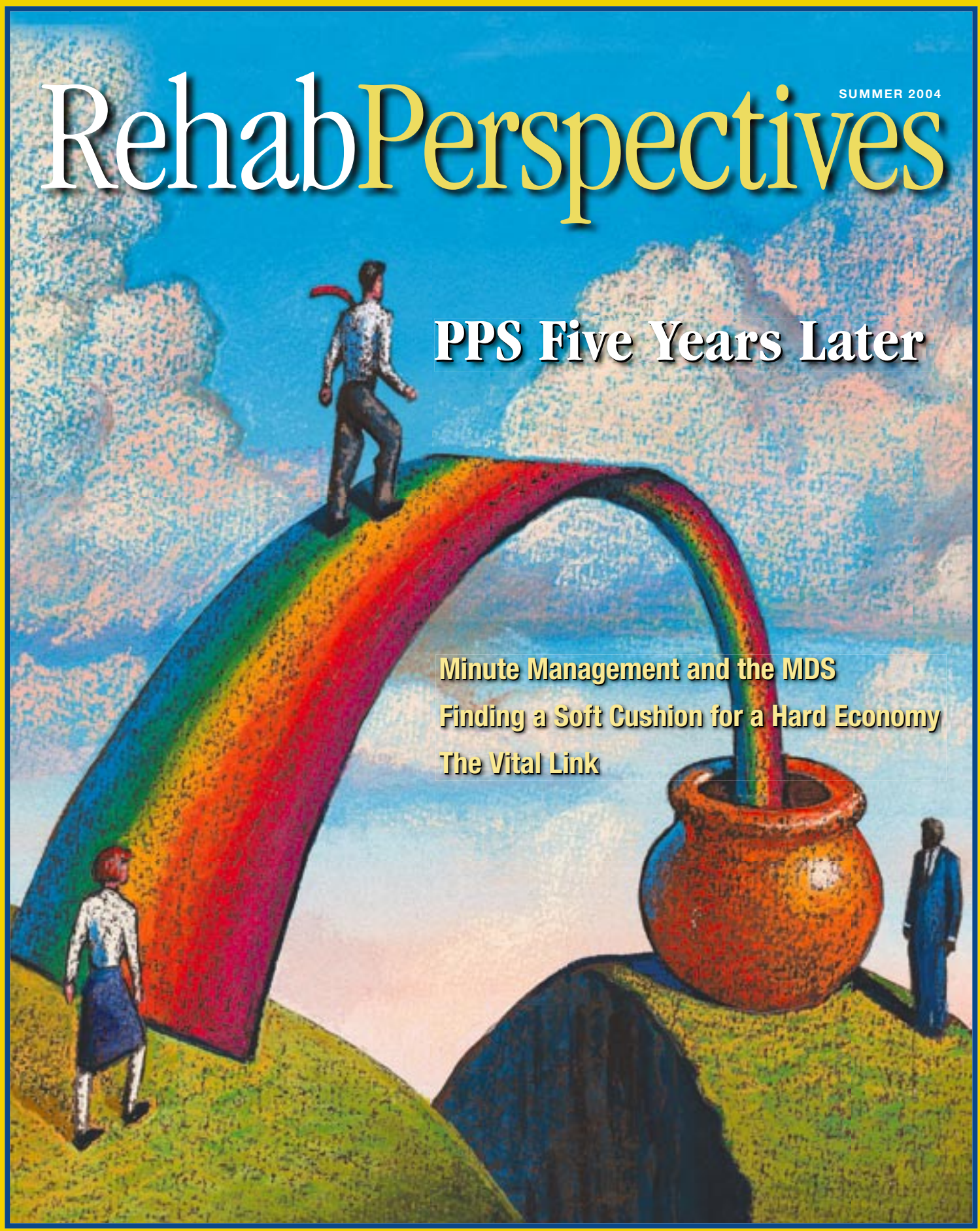
SUCCESSFUL REHAB MANAGEMENT IN LONG TERM CARE

RehabPerspectives

SUMMER 2004



PPS Five Years Later

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Welcome to Rehab Perspectives!

