MDS Alert

Quality Improvement: Solid Case Management Can Move Your Rehab Program to the Head of the Class

These fail-proof strategies address what ails many rehab programs -- and will get your RUGs jumping.

The right case management can earn your SNF optimal RUG scores and high marks with consumers and referral sources. Achieving that feat, however, requires paying attention to the details as well as longer-term goals.

A key prerequisite: Make sure rehab staff is up to speed on the SNF PPS, suggests **Elisa Bovee**, an occupational therapist and director of education and training for Harmony Healthcare International in Topsfield, Mass. "The rehab manager or the person directing therapy needs to understand his role in terms of managing the therapy minutes" and what data to consider, such as ADL scores and Extensive Service indicators, she says. And the person should coordinate with the MDS coordinator so that rehab knows the optimal days in which to obtain target therapy levels of care, Bovee adds. Also educate rehab staff about managing a resident's rehab therapy days and minutes. That's important because "it's very challenging for one rehab manager to oversee 25 to 30 Part A patients on a daily basis," Bovee says. And if the individual therapist doesn't understand RUG targets and case management techniques, then the department could fall short of the expected RUG by just a few minutes, she points out.

Also: When the rehab manager is away, and a patient doesn't receive the targeted therapy minutes on a scheduled day, the therapy staff person can change the schedule to provide the extra therapy minutes, if the patient can tolerate it, says Bovee.

Software can help: Benedictine Health Care Center at Innsbruck uses a SMART therapy software system that allows the therapist to enter daily treatment minutes, says **Melanie Phillips**, an occupational therapist and the transitional care unit program/therapy director for the facility in New Brighton, Minn.

The software includes an attestation statement where the therapist verifies that the treatment he provided is correct and in accordance with the plan of care, says Phillips.

Therapy staff can use the software to project and schedule minutes and days of therapy. "At midnight, the software repopulates the minutes as a reference for the therapist the next day. So if the PT fell short 10 minutes on Monday, it will add that 10 minutes to the total for the next day," adds Phillips.

See If the SNF Is Meeting Patients' Rehab Needs

Bovee finds that oftentimes facilities accept the therapy provided at face value and don't look closely to see if the resident could benefit from additional Part A rehab intervention.

A problem: "Very creative and talented clinicians in this industry" are for various reasons not providing "clinically indicated high intensity therapy," Bovee opines.

Sometimes this occurs due to staffing issues or a "corporate thrust" to avoid RUG levels beyond RH or RV out of fear of an audit, she adds. The bottom line, however, is that residents in such settings won't get the level of care they require in all cases.

Solution: To determine whether rehab is appropriate, the SNF has to review the evaluation, treatment plan and documentation, Bovee says. And you have to observe the resident and talk with the rehab therapist, she adds.

Make the Most of Daily Medicare Meetings

Benedictine Health System facilities conduct a daily Medicare PPS team meeting to review the PPS patients' Medicare status, ARD selection, and issues that would prevent the staff from providing the anticipated level of rehab, reports **Garry Woessner**, regional director of rehabilitation for the Cambridge, Minn.-based organization.

A costly mistake: Failing to communicate in that way -- for example, to address the fact that the speech therapist didn't make it in on the weekend to provide therapy -- means you're essentially delivering free therapy, cautioned **Martha Schram** in a presentation at the October 2008 American Association of Homes & Services for the Aging annual conference.

As part of the Medicare team meeting, look at whether setting the ARD can capture an ADL score that makes the difference between an X or L for a rehab resident with an Extensive Service indicator, such as an IV med or IV fluids -- or, an A, B or C, if he didn't have an Extensive Service indicator, advises Phillips. Also make sure to capture Extensive Service indicators. For example, if a resident with an ADL score of 16 to 18 receives 720 minutes of therapy, simply capturing his IV med from the hospital can provide more than $1,200 extra reimbursement for the first 14 days, said **Montelle Aspelmeier**, who also presented at the AAHSA meeting.

Promote Sustainable Gains

Take steps to help patients maintain their hard-earned outcomes.

Example: Part A-stay patients coming off therapy may be good candidates for rehab low, says **Jane Belt, MS, GCNS-BC, RAC-MT**, consulting manager with Plante & Moran Clinical Group in Columbus, Ohio. Providing rehab low "is an excellent way to ... strengthen the resident's skills before discharge and it also extends the resident's length of stay," says Belt.

The patient may also be a potential candidate for Part B therapy and/or restorative when he goes off Part A services, says Bovee. In fact, she sees "more opportunity for case management between payer sources than many facilities realize. Providers seem to be afraid of the Part B caps, but if you put someone on Part B, they may be able to hold onto their skills and not decline." A facility also "needs a restorative program that they run for residents on Part A [and other payers sources] who might benefit from restorative for a period of time."

Real-world practice: Benedictine facilities recommend two phases of therapy in most cases for their short-stay, high-intensity rehab residents -- an inpatient and an outpatient, says Woessner. "If the person can't go home and will be going to our long-term care side, we may set them up with a restorative program after rehab to help the person hold onto the gains they achieved in therapy."