities. They can convene a summit of local financial institutions, area offices for the aging, clergy, and others serving the elderly. The focus of the summit should be establishing a reverse mortgage program or other financial mechanism that will allow local seniors to access the equity in their homes without the fear of being forced to move. Many elderly people are cash poor.

Developing a trusted approach where they can access their equity will provide additional cash to purchase services they need. This is just one example of nontraditional thinking with the ultimate goal of providing the seniors in a rehab facility's market with services they need while assuring financial integrity for the rehab facility.

What services are creative in today's market? While you will need to conduct your own in-depth evaluation of your market, some of the current programs that are responsive and responsible for many markets include the following:

- **Incontinence programs.** This should be more than a part-time effort initiated in a physician's office or PT department. It needs to be a well-planned effort designed to identify seniors over 70 who have incontinence, hide their problem, and currently do not seek treatment. Recent studies

have shown as many as 30% of community elderly over 70 have a problem with incontinence, yet only one out of 12 seeks help! Just think of the impact your facility could have on an individual senior with incontinence by returning some control to his or her life. Multiply that by 30 or 40 each month. In addition, your facility can actually make money with an incontinence program through Medicare and most managed care programs.

• **"Operation Stay Independent."** Regardless of what name it goes by, this program includes a wide range of efforts geared to help seniors live safely in their homes for as long as possible. Rehab facilities should consider a full spectrum of support services to help seniors remain independent, including evaluations to assure safety, basic maintenance, shopping, house cleaning, visiting nurses, and homemaker services. Reverse mortgages as discussed previously offer an opportunity to make services available to more than just those seniors with the immediate resources to pay for them out of pocket.

• **Senior wellness centers.** Senior wellness programs have become popular in many parts of the country and are typically geared toward the younger, healthy senior cohort. Many facilities have tied them into wellness programs for their own staff gaining additional benefits.

Keep in mind that not every program will work in every market, and your facility may not be the best to offer a specific service. Carefully evaluate each opportunity and identify those that are best for your organization. Also, an important detail to remember is that not all needed services will have adequate reimbursement. That is where the creativity comes into play. In addition, don't lose sight of the fact that it is the overall system impact that is important — not the financial viability of a single program. For example, if your facility needs to pay $5 for transportation to assure a senior in the community can keep a physician appointment or a needed therapy treatment, isn't that cost offset by the overall financial benefit of the services provided?

Which senior services are right for your facility? To make such a decision, you first must have the facts and details needed to make an informed decision. Complete your in-depth market analysis, then apply the findings to your facility's mission statement, recognizing your available assets. Carefully evaluate the programs you have selected and develop revenue and cost projections. Don't forget to include the system impact in your financial review. Select the best programs and then make a decision and begin to implement the plan. Too many facilities study potential opportunities to death and move so slowly that a once-good idea may no longer be appropriate, effective, or profitable.

The important thing to remember is a rehab facility can meet the needs of its senior market while maintaining financial integrity. At times it may not be easy, but it can and should be done.

[Editor's note: Whitman can be reached at 3501 Masons Mill Road, Huntingdon Valley, PA 19006. Phone: (215) 657-9990, ext. 203. Fax: (215) 657-9547. E-mail: jwhitman@whitmangroup. com.] ■

Use this example to improve satisfaction

(Editor's note: This is an update on Warm Springs Rehabilitation Hospital's patient satisfaction quality improvement project. Rehabilitation Outcomes Review *first featured the San Antonio facility's program in May 1999. Since then, the hospital has been named a finalist in the 1999 "Client Success Stories" by Press, Ganey Associates in South Bend, IN.)*

Patient satisfaction is a quality improvement (QI) project that never ends. At least that's what Warm Springs Rehabilitation Hospital in San Antonio has discovered.

The hospital staff and management have worked hard to improve and refine the hospital's customer satisfaction rating. For example, the hospital's laboratory services area launched its own QI project after scoring poorly in 1995 on the hospital's first patient satisfaction survey from Press, Ganey Associates in South Bend, IN. The efforts soon were rewarded, and the laboratory services area's patient satisfaction scores rose considerably in the years after the first survey.