Aegis Therapies is proud to be the exclusive sponsor of this special insert in *Nursing Homes/Long Term Care Management*. Rehab Perspectives will be published several times a year, and we hope it will become an important resource as you seek to maximize the success of your facility's rehabilitation program.

The single most significant event in the last five years that has influenced how rehab is delivered and reimbursed is the Medicare prospective payment system (PPS). Therapy delivery under PPS is a challenge and requires great expertise. Since PPS was introduced, the industry has adapted to its rules and learned valuable lessons.

It hasn't been easy, and missteps along the way have been costly. Despite some dire predictions to the contrary, the industry has survived. Residents are receiving excellent treatment and facilities have sorted out the documentation procedures required for proper reimbursement.

We thought it might be useful to look at some of the changes that have taken place and what the industry has learned five years after PPS. The three articles in this issue explore various aspects of providing treatment, from the question of contracting or providing in-house services, to the role of restorative nursing, to the fine points of the MDS. All are designed to give you useful information so you can be more effective in providing rehabilitation.

Aegis Therapies has ten years of experience delivering contract therapy to nursing homes and eldercare venues, and currently provides clinical expertise to more than 1,000 facilities nationwide. We are committed to a leadership role in the rehab industry and to high standards in resident treatment. We hope you find Rehab Perspectives a useful tool, and we look forward to helping you build a solid foundation of knowledge and understanding in the field of rehabilitation. Aegis is your rehab resource.

Best regards,

Cindy Susienka

Cindy Susienka
President, Aegis Therapies

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RehabPerspectives

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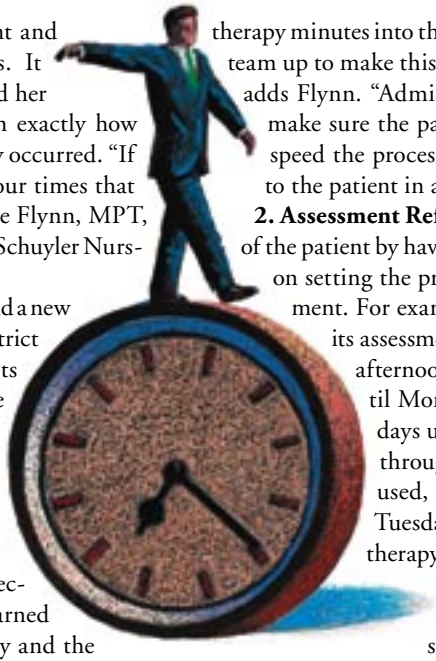
Minute Management and the MDS

Smart therapy delivery is based on PPS experience

Once upon a time, therapy reimbursement and scheduling were two different worlds. It mattered little when Mrs. Smith received her therapy—there was no intense focus on exactly how many minutes she received or in what time period they occurred. "If a patient missed a day, he may only have been seen four times that week instead of five—"it wasn't a big deal," says Stacie Flynn, MPT, master clinician and team leader in physical therapy at Schuyler Nursing Center in Schuyler, Nebraska.



Then came the Prospective Payment System (PPS) and a new paradigm: Minutes mattered—a lot. Confronted with strict new rules about what qualified for payment, therapists focused much more on time with the patient. Gone were the team meetings and periodic resident screenings. "We were also cut back from doing a lot of facility things, like marketing and committee meetings," says Flynn. "Our focus was on ensuring that our patients received the appropriate number of minutes of therapy."

But with five years of PPS experience has come a collective sigh of relief. Both facilities and therapists have learned to live with minute management. "I think the facility and the staff are more comfortable now—we survived the change and we can relax a little," says Flynn.

Flynn says she now goes to meetings every day to communicate with the executive director, nursing, and other department heads. She and other therapists even take part in promoting the therapy program. "And we're back to giving a high priority to screening residents in the building to watch for decline," she notes.

As with all things, experience is a great teacher. "Facilities have really refined their systems for communication between therapy and nursing and for minute management," says Mark Besch, vice-president of clinical services for Aegis Therapies. "Early in PPS we saw rehab backing off on how aggressively they treated patients. Now we see a more clinically appropriate approach to treatment minutes planning, and we see a division of patients throughout the RUG categories between high and low."

