The 3-Hour Therapy Criterion: A Challenge for Rehabilitation Facilities

Sharon Intagliata, Russell Hollander

Key Words: organizational objectives, organization and administration • Medicare • reimbursement mechanisms

Rehabilitation hospitals and units must meet certain requirements to be reimbursed by Medicare. Section 211 of the Medicare Hospital Manual specifies that at least 3 hours of physical and/or occupational therapy must be provided to each patient in addition to other required therapies and services. This article discusses the political and professional context surrounding the implementation of these guidelines and some of the practical issues that managers must address in the process. A case report is used to illustrate the management strategies and specific methods that have been implemented in the Occupational Therapy Department at the Rehabilitation Institute of Chicago in response to the 3-hour criterion. Data are presented to indicate how these efforts have contributed to raising our level of compliance with the criterion during the 1985–1986 fiscal year. The compliance data are discussed in relation to variation in both the number of patients and staff productivity over the course of the year.

This article describes the efforts of the Occupational Therapy Department at the Rehabilitation Institute of Chicago (RIC) to adjust to and comply with the 3-hour therapy regulation, which is one of the current criteria for the payment of service provided in exempt settings. The exact wording of the criterion can be found in the Medicare Hospital Manual, published by the Health Care Finance Administration in September 1982. This regulation mandates that at least 3 hours of physical and/or occupational therapy must be provided per day to each patient in addition to other required therapies and services. This level of intensity of service is to be provided on each of the 5 weekdays. Some type of functional therapy must also be provided on weekends. Exceptions to this level of therapy are permissible only if the medical condition of the patient makes such a level of treatment impractical.

This case report describes (a) the background or circumstances surrounding our efforts to meet the requirement; (b) the organizational setting; (c) the specific challenges posed by the 3-hour therapy mandate at RIC; (d) the actions taken by management to bring about the needed changes; and (e) the results of these efforts.

Background

A number of events have occurred in recent years to set the stage for the current set of criteria that regulate the roles that both acute care and rehabilitation hospitals are playing in our health care system. Since 1980 there has been increasing political pressure to reduce the overall budget deficit of the federal government. The escalation of federal health care costs has been a particular concern, and a variety of steps have been considered to strengthen the solvency of the Medicare Trust Fund (Colachis, 1984).

One major step to get Medicare costs under control was the passage of the Tax Equity and Fiscal Responsibility Act of 1982 that created the Prospective Payment System, which has been applied to acute care hospitals. Under the provisions of this act, rehabilitation hospitals, as well as distinct rehabilitation units within hospitals, received exemption from the Prospective Payment System (Zollar, 1985). It was thought at the time that the data base related to rehabilitation was inadequate to define an average level of resources required to treat a specific diagnosis (Delisa, 1985). In addition, professionals within the field of rehabilitation argued that the diagnosis-related groups (DRGs) presently being used for reimbursement in acute care settings would be inappropriate for rehabilitation facilities because of our emphasis on patient function as opposed to diagnosis (Fackelman, 1985; Zollar, 1985).

Sharon Intagliata, MS, MPA, OTR/L, is Director, Occupational Therapy, Rehabilitation Institute of Chicago, 345 East Superior, Chicago, Illinois 60611

Russell Hollander, MS, OTR/L, is Assistant Director, Occupational Therapy, Rehabilitation Institute of Chicago.
Although rehabilitation facilities were exempted from the Prospective Payment System, they were expected to comply with the 3-hour therapy criterion. However, it was not until the Deficit Reduction Act of 1984 that an enforcement mechanism was established. This act required that as of November 15, 1984, all hospitals receiving Medicare payment for inpatient services must contract with a peer review organization (PRO) to serve as its reviewing authority (Verville, 1985). In the Chicago area, Crescent Counties Foundation for Medical Care, in October of 1984, received the contract to perform Medicare audits as the PRO for the Chicago area. Several months later this organization also received a similar contract with the Illinois Department of Public Aid (Medicaid), because the Illinois department had decided to also adopt the Medicare guidelines.