The lab department also has won the Ernest A. Codman Performance Improvement Award from the Joint Commission on Accreditation for Healthcare Organizations in Oakbrook Terrace, IL, and the hospital was a finalist for the 1999 Press, Ganey "Client Success Stories" award because of its improvement in patient satisfaction with laboratory services. However, hospital and lab managers since have learned a humbling lesson that you can't coast after reaching the top.

In the latest survey, for the period ended Aug. 31, 1999, the hospital's overall patient satisfaction

score was 87.5% at a 58th percentile, and lab services scored 87.5% at a 48th percentile. The survey's mean score for lab services was 87.6%.

"Our latest scores weren't so good," says **Beverly Rhodes**, MSHP, RRA, director of quality standards/risk management. "But it's a good thing because it shows that making an effort does matter: You can't have a project and work real hard on it and then stop trying to improve it."

However, the hospital's very first patient satisfaction survey was a major disappointment to the lab staff, especially because they didn't know why patients had rated their services so low. To make matters worse, the patients who were surveyed said the lab services department was the No. 1 factor in determining their overall satisfaction with the rehabilitation hospital. "This was shocking to me," says **Jackie Keene**, MT (ASCP), director of laboratory services for the 66-bed hospital. "We're vital in determining a patient's health, but in terms of having one-on-one contact with patients, that's such a miniscule part of our day."

When she dug to find out why patients were displeased, she learned how important the seemingly trivial can be. For instance, patients wanted the person who was drawing their blood to be friendly, cheerful, and even bubbly.

Scheduling was another problem: Rehab hospitals, unlike acute care hospitals, try to avoid waking patients in the middle of the night for blood draws because patients need to be rested for therapy. So Warm Springs has all the blood draws conducted between 6 a.m. and breakfast time, which started at 7:30 a.m., Keene says. That created too much stress for phlebotomists who might have to draw blood from 25 people in an hour. Patients sensed that the phlebotomists were stressed, which led to their own dissatisfaction. To help resolve that problem, the hospital decided to have respiratory therapists help the laboratory staff draw blood during those crucial morning hours.

Here are some other strategies Warm Springs Rehabilitation Hospital devised as part of the quality improvement project:

1. Speak with patients. Managers now are assigned to certain patient rooms as part of the adopt-a-room program. Each manager is responsible for meeting patients and making sure they have everything they need.

2. Educate staff about what patients see as quality care. Patients were much more concerned with how the blood was drawn than what happened to it afterward. Moreover, patients assumed that the lab staff would handle the technical end of their work in an excellent fashion, so learning how well the lab did its behind-the-scene work did not impress them.

3. Educate patients and work with physicians. Keene solved the problem of disturbing patients with multiple blood draws by teaching phlebotomists and other staff how to educate patients about the reasons for them. Staff end the discussion by suggesting patients ask their doctors about the lab work if they need more information.

Lab staff began to keep a list of all add-on lab orders and pointed them out to the hospital's medical staff leadership. Keene showed physicians how the patients with add-on lab tests were the ones who gave low ratings to lab services and to the hospital. As a result, some physicians began to reduce their number of add-ons. ■

Need More Information?

- **Jackie Keene**, MT (ASCP), Director, Laboratory Services, Warm Springs Rehabilitation Hospital, 5101 Medical Drive, San Antonio, TX 78229. Phone: (210) 592-5363.
- **Beverly Rhodes**, MSHP, RRA, Director of Quality Standards/Risk Management, Warm Springs Rehabilitation Hospital, 5101 Medical Drive, San Antonio, TX 78229. Phone: (210) 592-5377.

2000 prospective payment could be the 'Big One'

Will rehab follow home health, SNF, hospital?

If rehab facility administrators seem a little edgy these days, it's quite understandable. The industry will enter the new year anxious about what may become a cataclysmic change in how Medicare reimburses for inpatient rehab services.

Rehab providers have been in the unfortunate position of watching a hurricane sweep through home health and skilled nursing facilities, all the time knowing the same "Big One," called the prospective payment system (PPS), was heading their way next.

