Marketing & Referral Development
Mining your Business Data
& Other Low Cost Ideas to Build Business Volume

Darlene L. D’Altorio-Jones, PT., MBA-HCM
Senior Consultant, Strategist
Mediware
About Mediware

- Rehabilitation and Respiratory Care Solutions
- Formerly MediServe (Merged with Mediware in 2012)
- Founded in 1980
- 400+ employees
- 3000+ customer facilities
- Specialists - Knowledge & Experience
  - Acute, IRF, SNF, LTAC, Home care
  - Outpatient Rehab
  - Respiratory
- Solution - MediLinks®
  - Compliance
  - Outcomes
  - Revenue
  - Efficiency
- Result: Dramatically Improved Clinical and Financial Outcomes
A Few of Our Clients

- Mercy Medical Center
- Spaulding Rehabilitation Hospital Network
- Central Vermont Medical Center
- Mount Sinai Rehabilitation Hospital
- Milford Regional Medical Center
- The Cleveland Clinic Foundation
- Johns Hopkins Medicine
- Vanderbilt Medical Center
- The State University of New York
- Duke University Medical Center
- Atlantic Health
- Lancaster General
- Botsford Hospital
- National Rehabilitation Hospital
The tactics in this presentation were designed to spark creativity in marketing and referral development using low cost strategies.

Aligning with facility policy/rules takes precedence in adopting tactics.

The content of this in-service is being shared as a professional courtesy in my capacity as a senior consultant, strategist with Mediware. Although some information aggregation are improved through the use of Mediware tools, these general ideas can be incorporated in part or whole by any inpatient rehabilitation department.

Mediware encourages participation as a guest speaker at regional and national rehabilitation events. If you would like to sponsor a local rehabilitation topic to offer CEU’s on education/training specific to IRF management, throughput, plan of care improvement – please contact darlene.dalteriorio-jones@mediware.com
20% of all Medicare Beneficiaries are hospitalized at least once per year for a wide range of reasons; Medical, Surgical & Functional Diagnoses.

Approximately **35%** will be discharged to a PAC: Of this…

- 41.1% · SNF
- 37.4% · Home Health
- 10.3% · IRH/U
- 9.1% · Outpatient/ Ambulatory Therapy *
- 2.0% · LTCH

*Source: Gage et al. (2009). Examining post-acute care relationships in an integrated hospital system, ASPE*
Stabilizing & Growing APPROPRIATE ADMISSIONS

- Don’t give up the battle – TAKE UP YOUR SWORD & EDUCATE
  - IRF Occupancy Average 63.3% of 38,265 Beds Utilized (2011; 371,298 stays – 6.46 Million)

- SNF Occupancy approximately 88%
  - In 2011, almost 15,000 SNFs furnished Medicare-covered care to 1.7 million fee-for-service (FFS) beneficiaries during 2.4 million stays.

<table>
<thead>
<tr>
<th>Type of IRF</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Average annual change</th>
<th>Annual change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All IRFs</td>
<td>1,221</td>
<td>1,235</td>
<td>1,225</td>
<td>1,202</td>
<td>1,196</td>
<td>1,179</td>
<td>1,165</td>
<td>-0.4%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Urban</td>
<td>1,024</td>
<td>1,027</td>
<td>1,018</td>
<td>1,001</td>
<td>992</td>
<td>981</td>
<td>972</td>
<td>-0.6%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Rural</td>
<td>197</td>
<td>208</td>
<td>207</td>
<td>201</td>
<td>204</td>
<td>198</td>
<td>193</td>
<td>0.5%</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Freestanding</td>
<td>217</td>
<td>217</td>
<td>217</td>
<td>221</td>
<td>225</td>
<td>233</td>
<td>234</td>
<td>0.5%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Hospital based</td>
<td>1,004</td>
<td>1,018</td>
<td>1,008</td>
<td>981</td>
<td>971</td>
<td>946</td>
<td>931</td>
<td>-0.6%</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>768</td>
<td>768</td>
<td>758</td>
<td>738</td>
<td>732</td>
<td>729</td>
<td>711</td>
<td>-1.0%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>For profit</td>
<td>292</td>
<td>305</td>
<td>299</td>
<td>291</td>
<td>295</td>
<td>294</td>
<td>294</td>
<td>-0.1%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Government</td>
<td>161</td>
<td>162</td>
<td>168</td>
<td>173</td>
<td>169</td>
<td>156</td>
<td>158</td>
<td>1.8%</td>
<td>-5.0%</td>
</tr>
</tbody>
</table>

Note: IRF (inpatient rehabilitation facility). For all years, the rural/urban breakdown is by Core-Based Statistical Area (CBSA) definition. For 2011, two facilities are missing ownership data in the source file.

Source: MedPAC analysis of 2011 fourth quarter Provider of Services files from CMS.

March MedPAC Report to Congress. Chapter 10
WHAT ARE THE STATISTICS?

- Total spending for outpatient therapy services in 2011 was $5.7 billion.
- 5 million Medicare beneficiaries received outpatient therapy services (15%)
- 45,000 PTs, OTs, and SLPs billed the Medicare program.

“The Commission's recommendations are intended to decrease inappropriate use of outpatient therapy services and to provide the Medicare program with essential data on patients’ conditions, services received, and outcomes.” (pg 229 Improving Payment System for OP)

Twenty counties listed from several states –

- Labeled disproportionate Use
- If you are in these areas – concentrate on improving documentation and medically necessary criteria because you are already in the
Learning Objectives for this Presentation

- Prioritize Stakeholder Messages (inpatient/outpatient)
- Quick Tactics vs. Long Range Tactics (QT / LRT)
- Create a Roadmap; Stick to the Course
- Hone Messages – Stakeholder tactics
- Continuously Evaluate Success
- Be Diverse and CREATIVE
- EVERYONE is RESPONSIBLE FOR SUCCESS
- Create a ‘can do’ attitude to reach your GOALS
  - NUMBER 1 PRIORITY – SET THE GOALS to ACHIEVE
Create the Vision - GOAL

- Stakeholders - objectives
- Past Performance – metrics / gather your data
- SWOT – strengths, weakness, opportunities, threats
- Plan – concrete expectations specific to stakeholder interests
- Action – create varied tools/strategies to reach stakeholders
- Communication – continuous feedback loop – PDCA
- EQUAL = SUCCESSFUL Referral Development

Visualize to Achieve
Who’s expectations are most important?

