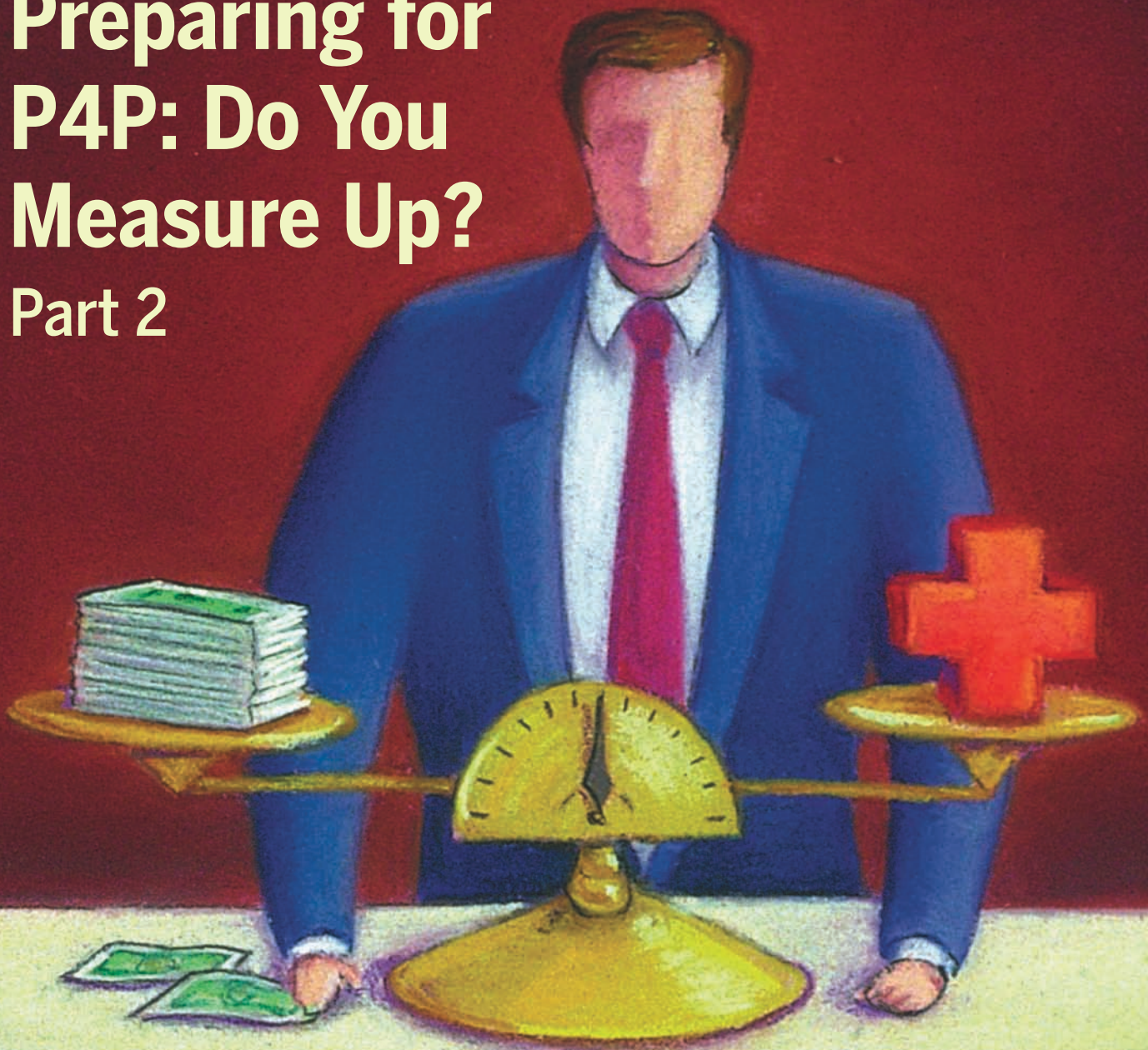


RehabPerspectives

June 2008

Preparing for P4P: Do You Measure Up? Part 2



The P4P Vision / The Value Equation / Partnering for Success



Balancing Cost and Quality

This is Part 2 of our three-part series on Medicare’s search for cost-effective care. Variously called P4P, pay-for-performance, or value-based purchasing, the initiatives of the Centers for Medicare & Medicaid Services (CMS) clearly indicate that providers are going to have to prove the value of the care they are being paid to provide.