In the home health arena, 20% of the agencies were forced to close in the past two years, and that was merely the result of the reimbursement changes under the interim payment system, says **Pauline Degenfelder**, PhD, MBA, FACHE, vice president of The MetroHealth System in Cleveland. The MetroHealth System provides a variety of post-acute services, including intermediate care, subacute skilled nursing, home health, adult day care programs, and rehabilitation.

The home health proposed rules on PPS were published in late October 1999, and home health industry experts have said they likely will result in more home care agencies closing their doors. One saving grace for the rehab industry might be that it never went through the rapid growth and expansion that characterized home health in the first half of the 1990s, she says. Like a coastline with too many wood-frame vacation homes, the home health industry was extremely vulnerable to the destructive forces of the Balanced Budget Act of 1997. "The rehab industry has had a more moderate type of growth," Degenfelder adds.

The rehab industry has supported legislation aimed at requiring the payment unit to be per discharge, says **Carolyn Zollar**, JD, vice president of government relations and policy development for the American Medical Rehabilitation Providers Association (AMRPA) in Washington, DC.

At press time for this issue of *Rehab Continuum Report*, it appeared that Congress would pass and the president would sign the Medicare relief bill, which would specify a per-discharge payment unit for inpatient rehab PPS. The act also would put a two-year moratorium on the annual caps for rehabilitation therapy. The caps, which went into effect this year, were a combined $1,500 for physical and speech therapy and a separate $1,500 for occupational therapy.

"We're very happy to see the moratorium placed on the rehab therapy cap," Zollar says.

Although the inpatient rehabilitation PPS proposed rule had not yet been released when *RCR* went to press, rehab experts point to several possible changes under PPS that could result in major changes to the industry. Those include the following:

• **Transition period.** The Baltimore-based Health Care Financing Administration (HCFA) is required by law to provide a two-year transition period, from 2001 to 2002. In the first year, rehab facilities will receive two-thirds of their TEFRA payment and one-third of their payment under the PPS. AMRPA chairman Ken Aitchison addressed this issue in an Aug. 26, 1999, letter to Robert Kuhl of HCFA's Chronic Care Purchasing Policy Group of the Center for Health Plans and Providers.

Recommendations from the chairman

Aitchison wrote, "We wish to assure that the TEFRA payments as calculated fully account for all inpatient operating costs, pass-through payments, adjustment payments, and incentive payments, plus any cost sharing and annual updates."

Aitchison also recommended that HCFA retain periodic interim payments until PPS is fully implemented because a rehab facility's cash flow could be disrupted if the facility has to wait until a case is discharged for payment. That would be particularly difficult in cases such as head injury and spinal cord injury, for which the average length of stay is considerably more than two weeks.

• **PPS payment rates.** HCFA is expected to propose an annual update under PPS beginning in the fiscal year 2001. The increase factor is expected to be based on what is considered the appropriate percentage increase for a market basket of goods and services that receive Medicare rehab services payments. AMRPA recommends HCFA use the hospital wage index in determining the labor-related share of the rates to be adjusted for local wages.

• **Criteria for exclusions.** This section is particularly troublesome to the rehab industry. The criteria include a requirement that 75% of inpatients receive intensive rehabilitation services for these 10 conditions: stroke, arthritis, burns, amputation, spinal cord injury, fracture of femur, major multiple trauma, congenital deformity,

head injury, and other neurologic conditions.

The rule is so strict that if a rehabilitation facility has more than 25% of its services in areas that are outside the list of 10, then the facility will lose its Medicare exclusion from the diagnosis related groups (DRGs) and will be paid under the DRGs, explains **Bill Munley**, MHSA, CRA, administrator of rehab / neuro / ortho services at St. Francis Hospital in Greenville, SC.

"And the 75% applies to all patients, not just Medicare patients," Munley adds. "When you're a designated specific inpatient rehab center, all patients have to conform to HCFA guidelines, and you can't, for example, put a Blue Cross patient with appendicitis on your unit because all patients have to meet Medicare criteria."