As a result of the adoption of the 3-hour therapy criterion in 1982 and an enforcement mechanism in 1984, occupational therapy departments in rehabilitation settings are faced with the challenge of demonstrating compliance with this regulation to ensure Medicare and, at least in our state, Medicaid reimbursement. As we pursue this goal within our individual organizational environments, it is also important that we note how the adoption of the 3-hour therapy criterion affects our broader professional environment.

The reaction of the general rehabilitation community to what is perceived as the regulation's appropriately narrow focus on occupational and physical therapy has been significant. The American Speech and Hearing Association (ASHA) is currently lobbying to convince the Health Care Financing Administration (HCFA) to include speech/language pathology in the 3-hour criterion (ASHA, 1985). The National Association for Rehabilitation Facilities (NARF) is supportive of ASHA's efforts and is also recommending that the rule be amended to allow for 3 hours of physical and/or occupational therapy and/or speech therapy (Zollar, 1986). These efforts have persuaded HCFA to publish revisions for inpatient rehabilitation in the Medicare Hospital Manual (Transmittal No. 1293) (Health Care Financing Administration, 1986, August). Important additions included in the revised manual, which became effective September 12, 1986, are as follows:

There can be limited exceptions because patients' needs vary. In a few instances, patients who require inpatient hospital rehabilitation services may need, for a brief period, other skilled rehabilitative modalities such as speech-language pathology services, or prosthetic orthotic services, on a priority basis and if their stage of recovery makes the concurrent receipt of intensive physical therapy or occupational therapy services inappropriate. In such cases, the 3-hour a day requirement can be made by a combination of these other therapeutic services instead of or in addition to physical therapy and/or occupational therapy. (pp. 38-38 59)

As a result of recent legal action taken by Legal Assistance for Medicare Patients (LAMP), a nonprofit organization representing Medicare beneficiaries, the court has requested that the plaintiffs and the Department of Health and Human Services (DHHS) agree on a proposed definition for hospital level rehabilitative care. This definition would also require amending the language in the 1982 Medicare Hospital Manual. The attorney representing the plaintiffs will be calling for the adoption of a less restrictive wording, which would include speech/language pathology services under the routine 3-hour criterion (Zollar, 1986). Circumstances such as these add a degree of uncertainty to the regulatory environment. As administrators of occupational therapy work to achieve compliance with the current criterion, they must do so with the clear understanding that this criterion may well undergo further modification.

Equally significant are the personal and ethical reactions and concerns of rehabilitation professionals who must translate this regulation into daily practice. As we proceed to implement the new policies, administrators of occupational therapy departments must be prepared to deal with a number of questions that have no easy answer. Examples of the difficult issues and circumstances we have had to confront at RIC include the following: deciding what to do when a patient does not really need another hour of occupational therapy, responding to a patient who arrives late for therapy and comes to the Director's office in tears fearful that Medicaid will not pay her bill that day, or dealing with a patient who refuses to make up an hour of missed therapy because the rescheduled session would interfere with his family's dinner hour. We have also struggled with the challenge of convincing therapists of the need to comply with this regulation when their clinical experience and professional judgment caused them to question the underlying tenet that more has to be better.

Clearly, the adoption and implementation of the 3-hour therapy criterion has filled the professional environment with uncertainty and turmoil. Nevertheless, the administrators of occupational therapy departments in rehabilitation settings throughout the country must take steps to achieve compliance with this criterion. We hope that the case report presented here will illustrate some strategies and principles for assisting departments to meet the demands of this regulation while coping with the practical difficulties and issues posed by both our external and internal environments.

The Organizational Setting

The occupational therapy staff at RIC, a 176-bed research and training hospital for children and adults with physical disabilities, consists of 60 registered
occupational therapists and certified occupational therapy assistants. Most patients are treated for spinal cord injury, head injury, and stroke. Others are treated for developmental, orthopedic, and neurological problems. An interdisciplinary team approach to treatment is stressed throughout all levels of the organization.