Measurements of quality pervade every level of our society, from book reviews to batting averages. Every healthcare provider strives for quality and every payor expects it in return for its investment. Yet quantifying quality in geriatric patient care in the post-acute setting is difficult. By what scale do you measure and how do you risk-adjust scores across a variable population? Do length of stay and discharge location prove quality? Should progress be measured by one therapy discipline or across all three? What about patients with comorbidities, frail patients who will never be able to go home, patients who, through no fault of the provider, are re-hospitalized?

With so many variables, the industry has long used nebulous terms to describe treatment successes, such as “increased quality of life” or “requires less assistance.” Such subjective opinions hardly give CMS the standards it needs to judge care across a broad spectrum of populations and settings.

At Aegis we have long understood that treatment and the quantifiable measurement of the result of that treatment go hand in glove. Actual patient outcomes data is the first line in proving value. That’s why we have been measuring rehab outcomes ever since the Prospective Payment System (PPS) came into existence.

In this issue of Rehab Perspectives, we’ll give you the current outlook for P4P and show you the importance of outcomes in demonstrating value. We’ll also show how making a commitment to a strong rehab program can increase your census, boost your outcomes, and position your building for success.

It’s all about partnering, and as ever, Aegis is your rehab resource.

Martha Schram
President
Aegis Therapies

Contents



- 3** The P4P Vision
“The right care for every person, every time”
- 5** The Value Equation
Using outcomes to prove the efficacy of rehab
- 7** Partnering for Success
Prepare for P4P and reap the rewards now

Rehab Perspectives

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The P4P Vision

“The right care for every person, every time”

Let's face it, healthcare in the United States is simply too expensive. All those baby boomers poised to jump into Medicare are about to swamp the system and the Centers for Medicare & Medicaid Services (CMS) is all too aware that it is in danger of drowning in red ink. Previous cost-cutting solutions, such as prospective payment and therapy caps, haven't stemmed the rising tide of costs. So CMS has turned to another solution: pay-for-performance, also called P4P or value-based purchasing.

The idea is pretty clear: Deliver measurable, quality, cost-effective care and you'll be rewarded in some way; perform poorly and you won't. In its report to Congress, dated Nov. 21, 2007, and titled “Plan to Implement a Medicare Hospital Value-Based Purchasing Program,” CMS stated its vision: “The right care for every person, every time.” The report states: “Value-based purchasing, which links payment to performance, is a key policy mechanism that CMS is proposing to transform Medicare from a passive payer of claims to an active purchaser of care.”

The transformation to a workable model that links payment to outcomes may not be swift, but it is inexorably moving forward. For hospitals, CMS has tied reimbursement to voluntary outcomes reporting in a demonstration project begun in 2003. “On the hospital side there are very imperfect models,” says Chip Kahn, president of the Federation of American Hospitals. “However, they are models, so I do see P4P progressing to other healthcare venues.”

CMS has also tied reimbursement for physicians to outcome reporting with its Physicians Quality Reporting Initiative (PQRI) that began in October 2005. That data is now being analyzed by CMS. Currently, private health plans and many states are developing various pay-for-performance programs.

It looks as if skilled nursing facilities may be next in line. As this supplement went to press, CMS had just announced that it was designing a value-based purchasing demonstration in the nursing home setting. “We are working towards implementing a demonstration in up to five states to test value-based purchasing in nursing homes,” says a CMS spokesperson. “Quality would be measured on several dimensions, including reductions of avoidable hospitalizations and achieving good outcomes on survey inspections.”

Demonstration projects are works in progress, so what P4P will look like in the post-acute arena is still murky. Because CMS' payment methodologies are prescribed by statute, Congress must act to give teeth to voluntary programs. And there's no guarantee that P4P will look the same in all post-acute settings. For example, the current hospital demonstration project imposes a penalty of 2% of annual payments for lack of reporting compliance. In the case of physicians,



How pay-for-performance will occur in the post-acute arena remains an unresolved issue. However, it's pretty clear that providers will need to deliver measurable value.



there is a bonus payment of 1.5% for reporting on 74 measures under PQRI.