- Providers
- Patients
- Payers

- “Pay me more”
- “Lower my costs”
- “Fix me quick”

Sweet SPOT for Everyone!

Courtesy Bob Habasevich.
Stakeholders – Start HERE!

Healthcare Stakeholders
- Patients/families
- Physicians
- Insurance Providers
- Government
- Regulatory Bodies
- Board of Directors
- Referral Base
- Community

Wants/Needs
- Responsiveness/Accountability
- Efficiency & Effectiveness
- Best Practice
- Watch Dog – Report Cards
- PPS & Accountability
- National Data Quality Indicators
- Compliance & Regulations
- Pay for Performance
- Best Value
LIST – Top of Mind…

• Top Four Stakeholders – Initial Focus:
  - 1.)
  - 2.)
  - 3.)
  - 4.)

• Top Four Performance Metrics for your organization:
  - 1.)
  - 2.)
  - 3.)
  - 4.)

• Two Strengths - Two Opportunities:
  - 1.)
  - 2.)
  - 1.)
  - 2.)
DESIGN to STAKEHOLDER OBJECTIVES

- Strengths & Opportunities
  - Design & Monitor
- Referring Facilities
- Patient
- Physician
- Payers
- Public – Community
Stakeholder Objectives

**MINE YOUR DATA**

- START with last 3 years - STATS
  - Volume of patients by CMG / OP by ICD-9 or Tx Dx
  - Payer by CMG / OP by ICD or Tx Dx
  - LOS by CMG / OP Visits per Diagnosis
  - Outcomes – Functional Achievements by RIC / OP Metric Goals
  - Satisfaction @ D/C & POST DISCHARGE

- Review Financial Performance by CMG / OP by ICD / Tx Dx
- Capacity – Answer NEED TO KNOW & BALANCE
- PLAN – BUILD EXPECTATIONS
  - Focus, Stay on Course, Communicate
  - REAL TIME Directives
Data REVIEW STAGE

START WIDE - THEN NARROW

SELECT AREAS FOR GROWTH and then REVIEW THOSE BY ZIP CODE
Focus is On REFERRAL Increase

- Gather PAST DATA on Referral Characteristics to build the PLAN

<table>
<thead>
<tr>
<th>Day of Week</th>
<th>Admission Time</th>
<th>After YTD PM 3 Total</th>
<th>% of Total</th>
<th>W/E % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A Referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td>3P 4P 5P 6P 7P 8P 9P 8A</td>
<td>51 28 9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td>25 10 12 3 3</td>
<td>53 28 9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td>29 7 15 6 5 1 1</td>
<td>64 35 12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td>22 18 8 4 2 1</td>
<td>45 32 8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friday</td>
<td>19 12 8 8 5 6 3</td>
<td>61 42 14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td>8 4 1 1</td>
<td>14 6 2%</td>
<td>14 5%</td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td>8 1</td>
<td>10 2 1%</td>
<td>10 3%</td>
<td></td>
</tr>
<tr>
<td>Hospital B Referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td>3P 4P 5P 6P 7P 8P 9P 8A</td>
<td>196 129 14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td>57 23 17 13 6 5</td>
<td>121 64 7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td>70 16 23 12 14 4 1</td>
<td>140 70 7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td>77 28 23 17 14 3 1</td>
<td>163 86 9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friday</td>
<td>76 26 16 22 11 11 2</td>
<td>164 88 9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td>40 12 13 9 13 5 1 2</td>
<td>95 55 6%</td>
<td>95 10%</td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td>49 12 2 5 3 2 1 1 75</td>
<td>26 3 1%</td>
<td>75 8%</td>
<td></td>
</tr>
<tr>
<td>Hospital C Referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td>9 5 1 3 1 1 1</td>
<td>24 15 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td>5 5 1 3 1 1</td>
<td>16 11 8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td>16 6 2</td>
<td>24 8 5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td>14 4 2 3 2</td>
<td>25 11 8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friday</td>
<td>15 5 5 3 1 1</td>
<td>30 15 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td>13 2 1</td>
<td>16 3 2%</td>
<td>16 11%</td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td>10 1</td>
<td>11 1 1%</td>
<td>11 8%</td>
<td></td>
</tr>
</tbody>
</table>
- Quick visual by location of referral based on YOUR specific targets
- Varied Ways to Strategize an 82 pt./month Goal
- If it’s the 22nd of August and there are 31 days in the month; 71% of the month has passed
- This facility is at 76% of goal with 9 days to go!
### OP Examples

#### PRESENT MONTH TO DATE DATA

<table>
<thead>
<tr>
<th>PRN</th>
<th>Day Program Location #2</th>
<th>Location Central Specialty Program</th>
<th>Specialty#2 Location #3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AUD PT OT SP REC. PT OT SP</td>
<td>PT OT SP</td>
<td>PT OT SP</td>
</tr>
<tr>
<td>Admits</td>
<td>3 2 3 3 4 3 2 9 11 6 5 3 3 5 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharges</td>
<td>3 4 4 4 1 21 4 1 51 25 3 0 0 42 9 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visits</td>
<td>2 113 122 103 14 598 93 32 1106 320 102 16 50 492 121 58</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td>$3,100.00 $18,621.00 $24,628.00 $21,816.00 $2,447.25 $18,646.00 $15,926.00 $6,795.00 $178,778.00 $60,153.25 $19,500.50 $12,676.25 $23,630.00 $75,815.00 $10,705.00 $12,975.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ave# Visits/Pt.</td>
<td>1.9 7.5 8.1 7.4 7.0 5.1 4.2 3.6 5.0 4.0 5.4 5.8 11.1 4.3 4.6 4.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ave $ Charge Visi</td>
<td>$1,550.00 $164.79 $201.88 $211.81 $174.80 $161.62 $149.74 $269.53 $268.31 $161.64 $166.17 $191.18 $169.42 $533.86 $161.64 $155.25 $223.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ave $ Charge Pt.</td>
<td>$1,550.00 $1,241.40 $1,641.33 $1,538.23 $1,283.65 $826.03 $653.00 $745.00 $808.35 $864.31 $1,026.34 $930.48 $645.50 $638.36 $751.40 $1,081.25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Admits = Patients admitted during the current period
- Discharges = Patients discharged during the current period
- Visits = Number of visits per loco-disc. accumulated by day. EX: - patient seen by three disciplines.
- Revenue = Total for period per loco-disc.
- Ave# Visits/Pt. = current period visits / active patients
- Ave $ Charge Visi = current period visits / revenue
- Ave $ Charge pt. = current period active patients / revenue
- Active Patients = Total Number of patients receiving treatment for current period [regardless]
Trend Average – Offset by ‘Instances’

- SET TARGETS AFTER REVIEWING HISTORICAL NORMS
- Plan to Expected.