Within the Department of Occupational Therapy, the Director and Assistant Director are responsible for the development of new procedures as well as for the ongoing management of the department. The supervisory group, consisting of six clinical supervisors and one clinical education supervisor, also assists in the development and implementation of departmental procedures. Each supervisor is directly responsible for a team of seven to nine staff members. These teams are organized on a treatment unit basis. Units are located geographically according to floors within the institute. Occupational therapy services are provided to patients on our five inpatient treatment units as well as in our outpatient service.

In our organization, the Chief Operating Officer and the Vice President of Finance are directly responsible to the board of directors to maintain a strong fiscal position. The ultimate responsibility for bringing our institute into compliance with the 3-hour criterion was delegated to the Vice Presidents of Allied Health and Nursing. Primary responsibility for development of the procedures necessary to accomplish this goal was assigned to the Assistant Director of Allied Health together with the Directors and Assistant Directors of Occupational Therapy, Physical Therapy, and Nursing. Clinical supervisors in each of these departments were responsible for participating in the process by providing input and feedback at various stages. In addition, they subsequently introduced and monitored the new procedures on their respective units. The clinical staff in occupational and physical therapy as well as nursing had primary responsibility for carrying out the procedures on a daily basis. Secretarial staff in our departments also played important roles in the collection of daily statistics.

Specific Challenges

Developing and managing a scheduling system that ensures each patient a minimum of 3 hours of combined occupational and physical therapy per day is a formidable task by itself. However, several additional factors added to the difficulties of this task. The first of these is not unique to RIC but an issue for most, if not all, rehabilitation facilities. Since the adoption of the Prospective Payment System, acute care hospitals are discharging their patients to comprehensive rehabilitation sites much earlier in the recovery process. As a result, we are increasingly admitting patients who are less medically stable and thus more difficult to engage in an intensive, 3-hour schedule of therapy, at least in the early stages of their stay. This trend makes it necessary for rehabilitation settings to review and monitor their admission policies and practices and put increased pressure on occupational and physical therapy departments to adequately document all cases where the patient’s medical condition makes it impossible to meet the treatment criteria.

A second complicating factor, which is more specific to RIC, has been the significant fluctuation in patient occupancy. The in-house census, which averaged 84% for the first quarter of the budget year, dropped to 81% during the second quarter and then steadily rose to 94% by the end of the fourth quarter. More pertinent to the issue of compliance was the fluctuation in the percentage of patients who fell under the 3-hour requirement. These figures rose from an average of 40% needing to meet the criterion during the first half of the fiscal year to an average of 50% needing to meet the criterion during the second half. Such variations make it difficult to plan and schedule for appropriate levels of staffing.

A third factor that makes compliance difficult at RIC is, ironically, a consequence of our having such a wide array of treatment services available. A comprehensive rehabilitation center such as RIC encompasses many other allied health disciplines in addition to occupational and physical therapy (e.g., nursing, communicative disorders, social services, psychology, vocational rehabilitation, the chaplaincy, orthotics and prosthetics, rehabilitation engineering, and therapeutic recreation), each offering beneficial services to patients. As a consequence, coordinating the scheduling of treatments is no simple task; additional time and effort are needed to grade patients’ daily schedules to deal appropriately with their varying energy levels. In addition, the variety and complexity of treatment services available creates a situation in which the success of the Occupational and Physical Therapy Departments in meeting compliance standards depends on broader organizational factors, many of which are beyond our direct control. For example, the nursing staff plays an important role in making sure that patients get to therapies at their scheduled times. If this link in the chain of responsibility is missing, our departments are still liable for making up the missed treatments.

A fourth and final factor that added to the challenge of our meeting the 3-hour therapy criterion relates to the reaction of other disciplines to this criterion. As described earlier, there has been considerable reaction within the professional rehabilitation community to the narrow focus on occupational and physical therapy in the criterion. Within RIC, the concerns of the disciplines not currently covered in the criterion were heightened during this year’s
budget planning process. As a result of the 3-hour mandate for occupational and physical therapy services, both of these departments were able to justify significant increases in staffing levels whereas many other disciplines were faced with the need to plan for decreasing staff levels through future attrition. Clearly one of the risks associated with this regulation in its current form is the danger of creating interdisciplinary conflict and competition.