As for the nursing home model, CMS is only saying that this particular demonstration is to be in place in early 2008 with a report to be submitted to Congress in 2011. Of course, the challenge for skilled nursing facilities is finding ways to assess care and adjust risk for case-mix patients. The tool being used in CMS' demonstration project is called the Continuity Assessment Record and Evaluation (CARE) tool. It will measure the health and functional status of Medicare acute discharges and then measure changes in severity in Medicare patients in post-acute care, examining resources and other outcomes associated with treatment in each type of post acute setting. Therapy outcomes will certainly play a part in measuring the effectiveness of rehabilitation. Payment could include financial and/or non-financial incentives.

The industry acknowledges that P4P is probably a good idea. "We are very much in favor of payment systems that reward and recognize value," says Barbara Manard, vice president of long-term care health strategies for the American Association of Homes and Services for the Aging. "We favor continued research and work to develop appropriate outcomes measures for other indicators."

PricewaterhouseCoopers, in its recently published paper, HealthCast Tactics: A Blueprint for the Future, indicates that pay-for-performance is the "key, yet radical, trend that would affect payers in this decade." Likening the payment shift to the arrival of DRGs in the 1980s, the company predicts that P4P will be "the major way payers reimburse providers in five years."

Whatever form it takes, there is no doubt that proving value should be a top priority for all healthcare providers. ■

Rehabilitation Outcomes Measure (ROM)

The following areas are measured on the ROM scale

PT Deficit Areas

Sitting balance	Transfers
Gait - uneven terrain	Skin integrity
Gait - level surfaces	Positioning
Wheelchair mobility	Stair climbing
Bed mobility	Physical restraints
Joint mobility	Standing balance

OT Deficit Areas

Toilet hygiene	Positioning
Emergency response / safety procedures	Physical restraints
Feeding	Functional communication
Medication routine	Bathing
Bed mobility	Home management
Joint mobility	Meal preparation / cleanup
Dressing	Grooming / hygiene
	Community activities

SLP Deficit Areas

Voice	Written expression
Expressive language	Auditory discrimination
Swallowing	Auditory comprehension
Reading comprehension	Cognitive linguistics
Speech production	

CMS' Vision for P4P

Overarching Principles: P4P programs must be:

- Data driven
- Beneficiary centered
- Transparent
- Developed through partnerships
- Administratively flexible

Quality Components: P4P programs should be built on:

- Evidence-based guidelines
- Consistent measures of access, quality, costs and satisfaction
- Coordinated care programs
- Health information technology

Incentive Structure: P4P incentives must be:

- Equitable and fair to program participants, including the beneficiary
- Timely
- Sufficient to motivate improvement
- Flexible enough to provide payment for innovative care processes
- Structured to avoid unintended consequences

Source: www.cms.hhs.gov/MedicaidSCHIPQualPrac/Downloads/qualitystrategy.pdf

Common Measurement Scales

AM-PAC - Activity Measure for Post-Acute Care. Used by PTs. Measures the difficulty of various functional and cognitive activities encountered by most adults during daily routines.

FIM - Functional Independence Measure. Used by PTs. Quantifies the amount of assistance required to complete 18 daily activities in motor and cognitive domains.

FOTO - Focus on Therapeutic Outcomes. Used primarily by PTs and some OTs. Data collection services for orthopedic, industrial, pain management, neurologic, speech, cardiopulmonary, wound, and pediatric patients.

NOMS - National Outcomes Measurement System. Used only by SLPs. A 7-point scale that describes the change in functional communication and/or swallowing ability after intervention.

OPTIMAL - Outpatient Physical Therapy Improvement in Movement Assessment Log. Used only by PTs. A 21-item scale used to assess the functional mobility of patients in performing the movements necessary for various functional activities.

ROM - Rehabilitation Outcomes Measure. Used by PTs, OTs and SLPs. Wide ranging 7-point interdisciplinary scale that measures 36 combined deficit areas of functionality, from dependence to independence, specific to the three disciplines. Includes both clinical and community re-entry skills. Measurable, descriptive, patient-specific information establishes standards for patient care based on cost, length of stay, and therapeutic outcomes derived from rehabilitation intervention.