Visit Trending 2011 - 2013

GOAL Reset

Memorial week = 4 days.
July 4th Holiday
## PLAN – Set Expectation – Target Volumes

### 2011 GOAL DASHBOARD

<table>
<thead>
<tr>
<th>Facility Experience Avg. LOS / RICS Captured</th>
<th>Average Reimbursement / Discharge</th>
<th>Patients</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke -2011</td>
<td>$18,906 Goal/mo. Goal/Yr.</td>
<td>22</td>
<td>418</td>
</tr>
<tr>
<td># admits:</td>
<td></td>
<td>264</td>
<td>5016</td>
</tr>
<tr>
<td>Brain Injury -2011</td>
<td>$18,958 Goal/mo. Goal/Yr.</td>
<td>14</td>
<td>294</td>
</tr>
<tr>
<td># admits:</td>
<td></td>
<td>168</td>
<td>3528</td>
</tr>
<tr>
<td>SCI -2011</td>
<td>$17,965 Goal/mo. Goal/Yr.</td>
<td>6</td>
<td>120</td>
</tr>
<tr>
<td># admits:</td>
<td></td>
<td>72</td>
<td>1440</td>
</tr>
<tr>
<td>Orthopedic -2011</td>
<td>$12,554 Goal/mo. Goal/Yr.</td>
<td>25</td>
<td>325</td>
</tr>
<tr>
<td># admits:</td>
<td></td>
<td>300</td>
<td>3900</td>
</tr>
<tr>
<td>Neuro -2011</td>
<td>$14,756 Goal/mo. Goal/Yr.</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td># admits:</td>
<td></td>
<td>24</td>
<td>240</td>
</tr>
<tr>
<td>All Other - 2011</td>
<td>$14,253 Goal/mo. Goal/Yr.</td>
<td>13</td>
<td>195</td>
</tr>
<tr>
<td># admits:</td>
<td></td>
<td>156</td>
<td>2340</td>
</tr>
<tr>
<td>Budgeted Por. days / Goals</td>
<td>Goal/mo. Goal/Yr.</td>
<td>82</td>
<td>1372</td>
</tr>
<tr>
<td>45pts/ day goal</td>
<td>Goal/Yr.</td>
<td>984</td>
<td>16,464</td>
</tr>
</tbody>
</table>

### CENSUS DAYS

- **Daily census**: 40 days, 14,600 Budgeted, 80% Occupancy
- **45 days**: 16,425 GOAL, 90% Occupancy

18,250 Full Census; 50 beds X 365 days/year
PLAN:

- Quick MTD Visual
- Communicates Goal in REAL TIME to Liaisons in the Field
  - Update Each Day
- Work Turnover to Open Beds
- Simple Excel Tool – constantly works budgeted expectations in mind as staff seek referrals.
- The larger your referral resource pool the more helpful the tool
- If you are mostly seeking internal referrals you may review % of Annual admissions in the given population to set achievable targets in YOUR PLAN
Plan Feedback - Continuous Feedback

When the month ends – GIVE FEEDBACK

Goal/Month:
- Stroke/Neuro 24, 26
- Brain Injury 14, 13
- SCI 6, 4
- Orthopedic 25, 30
- Miscellaneous 13, 11

Variance 2011
<table>
<thead>
<tr>
<th></th>
<th>Monthly Actual</th>
<th>Admits YTD Actual</th>
<th>Cumulative to Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>79</td>
<td>79</td>
<td>96%</td>
</tr>
<tr>
<td>February</td>
<td>85</td>
<td>164</td>
<td>100%</td>
</tr>
<tr>
<td>March</td>
<td>76</td>
<td>240</td>
<td>98%</td>
</tr>
<tr>
<td>April</td>
<td>85</td>
<td>325</td>
<td>99%</td>
</tr>
<tr>
<td>May</td>
<td>79</td>
<td>404</td>
<td>99%</td>
</tr>
<tr>
<td>June</td>
<td>86</td>
<td>490</td>
<td>100%</td>
</tr>
<tr>
<td>July</td>
<td>81</td>
<td>571</td>
<td>99%</td>
</tr>
<tr>
<td>August</td>
<td>84</td>
<td>655</td>
<td>100%</td>
</tr>
</tbody>
</table>

GOAL 2011

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number</th>
<th>% Type</th>
<th>Goal/mo.  Diagnosis</th>
<th>Number</th>
<th>% Type</th>
<th>Goal per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke &amp; Neuro</td>
<td>288</td>
<td>29.3%</td>
<td>24 Stroke &amp; Neuro</td>
<td>26</td>
<td>32%</td>
<td>24</td>
</tr>
<tr>
<td>Brain Injury</td>
<td>168</td>
<td>17.1%</td>
<td>14 Brain Injury</td>
<td>13</td>
<td>16%</td>
<td>14</td>
</tr>
<tr>
<td>Spinal Cord Injury</td>
<td>72</td>
<td>7.3%</td>
<td>6 Spinal Cord Injury</td>
<td>4</td>
<td>5%</td>
<td>6</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>300</td>
<td>30.5%</td>
<td>25 Orthopedics</td>
<td>30</td>
<td>37%</td>
<td>25</td>
</tr>
<tr>
<td>General Medicine</td>
<td>156</td>
<td>15.9%</td>
<td>13 General Medicine</td>
<td>11</td>
<td>13%</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>984</td>
<td>100.0%</td>
<td>82</td>
<td>84</td>
<td>102.4%</td>
<td>82</td>
</tr>
</tbody>
</table>
Bed Utilization — The overlooked foundation of profitability!