The problem is that the list is based on conditions that rehabilitation hospitals treated in the late 1970s and does not reflect all the changes in medical rehabilitation in the two decades since, wrote Aitchison. "We recommend that these criteria be revisited and changed. We recommend that it be revised to reflect the conditions included in the rehabilitation impairment categories (RICs) as outlined in the 1997 RAND report."

For example, HCFA should add the categories of chronic pain, cardiac, and pulmonary rehabilitation, Aitchison wrote.

Munley agrees those three categories, plus oncology rehabilitation, should be added to the list. "Our hospital has branched out into those four categories, and we take in patients who are debilitated and need rehabilitation," he says.

Without changes to the criteria list, rehab facilities that are not associated with trauma centers are at a significant disadvantage because they cannot receive referrals for spinal cord injuries, major trauma, or head injury, Munley notes. "And since congenital deformities are so rare, that means five out of the 10 categories we don't receive at St. Francis. That's why we're so dependent on orthopedic and stroke patients."

• **Research burden.** Collecting information under the MDS-PAC system, as HCFA officials have said is planned, will impose a research burden on rehab facilities, AMRPA officials say.

"Organizations that have participated in the MDS-PAC field studies are concerned about the size and time it takes to collect data," wrote Aitchison and Allen W. Heinemann, PhD, ABPP, chairman of the AMRPA PPS Task Force Work Group on MDS-PAC in an Oct. 13, 1999, letter to HCFA. "This assessment tool has become a very large and comprehensive instrument," they wrote. "However, its detailed nature imposes a large administrative burden on facilities."

The tool is expected to be costly to implement and will require considerable staff time and training. Rehab providers who have participated in field tests of MDS-PAC say completing the tool requires at least 60 minutes. Multiply that by the at least three times the tool is administered during a patient's stay, and that means completion will take three hours per case.

Aitchison and Heinemann also noted that most facilities would have to hire at least one extra employee to handle using the MDS-PAC, which would cost the rehab industry about $41 million.

• **Transfer rule.** HCFA's transfer rule for acute care hospitals has cost some hospitals thousands of dollars but hardly posed a financial ripple at others. The rehab industry has some concerns about how severe any transfer rule might be once HCFA imposes it.

The transfer rule, which was implemented for acute hospitals on Oct. 1, 1998, basically establishes a set length of stay for a set of DRGs. If a patient is discharged from acute care and sent to a post-acute facility, including rehab services, after a shorter length of stay than HCFA has established, the acute care hospital will lose a significant portion of its reimbursement.

HCFA devised this rule to prevent hospitals from shifting patients to a less costly setting after a brief length of stay and then collecting the full

Need More Information?

- **Pauline Degenfelder**, PhD, MBA, FACHE, Vice President, The MetroHealth System, 2500 MetroHealth Drive, Cleveland, OH 44109-1998. Phone: (216) 778-5020.
- **Chris Ensmann**, MS, Administrator/Director, Rehabilitation Services, North Mississippi Medical Center, 830 S. Gloster, Tupelo, MS 38801. Phone: (662) 841-4054.
- **Bill Munley**, MHSA, CRA, Administrator, Rehab/Neuro/Ortho Services, St. Francis Hospital, One St. Francis Drive, Greenville, SC 29601. Phone: (864) 255-1871.
- **Carolyn Zollar**, JD, Vice President, Government Relations and Policy Development, American Medical Rehabilitation Providers Association, 1606 20th St. N.W., 3rd Floor, Washington, DC 20009. Phone: (888) 346-4624.

acute care payment for a particular DRG. "Back when HCFA implemented DRGs in 1983, it made people more efficient and patients get out sooner, cutting costs by moving patients to a different level of care, such as skilled nursing or home health, which all have their own reimbursement system," Munley explains.

"The government's reasoning was that people were getting out too soon, and patients were not getting the time they needed, and they weren't sure outcomes would be the same," he adds.

The problem is that this transfer rule had a potential negative financial impact on hospitals that already had become very efficient in reducing the length of stay. St. Francis Hospital in Greenville, for instance, had estimated the change would cost $235,000 in its first year, Munley says, adding that the loss actually was less than that.