It is important to note that while a variety of disciplines have reacted to their exclusion from the current regulation, the Departments of Occupational Therapy and Physical Therapy have had to confront the practical realities and consequences of inclusion. Although the increased recognition and status associated with being considered a primary service has certain benefits, these have not come without increased expectations. As a consequence of receiving additional staffing, the Directors of Occupational Therapy and Physical Therapy have been charged with guaranteeing a corresponding increase in compliance. The standard that has been set at RIC is that 90% of all identified patients shall receive a minimum of 3 hours of combined therapy from our respective departments. This expectation assumes that 10% of the identified population would have appropriate medical documentation to justify limiting therapy.

Management Response

Our response to the challenge presented by the 3-hour requirement and the 90% compliance standard set by RIC included the following three essential phases: (a) assessing our initial level of compliance and gathering additional information necessary to guide our general response to this requirement, (b) developing systems and staffing configurations necessary to bring us into compliance, and (c) integrating the newly developed procedures into our normal daily routine and refining them to improve our performance and maintain a high level of compliance with this regulation over time.

Initial Response Phase

As part of the initial phase of response, our Utilization Review Committee conducted a targeted audit focusing on the 40% of our inpatient population who fell under the 3-hour requirement in September of 1985. Results of this audit indicated that these individuals were receiving 3 hours of combined occupational therapy and physical therapy on only 38% of the possible days; this was far from our goal of 90% compliance. At the time of the audit, it was not clear whether we would be liable for loss of payment on just those days on which 3 hours of treatment were not provided or if failure to meet the requirement on a number of days during a patient’s stay might result in the denial of payment for the entire length of stay. As our PRO was just beginning to develop its policies and procedures for implementing the audit process, many issues regarding the strictness of enforcement and allowable exemptions were unclear. However, the results of our initial audit indicated that we were at risk for the denial of a significant amount of reimbursement if the guidelines were to be enforced strictly.

Not surprisingly, an organization’s response to a regulation such as the 3-hour therapy requirement is often proportional to the financial consequences it may experience. A sound financial position that enables an organization to survive and prosper must always be a priority concern for management. Therefore, in light of the many uncertainties relative to this requirement, our administration decided to take a conservative stance on enforcement of the 3-hour criterion and to charge the involved departments with developing mechanisms to track and ensure that we would attain the highest level of compliance possible.

Another important effort in establishing our general response during this early actuation phase was to identify the problems we were already experiencing in the internal systems being used to coordinate our treatment efforts. We believed that the recommendations for any needed changes would best come from those most directly involved with implementing our current systems. The Vice President of Nursing and Assistant Director of Allied Health called a large group meeting to discuss current obstacles to meeting the requirement. The Directors, Assistant Directors, and Clinical Supervisors of Occupational Therapy and Physical Therapy and all of the Head Nurses attended. Although many of the identified problems concerned the institute as a whole, others related directly to the floor-based units. Therefore, follow-up meetings were held on a floor-by-floor basis to focus on suggestions for improvement strategies that could be implemented at that level. It was concluded that improved compliance would require active multidisciplinary cooperation as well as a centralized monitoring mechanism.

Systems and Staff Configurations

We began the second phase of our response to the 3-hour requirement by creating a task force which was led by the Assistant Director of Allied Health and included the Directors and Assistant Directors of Occupational Therapy and Physical Therapy and the Assistant Director of Nursing for Clinical Services as members. This task force was created to monitor instutwude compliance with the 3-hour regulation and to develop and ensure the efficiency of interdepartmental systems.