Every unit/facility has a specific number of beds, and to operate efficiently, you have to determine what the lowest denominator for those bed numbers can be with just a little play to allow appropriate gender/infection co-habitation allowances (non-private room management). Knowing that number also allows you to operationalize a staffing plan that is consistent and does not require floating unfamiliar staff onto the unit, or managing the difficult swings that occur when census varies significantly during the week. So I ask, what is your ideal bed capacity? Can you make that capacity more profitable is the next question?

Bed utilization is the foundation of profitability, if and when you know the number you need to remain
1.) Referring Facility

- Discharge – ASAP (UR Hat = Preadmission Screen)
  - Understanding PAC Regulations/Appropriate referrals
  - Complexity that benefits from Interdisciplinary Approach led by ‘Rehab Physician’ requiring no less than 3x/week review/management to guide progress toward weekly POC
  - Recognizing Rehabilitation candidates – educate on area specific to YOUR PATIENT population in regards to RN nursing capacity to guide a rehabilitation POC – 24/7

- Ease of use
- Prompt turnaround
- Resource Readiness
Referring Facility/PAC continuums

- Referral Care Management In-service (with CEU’s when possible)
  - Highlight Medicare regulations and the evolution of PPS in post acute care
  - End with requirements on HOW to refer to a licensed rehab bed – outline your process
    - Simplify a Decision Tree - Laminate
    - Educate basic pre-admission criteria
    - Why might YOUR facility be the best option for various types of patients you seek to provide services
  - Offer Assistance either on-site or in quick referral review
    - Checklist
  - Work with Quality department to reduce ‘bounce backs’
    - Huge importance with 30 day all cause readmission quality initiatives
Referring Facility/PAC continuums

- Pre/Post Test – PAC Referral Guidelines/Regs
- Nursing Education
- Case Mgmt Education / Throughput
- Physician Lounge – Story Boards
- Intern Rounds Education etc.

Opening the Door to Rehabilitation

Everything You Need To Know for the Efficient, Appropriate Placement of a Patient Needing Rehabilitation Services

Patient Placement

After Acute Care…What next?

Screening patients for Inpatient Rehab
Information to form judgments – THE RIGHT PT REFERRAL

Based on area prevalence of services in Medicare Compare Data of the HIGHEST Ranking providers of this area for RN coverage per patient day (18-59 minutes)

Use professional judgment in managing the risks this patient presents

Is an IRF/IRU level of interdisciplinary care most appropriate for the patient they are considering?

WHAT is your RN hppd?

   Along with daily (or no less than 3x/week) rehabilitation physician management of the POC, this patient is an excellent candidate to ...

   (state)

GIVE THEM a DECISION TREE to HELP guide appropriate referrals
Referring Facility/PAC Continuums

- Laminated Decision Tree / Clip board or pocket ready

Decision Trees Assist in Appropriate Patient Placement

<table>
<thead>
<tr>
<th>Decision Tree Step</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will insurance permit level of care suggested after patient information is reviewed?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Is there potential for significant improvement in a reasonable length of time that is practical value to the patient and may result in return to community?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>After medical necessity is met, is there a qualifying LOS or a diagnosis that follows the 70% rule?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Check with PPS coordinator and look at SNF criteria.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the patient a recent brain injury with a Rancho score?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Does the patient require a dialysis, radiation or chemotherapy?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Does the patient require that a treatment be facilitated within initial rehab stay?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Admit to REHAB</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical Necessity Admission Criteria

Rehabilitation vs. SNF Level of Care

- No - Follow Care
- SNF
- Level of Care

- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determines level of care
- If NO - Delay Admission until information is received and determin...
List of Considerations/Coversheet for 3rd Party Payer Defending IRF Level of Care

Per regulatory guidelines a patient eligible for rehabilitation must have no less than TWO therapies involved in their plan of care. For specialized diagnoses the resources are increased and often require three or more disciplines to be involved in the care. For each discipline required for involvement the care also becomes more complex to manage an interdisciplinary plan of care.

Rationale for a higher care demands over a skilled nursing level of care:

**Other Considerations for Increased IRF Management**

- Bowel & Bladder incontinence; regimented retraining
- Wound / Skin breakdown; education of risk factors to monitor/avoid and manage compromised skin conditions
- Nutritional counseling
- Tracheostomy care / respiratory needs / weaning as tolerated with intense monitoring (aspiration risks)
- Positioning every 1/2 hour (seated); 2 hours lying
- Dependence on functional assistance for all care (Bathing, dressing, mobility, basic functions often 2:1 ratio); TRAINING — not simply ‘doing it for the patient’ but training them & caregivers how to accomplish with newly onset impairments.
- May require feeding, Peg care etc.
- Equipment caregiver training - sliding boards, Hoyer lifts, specialized mattresses, specialized beds (clinitrons, air flow)
- Attachments such as trapeze, footboards, specialized call systems, phones - assessment & training of environmental control systems
- Specialized wheelchair assessment - self-propel or motorized
- Increased training in safety for mobility with use of device’s
- Increased educational needs for patient and CAREGIVER’s based on multi-systems impairment risks and avoidance of issues
- Self catheterization; & or bowel retraining programs
- Autonomic dysreflexia signs/symptoms and other risk factors (DVT, pulmonary edema)
- Hypotensive issues which require specialized leg wrapping, binders, compression hose.
- Neuro-motor care such as spasticity control (splinting, medications, positioning)
- Pain management techniques (cold, hot, guided imagery and relaxation techniques)
- Psychological support and or Neuro-psychology services as appropriate
- Sexual functional and education
- Family relations & coping skills
- Specialized device assessment, therapy retraining & or sling support systems for strengthening
- Time required for set up and care and additional staff, 2:1 ratio at times for high level activity retraining (safety)
- Respiratory care - 02 saturation monitoring with activity; secondary to respiratory compromise
- Safety when sensory issues exist (No longer have internal feedback that warns them of impending harm)
- Access to support groups and case management to increase community support networks
- Home accessibility discussions that assists family in recognizing modifications that may be required to take patient home.
- Community re-entry information and training
Finally, as one commenter highlighted, shifting IRF patients toward SNF care does not necessarily improve the quality of care provided to the beneficiaries. A March 2005 report in the Archives of Physical Medicine and Rehabilitation (available at http://www.archives-pmr.org/article/PIIS0003999304012493/abstract) found that 81.1 percent of IRF patients were discharged to home, compared to 45.5 percent of SNF residents. Additionally, IRF patients appeared to have shorter lengths of stay, averaging approximately a 13-day stay, compared to the average 36-day stay for a SNF resident.

when patients discharged from each setting were reviewed 24 weeks after discharge, IRF patients had consistently better outcomes and displayed a faster rate of recovery. Given these findings, we do not agree with those commenters who would assume that shifting patients from the IRF setting to a SNF setting is necessarily more beneficial to the patient or the Medicare Trust Fund.