As therapists and nurses have learned to manage minutes on the MDS, several strategies have emerged involving:

1. Admissions. Make sure patients who have therapy needs bring therapy orders from the doctor with them when they are admitted. "If the residents don't come with therapy orders, and you can't get orders from the doctor for two or three days, that can inhibit getting your therapy minutes into the MDS," says Flynn. Nursing and therapy can team up to make this happen. "Our nursing staff is so aware now," adds Flynn. "Admissions asks the hospital discharge planner to make sure the patient comes with therapy orders. That helps speed the process and provide the necessary medical services to the patient in a timely manner."

2. Assessment Reference Date (ARD). Capture the true needs of the patient by having the MDS nurse and therapists collaborate on setting the proper reference date for the first MDS assessment. For example, a facility may habitually use day five as its assessment date. But for a patient admitted on Friday afternoon who is too exhausted to receive therapy until Monday, it would make more sense to use grace days up to day eight, so that therapy from Monday through Friday could be included. If the day five were used, the reference days would be Friday through Tuesday—which would result in three days without therapy, hardly capturing the patient's true needs. "Grace days are there for this exact situation," says Besch. "You should be reimbursed for the services you are going to deliver."

3. Proper evaluation. Evaluate patient needs first, then fit the minutes required into a RUG category. For example, Aegis Therapies uses a "Scope of Practice Grid" that enables the therapist to evaluate the patient's areas of deficit before deciding on the therapy treatment plan. "It's a tool that assists the therapist to see deeper into the patient's abilities," explains Besch. "We want to treat residents as individuals and plan their minutes based on their needs."

4. RUG categorization. Coordinate all three disciplines of therapy to establish the minutes required to treat the resident, *then* establish the RUG category. "We don't want to restrict the therapist to the minimum," says Besch, "but we often see a lack of communication between therapists in coordinating therapy and considering the RUG requirement. In short, we want the total number of minutes delivered to our patients to be 'on purpose,' based on the patients' needs, and to be a result of coordinated planning."

5. Ongoing communication. As treatment progresses, make sure all therapists talk to each other in terms of managing minutes and that they keep nurses informed. "We have a planning tool book where we put our projected goals," says Flynn. "I look at that book every day and we have weekly meetings to make sure the plan is appropriate and to determine whether we need to increase or decrease minutes." It's par-

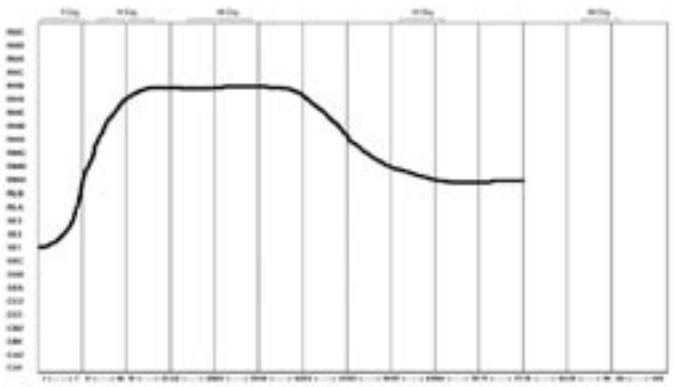
ticularly important to keep nursing informed of changes in minutes. "If we were tapering down patients to three times a week and if restorative nursing wasn't in place, then the MDS could default and the patient wouldn't qualify for Part A," explains Flynn. "Also, you need to manage changes in reference dates, especially if the patient is sick and can't come to therapy, so as to keep the MDS accurate."

6. Therapy staff education. Train new staff in the minutes required for each patient. It is important that all staff understand the importance of providing the minutes of therapy that are in each patient's care plan.

7. Mutual respect. Build a bridge of understanding between nursing and therapy through communication. Each needs to trust that the other has valid reasons for its behavior and is doing what is best for the resident. "I don't always understand nursing's plan of care or their reasoning," says Flynn. "Nursing doesn't always understand the therapy plan of care or our reasoning. Sometimes it's just a different perspective. Once we communicate and build the understanding, we build trust in each other."