Some specific modifications have resulted from
the efforts of this task force: (a) the implementation of a comprehensive tracking mechanism which allows us to measure compliance rates, (b) the development of separate feedback mechanisms directed towards the involved departments, specific team units, and physicians, (c) the scheduling of routine outside appointments during non-treatment hours whenever possible, (d) the development of a coordinator's role to assist with data collection and scheduling, (e) the development of itemized attendance records which clearly reflect the amount and type of treatment provided, (f) the development of documentation logs which therapists use to record acceptable reasons for missed appointments, (g) extended hours of programming which allow for greater spacing between therapies and provision of make-up sessions when appointments are missed, and (h) changed hours of programming by other departments and services to allow additional time for scheduling occupational and physical therapy.

There were many decisions to be made within the Department of Occupational Therapy as well. Early on we recognized a need to develop a more flexible staffing formula that would help us accommodate to the fluctuations in the number and distribution of patients. A new formula was developed that considered the variables of (a) the total number of patients, (b) the proportion of Medicare and Medicaid patients, (c) the number of patients that must be treated individually, and (d) the number of patients that could benefit from treatment in doubled or group situations. This staffing formula allowed us to manipulate staffing patterns on the basis of the distribution of patients by floor as well as on the intensity of care needed. The new formula has also been used to determine the need for on-call and temporary assistance and to successfully justify our requests for new positions in the budgeting process.

Another important aspect in the systems development phase of our response was the assignment of new responsibilities to our staff. This was done with great care since the available time was limited at all levels within the department. As staff therapists needed to provide more treatment, managerial staff had to provide greater accountability for scheduling and monitoring compliance. Additional responsibilities for various tasks were divided up to ensure time efficiency as well as equity in distribution. It is the supervisors' responsibility to ensure that each designated patient is scheduled for at least 3 hours of combined occupational therapy and physical therapy each day. Therapists are required to (a) record missed treatment units (a unit has 15 minutes) on a composite report as they occur throughout the day, (b) log missed or cancelled appointments, and (c) use their normal billing time at the end of the day to accurately record the specific type and amount of treatment they provided to each patient. Daily charges are recorded by the therapists and compiled by the department secretary. The secretary also records total hours of therapy provided in Occupational Therapy for designated patients each day. These figures are combined with the totals received from Physical Therapy to determine the scheduling of make-up treatments.

Integration and Refinement of Procedures

The final and most challenging phase in our response to the 3-hour regulation was the integration, refinement, and maintenance of the newly developed procedures. This phase has shifted our focus from solving an acute problem to incorporating procedures necessary for daily department functioning. Not surprisingly, we have had problems with the systems that were put into place to track our performance. Implementing a variety of new systems concurrently requires many people to make changes in their daily routines and increases the risk of human error. At present, most of our systems are manual. Inaccuracies in the data have occurred because some patients were not identified as recipients of Medicare or Medicaid. Other inaccuracies have stemmed from oversights or miscalculations in staff recording charges that reflect the units of service provided each day. An additional problem has been the difficulty in obtaining timely and accurate estimates of the number of days patients would be excused from the 3-hour requirement because of a documented (acceptable) medical complication. This is a crucial element in justifying the delivery of a decreased level of service to our less medically stable patients.

A critical feature in improving and maintaining performance has been the provision of accurate and timely feedback to responsible parties. Supervisors receive weekly reports which indicate the exact amount of therapy their designated patients received during the previous week. Specific cases of noncompliance that may require investigation are brought to their attention through this mechanism. This concrete evidence of the outcomes either reassures supervisors and staff that their efforts have resulted in a high rate of compliance or, if the rate of compliance is low, directs their attention to problems, perhaps relating to scheduling, staffing, transportation, or the documentation of medical severity.

In addition to the weekly reports, other methods have been used to provide positive reinforcement to our staff members for their cooperation and hard work: acknowledgments of outstanding performance during departmental meetings and staff pizza parties to celebrate impressive gains in our overall compliance totals. However, the most meaningful reinforcement for direct care as well as managerial staff has
been the approval of additional positions. Such approvals are the most direct indicators of the administration's commitment to a high quality of care.