Utilize empirical evidence and other published information to make your POINT!
Referring Facility / Skilled Compare (area code look up)

http://www.medicare.gov/NHCompare

HOW MUCH NURSING CARE - TEACH, TRAIN, CARRYOVER RISK FACTOR MGMT?
Referring Facility Education for Referrals
Evidence to Compare with Rehab 6-8 hppd Avg.

<table>
<thead>
<tr>
<th>Facility</th>
<th>Overall Rating</th>
<th>Staffing</th>
<th>RN Staff Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grace Living Center-Jenks</td>
<td>Much Above Average</td>
<td>Below Average</td>
<td>Much Below Average</td>
</tr>
<tr>
<td>Oklahoma Methodist Manor, Inc.</td>
<td>Much Above Average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inverness Village</td>
<td>Much Above Average</td>
<td>Above Average</td>
<td>Average</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility</th>
<th>Total Number of Residents</th>
<th>Total number of licensed nurse staff hours per resident per day</th>
<th>RN Hours per Resident per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grace Living Center-Jenks</td>
<td>148</td>
<td>1 hour and 16 minutes</td>
<td>18 minutes</td>
</tr>
<tr>
<td>Oklahoma Methodist Manor, Inc.</td>
<td>74</td>
<td>2 hours and 5 minutes</td>
<td>59 minutes</td>
</tr>
<tr>
<td>Inverness Village</td>
<td>40</td>
<td>1 hour and 15 minutes</td>
<td>38 minutes</td>
</tr>
<tr>
<td>Oklahoma Average</td>
<td></td>
<td>1 hour and 16 minutes</td>
<td>26 minutes</td>
</tr>
<tr>
<td>National Average</td>
<td></td>
<td>1 hour and 37 minutes</td>
<td>47 minutes</td>
</tr>
</tbody>
</table>
• Information to form judgments by – IN YOUR Pre-Admission ASSESSMENTs! EDUCATE & DEFEND a REHAB LOC.

• “Based on area prevalence of services in Medicare Compare Data of the HIGHEST 5 Star Ranking providers of this area for SNF RN coverage per patient day in THIS area are between 18 – 59 MINUTES/day; my professional judgment in managing the risks this patient presents rests best with a rehabilitation level of interdisciplinary care. This patient will receive on average 6.0 hppd of RN care to monitor, manage, teach & train this patient in the care of the listed risk factors & comorbid conditions. Improved education of this manner will help reduce return to acute care readmits.”

• “In addition, a physician with rehabilitation expertise will face to face manage the POC (no less than 3x/week) and staff a weekly conference. This level of care is much more frequent than the mandated SNF monthly recertification requirement, or distant review of the POC.”
Referring Facility/PAC Continuums

- **Pre-Admission**
  - Readiness / Appropriateness
  - High Training Resources – Alignment of Needs
  - Focus -
    - Show general patterns of Yes/No Type pts.
  - Be Prompt Responsive

- **Pre-Admission Screen** stays within the Medical Record & covers the following areas:
  - Prior level of Function
  - Expected level of improvement
  - Expected length of time to achieve expected improvement
  - Evaluates patient RISK for clinical complications
  - List Conditions that caused the need for rehabilitation
  - List combinations of treatments needed within expected frequency (x/week) and duration (x/day) to reach potential in the IRF.
  - List Anticipated D/C destination
  - List probable post discharge treatment & other information relevant to the needs of the patient.
Referring Facility/PAC continuums

- COMMUNICATION
- FAX COVER SHEET
- Referring Facility
- Physician Offices
- Third Party Payers
- Case Management – ongoing updates
- BED AVAILABILITY
- DIFFERENT VERSIONS – Data Appropriate to Situation
Referral Case-Mgmt

- Announcements – CARF or other certifications achieved
- Share Neuro/Ortho outcomes
- Update quarterly
- Follow-up Individually Liaison / Dir to Dir.
- Offer on-site in-services / Referral Outcomes Updates!

August 30, 2010

NAME OF CONTACT AT REFERRING HOSPITAL
NAME OF HOSPITAL
ADDRESS
CITY, STATE, ZIP CODE

Dear Ms. NAME OF CASE MANAGER:

I would like to introduce our admissions department and share some great news about OUR FACILITY! For our patients and our FACILITY, we were visited by CARF (Commission on Accreditation of Rehabilitation Facilities) and our survey went very well. We achieved our most recent patient outcomes. CARF award our facility the CARF Commission on Accreditation of Rehabilitation Facilities Status, which means we have met the standards for our accreditation.

We continue to strive to meet the needs of our referring hospitals from over surrounding counties. It is with pride that we share these outcomes, which have been achieved by neuro and orthopedic patients. We are celebrating these achievements with our patients and families.

The numbers below represent change in function on case. Each physician also receives an individual progress report demonstrating their patient outcomes.

NEUROLOGIC OUTCOMES:

ORTHOPEDIC OUTCOMES:

Treatment at a LICENCED REHABILITATION FACILITY is different than treatment in a facility with rehabilitation. Two studies have now demonstrated that patients placed on a nursing home level of care are taking twice as long to be discharged and only a third of patients admitted with hip fracture and joint replacements are returning home. Nationally, orthopedic patients who are placed in a care facility may experience delays in discharge.

Our hospital joint replacement patients returned home 50% of the time in 2010 after a 10.3 day length of stay. A report on discharge data for joint replacement patients is greater than the region average for joint replacement patients, and greater than that of hip fracture patients.

Our facility desires to be your rehabilitation location of choice. We hope to offer our patients and updated outcomes quarterly to demonstrate effective choices when care management works with third party payers on selecting care. If you have any questions, please do not hesitate to contact Admissions to schedule one of our NURSE Liaisons to visit your facility or meet with a patient.