The Value Equation

Using outcomes to prove the efficacy of rehab

The drums are sounding across the valley of healthcare. The whole post-acute care continuum can hear the message: Get ready to demonstrate value and cost effectiveness. Providers are wondering how they can measure the results of care and how to prove that their facility offers the best setting in the value equation.

“We all measure our cost, that’s easy,” says Bill Goulding, national director of outcomes and reimbursement for Aegis Therapies. “When I teach therapists about value, I liken it to a balance scale with two baskets: cost and impact. You achieve value when the two baskets balance. Cost sits in one basket, but what do we put in the other basket to prove the impact that treatment had on the patient?”

The answer is outcomes data on patient improvement. If the cost (X) of Mrs. Smith’s hip replacement therapy goes in one basket, then a measure of her functional improvement (Y) goes in the other basket. X is easy to capture. The trouble is, how in the various settings of post-acute care do we get that missing Y?

Two recent reports illustrate the difficulties the post-acute care industry faces in balancing the scale and proving worth to the Centers for Medicare & Medicaid Services (CMS) and other payors. Both tried to determine value by examining costs and quality. Both ran into difficulties when it came to outcomes.

A 2006 study by the Department of Health and Human Services titled “A Study of Stroke Post-Acute Care Costs and Outcomes: Final Report” lists as one of its goals an attempt to compare quality, outcomes, and costs in various post-acute settings. The study compares the post-acute care cost of direct discharge from acute care to a skilled nursing facility (SNF) with the cost of direct discharge to an inpatient rehabilitation facility (IRF) and subsequent discharge to a SNF. Its conclusion: “Relative to direct discharges to SNF, post acute care costs for IRF/SNF patients were three times higher, and 90-day costs for IRF/SNF patients were twice as high. Total post-acute care length of stay for the IRF/SNF group was about 73 days in contrast to 46 days for the SNF group.”

However, the study states, “Due to the differentiation in patient characteristics based on initial provider setting, it was not feasible to equitably compare outcomes for all patients. A uniform set of core measures is required to assess post-acute care outcomes for patients admitted to single or multiple settings. The current setting-specific assessment tools cannot be used for this purpose because they use different elements, only some of which can be cross-walked, and have different follow-up intervals, making it impossible to compare change over fixed time periods.”

A 2007 internal analysis by RehabCare encountered similar problems. Titled “The Impact of the 75% Rule on Patient Outcomes and



CMS has encouraged therapy providers to use outcomes measures and to incorporate them in clinical documentation. But many operators have been slow to respond.



Medicare Expenditures in IRFs and SNFs,” it attempts to quantify the relative value of the company’s IRFs and its SNFs in terms of outcomes and expenditures. The report concludes that RehabCare’s IRFs provide better post-acute-care value than its SNFs.

RehabCare’s analysis addresses three variables: length of stay, discharge destination, and cost. However it, too, ran into difficulties with patient outcomes. “We were not able ... to match or compare patients on the basis of functional status or severity of illness upon admission because both settings use different types of measures,” states the report.

“The lack of a common functional metric also limits one’s ability to adjust adequately for case-mix differences ... that might influence outcomes such as discharge placement.”

Confusing? You bet. Without solid, reliable outcomes measures, trying to assess the value of post-acute care in any setting is like catching hold of a swimming eel.

“We need to develop workable measures and we don’t have those yet in the skilled nursing area,” says Barbara Manard, vice president of long-term care health strategies for the American Association of Homes and Services for the Aging.

“We don’t have a way to look at outcomes for rehabilitation, even though 90% of Medicare SNF patients now fall in the rehab category.”

Unless SNFs want to be left behind when pay-for-performance begins to flow, they must be able to document the value of the care they provide. “If we’re going to have a value conversation, we must talk about the ability to prove success with patient outcomes,” says Aegis’ Goulding. “It is irresponsible to provide care without being able to measure it. That’s why Aegis has been measuring and collecting outcomes data in its SNFs since 1999.”

Aegis Measures SNF Outcomes

Aegis’ outcomes clearly support the cost-effectiveness of SNFs — the same conclusion reached in the HHS study. Based on data from patient groups roughly comparable in diagnosis to the RehabCare report, Aegis’ outcomes show that its SNF planned Part A patients had a length of stay (LOS) of 30 days (compared to RehabCare’s LOS of 34.9 days). Aegis Orthopedic Centers of Excellence (OCE) in SNFs show a 26-day LOS. For ortho-knee patients, Aegis LOS was 21 days (18 in an OCE) compared to RehabCare’s 24.9 days.