Results

We have attempted to assess, with both quantitative and qualitative indicators, the results of our efforts to comply with the 3-hour regulation. We are now in the final phase of our response to the regulation. As Figure 1 indicates, our compliance with the 3-hour regulation was only 38% in September 1985. However, as we put into place the various methods and strategies, our compliance rate rose steadily, reaching a high of 84% in January, and remaining fairly stable (±4%) during the remainder of the 1985–1986 fiscal year.

Table 1 summarizes how patient occupancy, treatment volume, staffing levels, and staff productivity have fluctuated throughout the fiscal year. The table indicates that the number of patients reached a low in December and January and peaked in July and August. In addition to changes in the overall count, the proportion of patients receiving Medicare and Medicaid also showed a significant upward trend during the final half of the year. Finally, the total number of days for which we are responsible to deliver a minimum of 3 hours of combined occupational therapy and physical therapy jumped from a level of 1,362 days in October 1985 to a high of 2,396 patient days in July 1986, which represents an increase of more than 75%.

Fluctuations in the number of patients have resulted in corresponding fluctuations in staff effort and productivity. The table illustrates that as a result of increased demand for occupational therapy services we were consistently delivering significantly more treatment units than budgeted during the latter half of the year. Because of this increase in the required volume of service we were able to justify the gradual addition of staff beginning in February. Since it was difficult to predict future numbers of patients, we chose to proceed conservatively and to supplement our budgeted staffing allotment with on-call and temporary staff. These nonbudgeted positions, approved verbally, were useful in justifying eight additional permanent positions in the budget year beginning September 1986.

It should also be noted that staff productivity has been consistently higher than our monthly budgeted units per full-time equivalent (FTE) of 354.98 per month. The only exception was December which historically has a lower level of patient care activity because of the holiday season. As the table indicates, high levels of productivity have been maintained despite the addition of staff because treatment volume has continued to increase. Since we anticipate that our staffing levels will first increase and then stabilize in the beginning months of the new budget year, we are confident that we will soon be able to bring our compliance rate up to our goal of 90%.

While tracking quantitative indicators such as our compliance level and productivity are important, there are also a number of more qualitative indicators that suggest our efforts are having beneficial effects. As the new procedures have become routine for supervisors and staff, fewer errors have been noted in the statistics. The feedback mechanisms have been effective in identifying isolated cases in need of further attention. Moreover, as a result of our close collaboration with other teams on scheduling, our teams have experienced greater flexibility and an improved spirit of cooperation.

Staff involvement in and commitment to meeting the 3-hour requirement have continued to grow. This growth may be attributed to clear communication regarding the administration's stance on this issue, the incorporation of new procedures into the interdepartmental team process, and an ongoing responsiveness to staff input. In addition, the staff's acceptance of the requirement has increased with the awareness that exceptions to the 3-hour regulation do exist. Staff members' commitment is demonstrated by their efforts to foster compliance by communicating to patients the benefits of intensive rehabilitation. This message is repeated by all disciplines that come in contact with the patient. As direct care and support staff have become committed to the requirement, their willingness to provide input has been most beneficial in the refinement of procedures and in translating regulation into practice.

Staff members have been encouraged to document the reasons that have prevented their patients from receiving the 3-hour allotment of therapy as well as to report cases that appear to be questionable admissions. This process has assured staff members

Figure 1

Rates of Compliance by Month (FY 1985–1986)
Table 1
Number of Patients and Staff Productivity by Month (FY 1985–1986)

|                  | SEPT | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUNE | JULY | AUG |
|------------------|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|------|-----|
| **Average per month** |      |     |     |     |     |     |     |     |     |     |      |      |     |
| Number of Patients | 152.5| 140.0| 147.7| 134.3| 138.9| 151.4| 148.9| 146.4| 139.6| 152.0| 158.9| 166.0|     |
| Percent receiving Medicare or Medicaid | 32.5 | 31.9 | 31.9 | 43.4 | 46.2 | 39.2 | 44.1 | 47.0 | 49.6 | 46.5 | 48.8 | 44.0 |     |
| Total Medicare/Medicaid days | 1489 | 1362 | 1698 | 1789 | 1972 | 1665 | 2014 | 2055 | 2138 | 2103 | 2396 | 2262.0 |     |