Sincerely,

[Signature]

Daniele L. D'Attilio, PT, MBA
2.) Patient

- Location/Ease of decision process
- Guide Appropriate Expectations – You Know Avg Stats
- Build Reputation Knowledge
- Pre-admission process insight
- Achievement Prospects – data & information
- Initiate a Home Going TO DO LIST
  - They will help develop true ‘barriers to discharge’
  - Greatest Hopes
  - Greatest Fears
  - List known resources
  - Top Questions I have – List 3
Patient

- BUSINESS CARD – WEB INFORMATION / PHONE NUMBER of who to contact
  - Annual Report Link
  - Outcomes by Diagnosis Link
  - Resources Available for this population
  - AP for that? Be Resourceful

- Web based Program Flyers / Expectation for specific diagnosis

- Community Resources by diagnosis – Book Markers
  - Jump Drive – Sponsored by…

- DISCHARGE CHECKLIST OR PRIORITY ISSUES LIST
  - Family print and bring

- Common Barriers – Begin Planning NOW – DATA
Patient Directed business/calling cards

YOUR REHAB HOSPITAL/UNIT

Admission Coordinator/Sally  222-222-5555

WWW.REHABSAMPLE.com

Link to “What to Expect”
3.) Physician

- Ease of use
- Outcomes – Expectations
- Message Education – Fax Covers
- Progress updates
- Valued partner – Service Satisfaction
- Validation of Choice
  - Provide Aggregate Data As Appropriate
- Vendor Report or
- Design a simple outcomes ‘report card’
  - Who
  - Dx
  - Actual LOS to Avg LOS
  - Initial Functional Score / Total possible …Ending Score / Total Possible
  - Pt. improved …..% & returned to ….. Expect them to follow up within …. days
- Referring Physician Feedback
- Provide with Rehab Doctor Discharge Summary
August 30th, 2010

REFERRING DOCTOR
ADDRESS
ANYWHERE, USA ZIPCODE

RE: PATIENT, LAST NAME

Dear REFERRING DOCTOR,

Thank you for referring PATIENT LAST NAME to THIS HOSPITAL NAME. It is our pleasure to contact you at this time to tell you that PATIENT has been discharged from our inpatient rehabilitation unit.

Please find attached your patient’s REHAB REPORT SUMMARY at the time of discharge. When patients come to THIS HOSPITAL NAME, we use a national scoring tool that ranges from 18 to 128 points to measure functional independence in 15 different areas such as self-care, mobility, cognition, communication and bladder/bowel management.

The spider graph allows you to visualize PATIENT’S initial functioning level and the progress made in the time here at our Hospital. We hope you find this tool helpful in your follow up and in furthering your medical management with your patient. Proudly, over the past NUMBER OF years, our patients overall improvement in the 21 diagnostic categories we treat has BLANK INFORMATION COMPARED TO national and regional outcomes.

We welcome any specific questions you may have regarding your patient’s progress, so please don’t hesitate to call us at (222) 222-2222. We hope OUR HOSPITAL will continue to be your provider of choice for all of your patients’ inpatient skilled and rehabilitation, and outpatient therapy needs.

Sincerely,

PHYSICIAN FOR THIS HOSPITAL, CREDENTIALS
American Academy of Physical Medicine and Rehabilitation
Medical Director, FOR THIS HOSPITAL

XXX/xxxx
cc:

Enclosure
Physician

- Accreditation Announcement
  - Run Referral Reports
  - Review Stats
  - Select who to target/communicate.

Dear Dr. (Name),

Achievements at THIS REHAB FACILITY are at an all-time high. Our Hospital received the results of a CARF survey, # of services were accredited for a three-year term; this commitment has benefitted (ANNUAL NUMBER OF PATIENTS) over the past year. In addition, BLANK # of exemplary ratings was stated within our report:

- STATE SURVEY EXEMPLARY ITEMS
- STATE SURVEY EXEMPLARY ITEMS
- STATE SURVEY EXEMPLARY ITEMS
- Etc.

YOU HAVE REFERRED ________NUMBER OF PATIENTS to us in the last 3 years.
YOUR PATIENTS IN PARTICULAR have succeeded in RETURNING TO THE COMMUNITY ________% of the time; AFTER AN AVERAGE OF BLANK DAYS STAY. THEIR FUNCTIONAL IMPROVEMENT ENABLED THEM TO move ________POINTS from admit to discharge

Our patients’ outcomes continue, on average, to exceed regional and national outcomes. Functional improvement gains met or exceeded national and regional benchmarks in _______NUMBER of BLANK NUMBER OF diagnostic categories in 2010 and _______NUMBER OF diagnoses treated through the first quarter of 2011.

We continue to provide an individual report card by patient in addition to a summary of their discharge status. If you would like to know more about our services and our programs, please contact the Hospital at 222-222-2222. Our liaisons will visit your patient directly to expedite admission for all cases eligible to receive an inpatient rehabilitation level of care.

Sincerely,

THIS MEDICAL DIRECTOR
- **Area physician information** -
  - Informational materials that highlight a diagnosis and write what and how a patient benefits from a short intense rehabilitation level of care.
  - Educate on PAC and the significant differences between admission criteria for these settings.
  - Publish 5 Simple questions on appropriate referral levels that physicians can recognize quickly.
  - An article of interest – highlight a recovery story and the interdisciplinary coordination of that care etc.
  - Complicated Case Study Review – (May need permission/sign offs through marketing department).
  - Link an informative blog / rehab topics to your physician log on portal (or steal our links!)
  - Give us your NEED TO KNOW topics – let us blog for you.
4.) Payer

- Access – align insurers of choice / agreements
- Focus on discharge objectives
- Value proposition
- Communicate successes
- Know case workers / case managers
- Educate on process / expectations
- Make information easy to digest
- Master discharge focus
Payer – Outcomes MEETING

- Payer Specific by diagnosis/patients they referred

- 20 Slide-slideshow Tell them what they get for their $$$

- Value Networking

- Check your contract
  - Provide Data as required
Payer – Intensity of Specialization

- FACTS ON HAND
  - When SCI requires Rehab LOC
- Talking points
  - Justification
- IF YOU FAX
  - OUTCOMES specific to the patient population you are SEEKING APPROVAL!
  - Volumes DATA etc.