In terms of discharge, Aegis reports that 60% of SNF patients are discharged to home compared to 37% of RehabCare SNF patients. Aegis OCE facilities discharged 81% to home which matches the 81% of RehabCare’s IRF discharges to home, although Aegis’ OCEs had shorter lengths of stay.

Filling in the value equation, Aegis was able to determine, for example, that its ortho-knee patients had an overall SNF cost of \$8,337 (\$7,146 in OCE) compared to roughly the same population in RehabCare’s IRFs with a cost of \$10,859.

Choosing a Measurement Tool

CMS has encouraged therapy providers to use outcomes measures and to include those measures in clinical documentation. Yet surprisingly, few SNFs actually measure therapy outcomes in a meaningful way. “It is absolutely essential for SNFs to start paying attention to measuring outcomes,” says Bruce Yarwood, President and CEO of the American Health Care Association (AHCA). “You have to be able to prove quality. We’re starting to heat up outcomes reporting now.” AHCA is putting together its own task force to consider what P4P should look like for skilled nursing facilities.

Deciding to measure outcomes is the first step; choosing the right tool is the crucial next step. “Even SNFs who use an outcome measure often use one that is inconsistent with the geriatric population in

the SNF world,” notes Mark Besch, vice president of clinical services of Aegis Therapies.

“Choosing the right tool is almost as important as deciding to measure outcomes at all.”

A number of scales are available to track patient progress. To be effective, the measurement scale must have been validated and tested and have some evidence of interrater reliability. “If someone in Dubuque scores a patient at a 2.5 level, someone in Boston should be able to evaluate the patient on the same scale and arrive at exactly the same score,” notes Besch.

The scale also should reflect the treatment being performed. “Some scales only measure progress in one discipline,” says Besch. “Therapy is a multi-disciplinary endeavor, so if you want to measure the total impact of rehab, you must use a scale that has applicability across the all disciplines.”

Patient population, too, should be considered in choosing a scale. “The Functional Independence Measure (FIM) is widely used and is interdisciplinary, but it lacks specifics for the geriatric population,” notes Besch. “For example, swallowing issues, skin integrity, and pressure ulcers are very common in the geriatric population. Those problems are not captured or measured by the FIM.”

Rehabilitation Outcomes Measure for Post-Acute Care

In choosing a measure, Aegis sought a tool that crossed disciplines, but at the same time had real discipline specificity. The company selected the Rehabilitation Outcomes Measure (ROM).

“We find the ROM is sensitive to a broad cross-section of functional abilities that are common in post-acute populations,” says Besch. “It measures everything from how a person moves in bed — the basic lower-level functions of rolling or coming to a sitting position — all the way to categories such as simple home maintenance, medication self-administration, and those functions we consider higher level, almost community reentry skill levels. It measures a wide range of functional areas.”

The ROM is designed around the treatment approaches and the deficit areas within each discipline. “It’s different from other outcomes systems,” says Bill Cummins, SLP, Cypress Product Director for Accu-Med Services, which created and markets the ROM. “It has 12 deficit areas for PT, 15 for OT, and 9 for speech therapy. Because it has more specific scoring, you can show incremental improvements and score specifically the areas your treatment impacted.”

The ROM uses a seven-point scale in half-point increments. But to make the numbers transparent to those not trained on the system, Aegis has created ELI, the Estimated Level of Independence scale, which expresses the ROM scale in lay terms.

“What does it mean to a Medicare claims reviewer, a doctor, or a family member that Mr. Cubbs went from a .5 to a 1.5 in a specific area of deficit on the ROM scale?” asks Besch. “But if we convert those scores to the ELI, we can say that Mr. Cubbs went from a 25% ability to perform the task to a 75% ability. That’s easier for everyone to understand.”

There’s no doubt that pay-for-performance in the post-acute setting will take time to develop and probably will have many interim steps. CMS is already calling for either “the results of a specified performance measure tool ... or objective, measurable beneficiary function” to be included in therapy documentation.