However, the other impact from the transfer rule is on referrals to rehab facilities. Some hospitals will refer patients later in their recovery process under the transfer rule, he notes. "We wouldn't do that at St. Francis, but we've noticed that referrals from outside facilities are coming to us later from the patient's onset of injury. It's not a big difference, but we've noticed it."

Other hospitals have noticed no impact from the acute care transfer rule. "Our DRG lengths of stay worked out to the point where we didn't have to adjust anything or change our discharge patterns at all to come into compliance for transfer rules," says **Chris Ensmann**, MS, administrator / director of rehabilitation services for North Mississippi Medical Center in Tupelo, MS. The large rural hospital has 650 beds, with a 30-bed rehab facility, and it serves 22 counties in northeastern Mississippi, northwestern Alabama, and southern Tennessee. ■

Pleasing patients is all in the details

Hospital knows what it takes to make them happy

It's the little things that sometimes count the most when a rehabilitation facility is attempting to improve patient satisfaction. Patients already expect therapists to do their jobs competently and cheerfully, and they may not give you a lot of credit for meeting those expectations. But they will notice if their dinners are lukewarm or if no one is paying attention to their complaints.

Those are the lessons Warm Springs Rehabilitation Hospital in San Antonio has learned during its long focus on improving customer satisfaction. The hospital's success with patients recently was recognized by the Press, Ganey Associates of South Bend, IN, which named the hospital a 1999 finalist in its "Client Success Stories" awards. **(For more information, see story on the hospital's lab department's efforts to improve patient satisfaction, p. 7.)**

Making patients happy sometimes boils down to simply making sure they receive their cold food cold and their hot food hot, notes **Beverly Rhodes**, MSHP, RRA, director of quality standards / risk management for the hospital. "Small things make a big difference."

Rhodes and other managers dissected their patient satisfaction survey results and discovered that many problems centered around patients' special diets. "We have them on a special diet, and we have no choice in what they can eat, and so they think, 'Yeah, I'm on a special diet, but if they ask me if I like it, then the answer is no, I don't like it,'" Rhodes says.

There were other little irritations that caused patients to rank the hospital lower than managers would prefer. So the hospital's quality standards staff and managers set about to make changes that ultimately increased scores from 85% to a peak of 89.5%.

Here are some of the hospital's changes:

- **Improve food service.** While hospital staff couldn't do much to change patients' special diets, they could make sure the food at least was served at the correct temperature. Patients had expressed dissatisfaction with their meals' temperatures, so the hospital invested in microwaves on every floor and examined its entire food delivery process.

Managers discovered that the food often cooled before it was served for two reasons: the insulated serving trays were old and had begun to lose some of their insulating ability, and it took a long time for employees to serve patients. One employee might have 30 trays to take to a unit, but as he is delivering meals, patients would make additional requests. For example, a patient might ask the employee for help in sitting up or with taking a pain pill or with going to the bathroom. Handling all of those requests takes time and results in cold food.

The facility solved that dilemma by altering staff's lunch and dinner breaks, so nurses and others would be available to provide extra assistance during mealtimes. If a patient says her meal is cold, staff can heat it up in the microwave on the floor.

Because this required staff to spend more time with patients during their meals, hospital managers emphasized to them the importance of improving patient satisfaction.

• **Handle family communication.** This is a tricky issue because different family members will have different expectations and agendas, and their perceptions might lead to an unhappy patient.

"One family member might want to take Mom home, while another wants to put Mom in a nursing home," Rhodes says, adding that there might be several different perceptions of what the goals should be for the patient. Plus, the nursing staff might think the family wants one thing, while therapy staff have an entirely different idea. Communication problems between family members and departments can become confusing.

Warm Springs Rehabilitation Hospital has found that the best way to prevent major communication problems is by meeting with family members to set goals before expectations can become unrealistic.

"We ask family members, 'What are your expectations for your loved one?' and we use that information along with the physician's goals and clinical goals," Rhodes says. "This way, we have a better idea of what everyone's expectations are and what the patient's ability and potential is."