Per regulatory guidelines a patient eligible for rehabilitation must have no less than TWO therapies involved in their plan of care. For specialized diagnoses the resources are increased and often require three or more disciplines to be involved in the care. For each discipline required for involvement the care also becomes more complex to manage an interdisciplinary plan of care.

Rationale for a higher care demands over a skilled nursing level of care:

- Bowel & Bladder incontinence, segmented retraining
- Wound / Skin breakdown; education of risk factors to monitor/avoid and manage compromised skin conditions
- Nutritional counseling
- Tracheostomy care / respiratory needs; weaning as tolerated with intense monitoring (aspiration risks)
- Positioning every 1/2 hour (seated); 2 hours lying
- Dependence on functional assistance for all care (Bathing, dressing, mobility; basic functions often 2:1 ratio); TRAINING – not simply ‘doing it’ for the patient but training them & caregivers how to accomplish with newly onset impairments.
- May require feeding, PEG care etc.
- Equipment caregiver training - sliding boards, Hoyer lifts, specialized mattresses, specialized beds (clinitraps, air flow)
- Attachments such as trapeze, footboards, specialized call systems, phones – assessment & training of environmental control systems
- Specialized wheelchair assessment - self-propel or motorized
- Increased training in safety with use of devices
- Increased educational needs for patient and CAREGIVERS based on multi-system impairment/risk and avoidance of issues
- Self catheterization; & or bowel retraining programs.
- Autonomic dysreflexia signs/symptoms and other risk factors (DVT, pulmonary edema)
- Hypotensive issues which require specialized leg wrapping, binders, compression hose.
- Neuro-motor care such as spasticity control (splinting, medications, positioning)
- Pain management techniques (cold, hot, guided imagery and relaxation techniques)
- Psychological support and or Neuro-psychology services as appropriate
- Sexual functional and education
- Family relations & coping skills
- Specialized device assessment, therapy retraining & or sling support systems for strengthening
- Time required for set up and care and additional $134.11 2:1 ratio at times for high level activity retraining (safety)
- Respiratory care – 24 saturation monitoring with activity; secondary to respiratory compromise
- Safety when sensory issues exist (No longer have internal feedback that warns them of impending harm)
- Access to support groups and case management to increase community support networks
- Home accessibility discussions that assists family in recognizing modifications that may be required to take patient home.
- Community re-entry information and training
Payer – Intensity of Specialization

Brain Injury:
Consideration of Rancho level and specialized needs dependent on this. (See What is a Brain Injury & Modified Agitated Behavior Scale)
Possible tracheostomy care / respiratory needs
Behavioral Assistants when safety is a concern. (Approx. $368.00 additional dollars’ 24 hours based on salary/benefits)
Time required for set up and care and additional staff 2:1 ratio at times for high level activities especially when impulsive
More equipment such as secure unit ankle brace/bed security system, specialized beds (net enclosure to reduce use of restraints; alarms)
Intensive speech pathology interventions for cognition perception, swallowing, expression, day to day reasoning etc.
Dependence on functional assistance for all care (Bathing, dressing, mobility, basic functions often 2:1 ratio)
May require feeding, Peg care etc.
Brain Injury protocol progression (special training to work with these patients).
Specialized Functional Cognitive Training progression program.
Bowel & Bladder retraining
Increased training in safety for decreased cognitive abilities
Increased educational needs for patient and CAREGIVERS specific to agitation and stimuli
Neuro-motor care such as spasticity control (splinting, medications, positioning)
Pain management techniques (cold, hot, guided imagery and relaxation techniques)
Attires helmet & increased fall precautions
Psychological support & appropriateness of behavior in all interactions
Substance abuse counseling when indicated
Family relations & coping skills specific to BI
Respiratory care (O2 saturation monitoring secondary to respiratory compromise)
Specialized training of staff working with Brain Injury to meet the educational needs of this population
Access to support groups and case management to increase community support networks
Specialized pamphlet provided for discussion of progression in brain injury expectations
Additional staff added when number of patients with high acuity are cared for.
Community re-entry information and training

- FACTS ON HAND
  - When BI requires Rehab LOC
- Talking points
  - Justification
- IF YOU FAX
  - OUTCOMES specific to the patient population you are SEEKING APPROVAL!
  - Volumes DATA etc.
Payer Presentation –

- Mission
- Values
- History
- Patient Population
- Medical Staff
- Specialist/Specialty Programming
- Accreditations
- Nursing hppd
- Education Met
- Goals / Barriers Met

- How you screen
  - Criteria for Admission
- Scopes of Service
- Demographics Served
- Outcomes
  - LOS, Gains, Efficiency, Community Discharge
  - Pictures – personalize!
  - Graph Visual Ease
- Educate area data on comparative venues of care
  - CMS.gov Compare websites
Focus information specific to discharge achievements / barriers dissolved

Educate like scenarios / expectations

Master discharge focus goals and aligning resources from initial contact

HISTORICAL review for average improvement, LOS and resources required for this type of patient
  • Bring their expectations into alignment with experienced outcomes!

Use your data
# Outcomes Report

**Physical Medicine & Rehabilitation**


OUTCOMES tool, (required by Medicare), is used to collect and report demographics and functional data. Data permits us to benchmark patient outcomes at a regional and national level. The following information was obtained VENDOR on 1/18/2011 for all inpatient rehabilitation discharges in 2010.