PPS, so threatening at first, has been tamed. "A critical point in MDS and rehab success is coordination between the disciplines and a commitment to minute management," says Besch. When nursing and therapy communicate frequently and effectively, they create the most accurate MDS, and the facility receives the most accurate reimbursement. ■

Skilled Nursing Facility Care Map



Care mapping is the process of plotting the long-term patient's Medicare Part A stay in order to most effectively use SNF resources to achieve optimum patient care outcomes and an appropriate discharge plan. Rehab therapy should have input into the initial and ongoing development of the care map. As the care map is developed by the Medicare Part A assessment team as a whole, the MDS assessment nurse can set the ARD at the most opportune date to capture the necessary medical and treatment data for input into the MDS assessment. The setting of the ARD will be more objective within the context of the care map, because it will be based on documentation and input from the SNF care team. The type of MDS assessment (comprehensive, full, OMRA, or SCSA) is also determined by the information used to develop the care map.

A Consultant's Observations

Gary Phillips is an associate with BKD, one of the leading public accounting and consulting firms in the United States, and assists some 150 SNFs and swing-bed hospitals in several states with their financial, cost reporting, and reimbursement issues. Along the way, he has seen his share of costly MDS oversights hitting unsuspecting facilities in the pocketbook. He offers several observations:

- "Setting the ARD for the Medicare five-day assessment at day five sounds logical, but can be very expensive. Often the patient is not able to participate in a high level of therapy services upon admission to the SNF because he has been in the hospital. That can cause him to be classified into the lower payment level of rehab. In a case such as this, the better ARD to choose might be day two or three. More hospital time would be included in the seven-day look back, so more medical data from the hospital could be incorporated, classifying the resident into the higher non-rehab RUG."
- "Quite often, if there is a decubitus ulcer, it's not appropriately communicated by the hospital to the nurse at the SNF. This could have a negative impact on RUG classification."
- "The RAI Manual specifically instructs facilities to do an Activities of Daily Living (ADL) assessment on a newly admitted resident over a 24-hour period to determine the amount of assistance that will be needed. Let's say 'Mrs. Anderson' is able to feed and clothe herself independently during the daytime, but needs a great deal of assistance overnight to get to the bathroom safely. If her ADL assessment were done during the day only, the SNF would miss out on the opportunity to bill adequately for the help she needs from nursing staff at night. I recommend that a flow sheet be set up for the CNAs to record how often they are needed to assist residents to assure their safety, thus ensuring sufficient reimbursement."
- "I think it is preferable that CNAs perform ADL scoring, rather than therapists. From my perspective, patients particularly want to perform well for therapists, on grounds that 'I'll be able to get out of here and get back home all the sooner.'"

Phillips (whose "ideal" care map for maximum RUG utilization for resident care and reimbursement is exemplified in the figure) acknowledges that the PPS is "an extremely complicated system, and makes it difficult for nurses without proper training to find out how to determine the best RUG grouping for the patient. Yet I'm amazed that government has developed a system that, when you benefit the patient the most, you get paid the best."

Finding a Soft Cushion for a Hard Economy

Five years after PPS, does contracting for therapy make sense?

Healthcare delivery in an uncertain economy is something like sitting on a hard chair. There's just not much cushion if you make a wrong move. That's why long-term care providers who offer therapy increasingly are looking for ways to keep therapy costs flexible, maintain a competitive edge, and share financial risk.

In the five years since the Medicare Prospective Payment System (PPS) changed the face of healthcare reimbursement, the business of providing therapy has evolved. "When PPS first went into effect, facilities felt they needed to take control of rehabilitation, so many of them took therapy in-house," says Cindy Susienka, president of Aegis Therapies, which offers rehab services to more than 1,000 facilities in 36 states. "But since PPS, facilities are beginning to see the value of variable costs versus fixed cost. They also realize they don't have the expertise to manage the therapy program. Many are beginning to outsource therapy again. In the last quarter alone, we've noticed a large increase in the number of facilities coming to us that previously provided therapy in-house."