As happened with the shift from fee-for-service to prospective payment, providers who plan ahead will be the most successful. “You’d better be able to demonstrate value,” says Aegis’ Goulding. “You can’t do that unless you are measuring outcomes — and not just any old outcome, the outcomes appropriate to progress in the various post-acute settings.” ■



Partnering for Success

Prepare for P4P and reap the rewards now

Golden Living Center, a 110-bed skilled nursing facility in Plattsburgh, NE, was in a bit of a pickle. Its Medicare Part A business was evaporating. Watching census plummet, Executive Director Jeffrey Schmidt knew he had to make a dramatic change to reposition his facility in the marketplace — and he knew that rehab was the key. “To stay viable in the marketplace, unless you are associated directly with a hospital or in a rural community where you are the only game in town, you have to have an enhanced rehab product,” says Schmidt.

That meant some re-thinking and some renovation. He needed an environment for his short-term rehab that matched the strong services he could provide. “We wanted to give folks a nicer place to stay during rehab,” he explains. “We took our entire southeast wing — 11 semi-private rooms — and converted them into 11 private short-term-stay Medicare suites. We put in the amenities of a hotel — new carpet, new bathrooms, new furnishings, sitting areas for families, flat-screen TVs, private telephones, and living and dining areas separate from the rest of the facility.”

The renovation cost \$125,000. The facility was able to save some dollars by utilizing its in-house maintenance staff, local contractors, and operating as its own general contractor.

Was such a massive investment worth it? “The payoff was huge,” says Schmidt. “We opened in mid-November and by the end of December, we had eight of ten completed rooms occupied. By the beginning of the year, our Medicare Part A census was 17 on a budget of nine.”

The success at Golden Living Center in Plattsburgh illustrates how important a commitment to quality rehab is in positioning your skilled nursing facility for success. Here are a few more ways to position your facility at the top of the heap today — and to be ready for P4P tomorrow.

Create Strong Clinical Rehab Programs

Rehab once consisted of fairly standard therapeutic exercises. Today, specialty clinical rehab programs, such as falls prevention, pain management, and continence strategies, address the specific needs of the geriatric population and lead to greater patient improvement. “With the specialty programs, we don’t see patients who are discharged from therapy recycling back into treatment,” says Don Jones, director of operations for Golden Living Centers. “That says to me that residents are getting a better service and are maintaining their improved condition. We can easily demonstrate better value. I have seen a number of enhanced therapy programs installed in different facilities, and hands down, I would say it is a great return on your investment and one which you can see results in very quickly.”

Use Technology to Enhance Rehab Outcomes

Scientific studies have produced voluminous evidence for the value of technology in rehab programs. Examples include strength-building programs that use Nautilus equipment specially adapted for seniors, such as Aegis’ Freedom Through Functionality program, and electrotherapy, using ultrasound, diathermy and electrical stimulation, such as Aegis’ Geriatric Enhanced Modalities program. “Technology has come so far, and you really can correlate the outcomes closely to the enhanced programs,” says Jones. “It’s a step in the right direction when it comes time for pay for performance.”

Create a Niche and Invest in the Physical Plant

“When you develop a niche, almost by definition you are developing something that you do well,” says Bill Goulding, national director of outcomes and reimbursement for Aegis Therapies. “Developing specialty areas means going beyond surviving because you are identifying a need and fulfilling it in your marketplace.” For example, Aegis’ Orthopedic Centers of Excellence for short-term therapy have racked up impressive outcomes, shorter lengths of stay, and lower costs than traditional SNFs. They also have increased consumer satisfaction.

Use Outcomes Data to Market Your Facility

An outcomes data collection system, such as the Rehabilitation Outcomes Measure (ROM), does more than show patient improvement. It’s also a marketing tool. “We definitely see a rise in census when we market with our ROM data outcomes,” says Jones. “It differentiates us in the marketplace to be able to show our therapy product and the equipment we use compared to other nursing homes. We win hands down.”

Because 90% of long term residents require rehab, and because hospitals are increasingly seeking venues for short-term therapy patients, a commitment to a strong rehab program is a commitment to patient success and to the success of your SNF. “It’s all about partnering,” says Goulding. “With outcomes data, specialty programs, and technology, we can document that improvement in therapy equals reduction in cost.” That kind of proof will be very helpful when CMS begins to pay for performance. ■

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