• **Make the pediatric wing more fun.** It's difficult for children to spend weeks in a hospital, so Warm Springs has attempted to at least make the pediatric rooms more fun with Winnie the Pooh bedspreads and children's videotapes, toys, and books. The waiting room is comfortable area with bright colors, fun pictures, soft floors, and bean bags. The rooms are painted in bright colors and have soft floors with bean bags.

"We can show families pictures of different options for the their children's rooms," Rhodes says, "and we make sure the staff is trained and understands how to treat children differently from adults."

Staff make sure families are closely involved in children's care, and staff understand that treating pediatric patients means they essentially are treating the parents as well, Rhodes adds. "The family members are the ones who are going to take the kids home and continue the treatment." ■

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.

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Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@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), $449. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $359 per year; 10 to 20 additional copies, $269 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 $75 each.(GST registration number R128870672.)

Editor: **Melinda Young**, (828) 859-2066, (youngtryon@mindspring.com).
Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Managing Editor: **David Flegel**, (404) 262-5537, (david.flegel@medec.com).
Production Editor: **Terri McIntosh**.

Editorial Questions
Questions or comments? Call **David Flegel**, (404) 262-5537.

These organizations have more info on fibromyalgia

If you would like to do a little research about fibromyalgia, the following organizations will provide you with some literature on the condition:

1. **American College of Rheumatology** has information about fibromyalgia available on its Web site at www. rheumatology.org. Or you may contact the organization at 1800 Century Place, Suite 250, Atlanta, GA 30345-4300. Telephone: (404) 633-3777.

2. **American Occupational Therapy Association Inc.** has a 60-page consumer guide on fibromyalgia that is available for $6, plus $4 for shipping and handling (members receive a discounted price of $5); packs of 10 are $55 ($45 for members), plus $7 shipping and handling. Contact the association at 4720 Montgomery Lane, P.O. Box 31220, Bethesda, MD 20824-1220. Telephone: (301) 652-2682. Fax: (301) 652-7711. Web site: www.aota.org/.

3. **American Pain Society** has educational information about chronic pain on its Web site at www.ampainsoc.org. Although its information is not specific to fibromyalgia, the society also has some pain literature available. Contact the society at 4700 W. Lake Ave., Glenview, IL 60025. Telephone: (847) 375-4715. Fax: (847) 375-6315.

4. **Arthritis Foundation** has educational information about fibromyalgia on its Web site at www.arthritis.org. The organization also has a fibromyalgia brochure that can be obtained by contacting the foundation at 1330 W. Peachtree St., Atlanta, GA 30309. Telephone: (800) 283-7800 or (404) 872-7100.

5. **Fibromyalgia Association of Greater Washington, Inc.** has extensive literature, audiotapes, and other resources available. Some fibromyalgia educational information is on its Web site at www.fmagw.org. The association also can be reached at FMAGW, 13203 Valley Drive, Woodbridge, VA 22191-1531. Telephone: (703) 790-2324. Fax: (703) 494-4103. Included among FMAGW's resources are the following:

— FMAGW sample packet, available for $5, has information sheets, question and answer documents, a newsletter, catalog, and membership brochure.

— Fibromyalgia support group information for other states is listed on FMAGW's $1 brochure.

— North American Directory of Fibromyalgia Support Services book costs $16.

— "Introduction to Fibromyalgia" tape is available for $10.

— "Sleep and Its Relationship to Fibromyalgia Syndrome" tape is available for $10.

— "Current Neurological Studies in Fibromyalgia Syndrome and Myofascial Pain" tape costs $10.

— "Emotional Aspects of FMS" tape costs $10.

— "Fibromyalgia, Work & Disability" tape costs $10.

— "Fibromyalgia From Head to Toe," a tape that discusses disorders of both the temporomandibular joint and feet is available for $10.

— "Allergic Responses in the Individual With FMS" tape costs $10.

6. **Fibromyalgia Network** has some educational information on its Web site at www.fmnetnews.com. Or the network can be contacted at P.O. Box 31750, Tucson, AZ 85751. Telephone: (800) 853-2929.