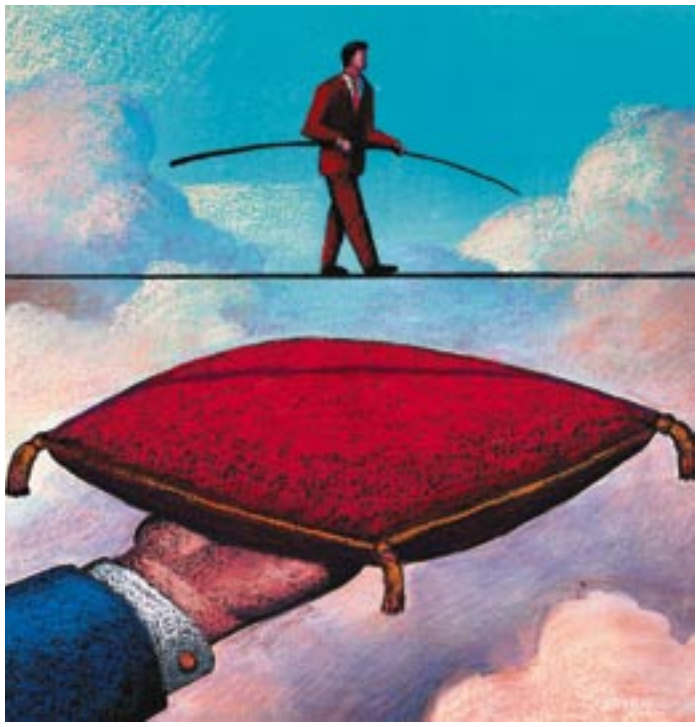
Ensuring expertise is one of the reasons John Knox Village, a continuing care retirement community in Lee's Summit, Missouri, decided to outsource therapy. When the facility was approved to increase its number of SNF Medicare beds from 44 to 107, Administrator Lynn Carroll took a hard look at her in-house therapy program. Although John Knox had a lot of resources on campus, Carroll saw an opportunity to expand therapy services.

"We have an excellent reputation in the Kansas City area for rehab," she says. "But we wanted to offer more alternatives for medically complex residents. When rehab becomes a significant add-on or becomes complicated operationally, referring to outside expertise can save time and generate more appropriate reimbursement."

While expertise can be taken to mean the delivery of knowledgeable and efficient treatment, it goes further than that. A good contract therapy company, according to Mark Besch, vice-president of clinical services for Aegis, reaches beyond the status of vendor to the facility. "The therapy company brings a commitment to the facility in terms of clinical expertise and outcomes," he says. "It can provide the facility with more options in terms of continuing education, the knowledge necessary to meet the special needs of residents, and the sharing of risk by partnering in the responsibility for surveys."

The therapy company also acts as a resource for therapists. "Therapists in an in-house model are pretty much on their own," says Besch. "If they have questions on treatment technique or equipment, or want to consult with others about a problem, where do they go?"

Moreover, because of the size and geographic reach of a therapy company, it can easily benchmark outcomes against those of other facilities, track diagnoses and length of stay for specific diagnoses, and utilize outcomes information to enhance the public's perception of the facility's program.



Finding Flexibility

Recruiting and maintaining staff may be one of the biggest headaches for a facility, not to mention a significant cost center. Because PPS reimbursement is tied so tightly to the minutes of therapy a patient receives, using only those therapists who are necessary to the patient load makes financial sense. Facilities that must keep therapists on staff (and possibly idle) during fluctuating census take a hit in the pocketbook. "The importance of variable costs is that you are only paying for the services utilized and the services that you're going to get reimbursed for," explains Darryl Bueker, partner in BKD, LLP, a financial and reimbursement consulting firm in southern Missouri.

"Most of our clients negotiate their therapy contract for Part A Medicare services so they pay on a per-minute basis," says Bueker. "In Part B, they negotiate a percentage of the fee-schedule amount for each type

of service." That means that as therapy expenses go up, Medicare Part A and Part B billings go up. If Part A and Part B volume drops, the amount owed to the therapy company declines as well. "By outsourcing, you avoid the risk of having all these people on staff and not being able to keep them productive," he adds.