Patient ‘n’ comparisons: OURS \( n = 792 \) patients; Regional \( n = 32,773 \) patients; National \( n = 144,316 \) patients

<table>
<thead>
<tr>
<th>21 Rehab Diagnoses:</th>
<th># Pts. OUR</th>
<th>OUR Gain</th>
<th>Regional FIM Gain</th>
<th>National FIM Gain</th>
<th>% Co-morbidities OURS to Region &amp; Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OURS - Regional National</td>
</tr>
<tr>
<td>Stroke</td>
<td>155</td>
<td>23.81</td>
<td>20.26</td>
<td>20.91</td>
<td>32% 29% 25%</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>114</td>
<td>38.96</td>
<td>28.44</td>
<td>28.47</td>
<td>75% 57% 53%</td>
</tr>
<tr>
<td>Non- Traumatic Brain Injury</td>
<td>45</td>
<td>23.58</td>
<td>20.06</td>
<td>20.68</td>
<td>62% 61% 58%</td>
</tr>
<tr>
<td>Traumatic Spinal Cord Injury</td>
<td>13</td>
<td>21.85</td>
<td>21.33</td>
<td>21.23</td>
<td>15% 48% 40%</td>
</tr>
<tr>
<td>Non-Traumatic SCI</td>
<td>29</td>
<td>19.97</td>
<td>19.98</td>
<td>20.04</td>
<td>48% 39% 34%</td>
</tr>
<tr>
<td>Neurological</td>
<td>25</td>
<td>19.28</td>
<td>18.01</td>
<td>19.24</td>
<td>56% 46% 43%</td>
</tr>
<tr>
<td>Fracture Lower Extremity</td>
<td>87</td>
<td>23.99</td>
<td>20.60</td>
<td>21.83</td>
<td>39% 26% 23%</td>
</tr>
<tr>
<td>Replacement LE Joint</td>
<td>121</td>
<td>25.41</td>
<td>23.27</td>
<td>25.08</td>
<td>54% 25% 22%</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>26</td>
<td>21.77</td>
<td>18.98</td>
<td>20.90</td>
<td>46% 30% 27%</td>
</tr>
<tr>
<td>Amputation; Lower Extremity</td>
<td>21</td>
<td>17.67</td>
<td>17.22</td>
<td>18.58</td>
<td>71% 63% 60%</td>
</tr>
</tbody>
</table>
Stakeholder Objectives

5.) Public

- Target public access to your information –
- Target success stories – provide for local papers
  - Engage College Journalists – Relevant Subject Matters
  - Congratulate staff on achievements publically
- Align speaker opportunities or continuous messaging
  - Churches
  - AARP
  - Assisted Living
  - Adult Daycare
  - Organization meetings – professional/disease specific
  - Employee champions – pick an organization & participate
  - Provide Logo Shirts for patients/families
Speaker Bureau- Standardize Messages

- Incentivize staff for 2 hours PTO for every speaker engagement – with report
- Target Church groups
- Adult Day Care centers
- Professional meetings – specifically disease specific
- American Heart
- Arthritis Assoc
- Accessibility Project – Create logo for restaurants/businesses to use when ‘approved for access’ (Like heart smart menus etc)
- **Speaker Bureau-**
  - Insurance agents – especially those that sell LTC insurance
  - Presence at local fund raising – runs, marathons, provide drink station – logo cups
  - Patient profile wallet cards @ mall health fairs
  - Start Respite Care giver Support topics
  - Hand deliver reports for high volume referral sources
  - Flu Season – tissue packs with logo stickers
  - Encourage staff involvement in high school career days
  - Senior Brunch – Topics
  - Trips / Tours / Community Reintegration – RT Department
- Playing Cards with logo/website/outcomes & phone #
- Tee shirts –
  - Admission packet
- Useful gadgets
  - Rubber jar openers
  - Long Handle Shoe Horns
  - Mouse Pads
  - Logo Walker Pouches
  - MAKE THEM
  - IRON ON LOGO’s!
Public / Marketing

Education Opportunities

- Local Radio Shows
  - Health focus
- College Newspapers
- Congressional Education – it’s your duty
- AARP local chapters
- Health Questions corner @ community newspapers – DID YOU KNOW?
- Utilize outcomes/facts to BETTER PREPARE THE CONSUMER
Mining Referrals – Business Data

- **Visualize Success to Achieve**
  - What is YOUR ROI for every patient you discharge to the community?
  - Patient / Family Satisfaction Comments
  - Referral Source Satisfaction
  - % of Goals achieved
  - Discharge location Predictions/Results.
  - Is your Performance worth paying for?
  - What is your value proposition & does it speak toward real outcomes?
Mining Referrals – Business Data

- DESIGN to STAKEHOLDER OBJECTIVES - YOUR TURN!!
- 1 = Quick Tactic  
  - Referring Facilities
    - 1.)
  - Patient
    - 1.)
  - Physician
    - 1.)
  - Payers
    - 1.)
  - Public – Community
    - 1.)
- 2 = Long Range Tactic
  - 2.)
BE CREATIVE

- Every Person within your organization is responsible for referrals & marketing
  - Follow: www.mediware.com/rehabilitation/blog

Questions?
References:

- Articles
  1.) "Marketing Matters"
  by Kimberly E Wynn, in
  PT-Magazine of Physical Therapy, Vol 6, No 12, 1998

  2.) David C. Steinberg and Trent Wehrhahn
  Potent Marketing Strategies
  Which ones work, which ones will leave you bankrupt and begging at physicians’ doors?
  Published Article – Advance Magazine
  Sept 16, 2010
  http://physical-therapy.advanceweb.com/Archives/Article-Archives/Potent-Marketing-Strategies.aspx

  3.) Customer Relationship Management: How to Turn a Good Business into a Great One!
  by Graham Roberts-Phelps
  Publisher: Thorogood
  Published: September 2001

  4.) Customers for Life: How to Turn That One-Time Buyer Into a Lifetime Customer
  by Paul B Brown and Carl Sewell
  Publisher: Crown Business
  Pub Date: July 1, 2009

  5.) The One to One Manager
  Written by Don Peppers and Martha Rogers
  Publisher: Crown Business | Business & Economics - Marketing
  ISBN: 978-0-385-50229-0 (0-385-50229-X)
  Pub Date: January 15, 2002
6.) Bob Wiersma, PT, CPE, CHFEP, FAFS
   President Performance Builders, LLC
   Speaker Annual Conference MediServe, August 2010
   http://performancebuilders.com/about.html

7.) Darlene L. D’Altorio-Jones, PT., MBA-HCM
   Making Performance Management Meaningful

8.) Lynn Steffes
   Steffes & Associates Consulting Group
   Professional Referral Relations Toolkit

9.) Nitkin Chhoda PT, DPT
   Marketing for Physical Therapy Practices
   http://www.physicaltherapywebsite.com/Marketingforphysicaltherapyclinics.pdf

10.) MedPAC Reports to Congress March, 2012/March 2013 & June 2013 Reports/Data