Contract vs. In-House Scorecard

Therapy Needs Assessment

1	Yes
2	No
3	Not Sure

For each issue identified below, please circle the number to the right that best fits your therapy program. Use the scale above to select the number. When completed, see scoring below for results.

Description/Identification of Therapy Issue	Score		
1. Do you know how much profit your Therapy Department is contributing to the overall operation of your Facility?	1	2	3
2. Is your Therapy Department always adequately staffed?	1	2	3
3. Do you have the ability to shift or "flex" therapy staff?	1	2	3
4. Is your Therapy Program divided into Specialty (Stroke, Ortho, etc.) Programs?	1	2	3
5. Does your Skilled Census fluctuate?	1	2	3
6. Are you reasonably sure that therapy is in compliance with current coding standards and guidelines?	1	2	3
7. Do you have a system in place to train your therapy team and keep them up to date?	1	2	3
8. Do you have a Budget for your Therapy Program?	1	2	3
9. Do you manage your Therapy Program by Budget?	1	2	3
10. Is your Part B Therapy Program effective clinically and operationally?	1	2	3
11. Does your rehab RUGs distribution reflect the acuity level of your patients?	1	2	3
12. Are you confident you are always up to date with all billing and regulatory changes?	1	2	3
Add up your circled items and enter the total here:			

12	**You have a good Therapy Program in place. If In-house, you are doing well. If Contract, you have a good provider with strong therapy management.**
13-24	**Consider Contract Therapy. You may have fewer management headaches. Be sure to select a good contract therapy provider.**
25-36	**Complete a detailed analysis of your Therapy Program. Then consider all your options.**

Outsourcing, while clearly not right for all providers, offers an array of advantages. To evaluate which course makes sense for your facility, fill in the Contract vs. In-House Therapy Scorecard above.

Promoting Productivity

These days, the infrastructure required to deliver efficiency and to make therapy profitable and competitive is a full-time undertaking, often difficult for a single facility. Think, for example, of the resources needed to develop the proprietary systems and software to simplify procedures and the management of therapy minutes in order to streamline service and capture more accurate reimbursement.

Or consider the time and cost of ongoing staff education. "In an in-house model, the facility itself is responsible for ensuring that the rehab staff remains current in recent professional developments," says Besch. "The facility must have a mechanism for therapists to learn all of the compliance and regulatory issues, including upcoming legislation, changes in procedures, changes in codes, CMS interpretations, etc." Outsourcing shifts that burden to the therapy company. Aegis, for example, offers a stipend for therapists to attend continuing education classes and actually pays for education days. And an Aegis compliance officer handles all compliance issues at the facility.

Expanding the Market

Establishing a specialty niche can place a facility in the forefront of its market. Susienka explains, for example, Aegis' program "Freedom through Functionality," a partnership with Nautilus that emphasizes muscular strength and fitness development: "We use Nautilus equipment that's been augmented for the senior population. The results are astonishing. People who thought they would never walk again end up not only walking, but are able to go home." She cites an added benefit for the facility: "Former residents often return to the facility to continue the program from a wellness standpoint."

What to Look for in a Therapy Company

If you decide to contract, what should you look for?

At John Knox, Carroll says she looked at several factors, including the number of therapy contracts and facilities the company oversees, the sophistication of its systems, its knowledge of PPS, and its detailed approach to developing and tracking quality outcomes.

Susienka suggests first looking for a "high level of clinical expertise." Then she says to consider the following:

- Consistent quality staff and the ability to move therapists in and out of a facility as necessary
- Specialty areas of service that might enhance the facility's therapy program
- A commitment to the facility to work as a partner, not just a vendor, so therapists are invested in and responsible for patient outcomes
- Partnering in responsibility for survey outcomes and addressing any survey risk areas
- Dedicated computer software that catches errors and makes documentation accurate and faster
- Commitment to continuing education, training, and ongoing monitoring of staff, including keeping therapists up to date on new techniques and treatments
- A dedicated therapy compliance officer who is familiar with current regulations, changes in codes, and CMS interpretations
- A mechanism to deal with denials
- User-friendly outcomes measurement, quality indicators, and the ability to benchmark against a large group of facilities
- A strong lobbying voice in Washington ■

The Vital Link

Restorative nursing and therapy combine for better outcomes

The gentleman was diabetic and his leg had just been amputated below the knee. He arrived at Beverly Healthcare Foley, in Foley, Alabama, where extensive occupational and physical therapy strengthened his balance and helped him with transfers. He was fitted with a prosthesis. Three months later he could walk, put on his own prosthesis, and participate in community outings.

It wouldn't have happened without restorative nursing, according to Jeff Nobles, occupational therapist and rehab coordinator at the facility. "Without restorative nursing, he would not have maintained the progress he made in therapy," says Nobles. "After being discharged from therapy, traditional nursing would have helped him out of bed, assisted him with his prosthesis, and transferred him into his wheelchair. Restorative nursing worked with him every day and he's maintained a better quality of life."

Restorative nursing, the link between therapy and nursing aimed at maintaining the gains residents achieve while receiving skilled therapy, has been receiving a lot of attention. Some facilities choose to implement a formal program using restorative nursing aides (RNAs) trained by therapists. Others prefer an informal program, with various staff in the facility performing scheduled tasks recommended by the therapist. Whichever way it happens, it seems clear that restorative nursing makes a big difference in resident outcomes and in maintaining a resident's level of independence.

Beverly Healthcare Foley has one part-time and two full-time RNAs who have been trained and certified by therapists. They perform certain activities that are an adjunct to therapy, including ambulation, passive range of motion, splint and orthotics applications, and other modalities, such as hot and cold packs. "They have taken some tasks off the CNA's plate," says Nobles. "Because they have been trained by the therapists, they know what to look for, such as skin degradation, signs of fatigue, or other problems such as pain that may be related to the orthotics."

RNAs also act as the therapists' eyes and ears. "They are in the halls," adds Nobles. "They help us monitor the resident and give us feedback."

Whether the restorative nursing program is formal or informal, communication between nursing and therapy is the key to success. "Good communication means we are addressing residents' needs first and foremost," says Nobles. "Nurses don't know what went on in therapy. Without a restorative nursing program, once therapy is over, nursing doesn't know how to follow through with what was set up for the resident. Restorative nursing has been a huge success because, through interaction, we can carry on what the patient has been doing and it doesn't all get lost."

Facilities can benefit from a restorative program, whether formal or informal, in several ways, according to Mark Besch, vice-president of clinical services at Aegis Therapies. The program can:

1. Elevate the quality of care, which allows residents to maintain the maximum level of function post-skilled therapy.
2. Provide better outcomes in terms of facility statistics and surveys.
3. Contribute to the MDS and, depending upon the timing and level of service, it might move the resident into a rehab low RUG category for a short period of time.
4. In Medicaid case-mix states, raise the case-mix calculation because residents are receiving services beyond normal nursing, which might raise the facility's Medicaid reimbursement level.
5. Contribute to the Quality Measure ratings established by CMS and, in the process, act as an effective marketing tool.

"Since PPS came in, there has been an evolution as to how restorative nursing can contribute to the low-rehab piece on the Medicare Part A side," says Besch. "There's been an increase in sophistication as to how people have been able to utilize that opportunity.

"Anyone can deliver restorative nursing," adds Besch. Indeed, some facilities without a formal program provide excellent therapy follow-up. Where there is no formal restorative program, facility leadership—the administrator, executive director, director of nurses, even the supervising nurse—should be aware of the element of restorative nursing in general nursing care and, when provided, that it is documented in order to capture those minutes on the MDS.

Doing restorative nursing well requires a staff commitment to the idea of scheduling time to follow the therapists' recommendations. On the therapy side, it's important that therapists write a restorative program that is realistic from a time perspective, understandable, and validated by the folks who will deliver it.

"When staff have extra training, they may be a little bit better at it," says Besch. "A formal program, though, allows the facility to have a higher degree of comfort in terms of proper documentation. With delivery logs in place, care can be captured for the MDS or in a case-mix state. Our experience across all our facilities is that those who have dedicated resources have more success with the quality of service being delivered." ■

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