**Staff Productivity**

<table>
<thead>
<tr>
<th></th>
<th>Treatment units</th>
<th>Treatment units ± budget</th>
<th>Inpatient FTEs</th>
<th>Treatment units/FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17029</td>
<td>17368</td>
<td>46.12</td>
<td>369.23</td>
</tr>
<tr>
<td></td>
<td>+1592</td>
<td>-344</td>
<td>45.12</td>
<td>384.93</td>
</tr>
<tr>
<td></td>
<td>-1352</td>
<td>+903</td>
<td>45.72</td>
<td>341.61</td>
</tr>
<tr>
<td></td>
<td>-585</td>
<td>+3984</td>
<td>46.71</td>
<td>324.65</td>
</tr>
<tr>
<td></td>
<td>+1252</td>
<td>+1161</td>
<td>46.71</td>
<td>324.65</td>
</tr>
<tr>
<td></td>
<td>+1205</td>
<td>+1899</td>
<td>45.95</td>
<td>379.53</td>
</tr>
<tr>
<td></td>
<td>+4969</td>
<td></td>
<td>47.74</td>
<td>371.65</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>49.64</td>
<td>347.40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>49.37</td>
<td>350.52</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>428.68</td>
<td>376.99</td>
</tr>
</tbody>
</table>

Note. FTE = Full-time equivalent. FTE totals include both direct and indirect care staff and permanent as well as temporary and on-call staff. Budgeted average monthly staffing = 45.30 FTEs. Budgeted average monthly productivity = 354.98 units/FTE.

that their clinical judgment is still essential and that the needs of patients still have the highest priority. As we have been able to increase our staffing levels, we have also been able to better guarantee that attention can be paid to the patient's needs in general as opposed to limited specific needs prioritized solely on the basis of financial class. This has been effective in alleviating some of the initial fears and ethical concerns that many of us entertained earlier in the process.

**Conclusion**

Developing and implementing an effective organizational response to the 3-hour therapy criterion has been a major undertaking at RIC. Over the course of the past fiscal year we have introduced a variety of new systems and procedures to help monitor and ensure compliance with this criterion. We have succeeded in motivating our staff to meet this challenge. As a result, we have achieved a significantly improved rate of compliance, putting us within reach of our goal of 90%.

A number of key administrative decisions and actions have contributed to the positive results. These included (a) a careful assessment of the status quo and of the obstacles in our way before we began to formulate our plan of action, (b) an extensive involvement of staff members in the development of monitoring systems and procedures that not only meet instutewide concerns but also are sensitive to variations at the individual unit level, (c) the establishment of a specific organizational structure (i.e., task force) to facilitate the interdepartmental planning and ongoing cooperation required to comply with the 3-hour criterion, (d) the development of a new staffing formula that would enable us to cope effectively with significant variations in patient occupancy levels, and (e) the development and consistent use of mechanisms to provide our staff with the accurate and timely feedback needed to maintain and improve our performance. Although developed for RIC, these actions are likely to be applicable to most, if not all, treatment settings in which administrators are confronting the 3-hour requirement.

We have not attempted to assess the impact of implementing this regulation on patient-related outcomes. One recent study (Johnston and Miller, 1986) investigated such impacts by comparing the costs of care as well as treatment results in a facility before and after the implementation of the 3-hour regulation. The authors reported that the adoption of the regulation did result in a significant increase in the average daily number of hours of occupational and physical therapy provided to patients and in a corresponding increase in patient charges per stay. However, patients treated after the implementation of the regulation did not show significantly greater benefits such as shorter length of stay, improved function (i.e., mobility, self-care status), or avoidance of institutional placements after discharge. Further research is needed to determine whether the 3-hour therapy regulation, at least in its present form, is producing the intended benefits.

Rehabilitation medicine is seeking methods that will allow a more accurate prediction of patients' responses to various treatment regimens and the effect of treatment intensity on long-term outcomes. As new information is being gained, rehabilitation professionals must respond to the challenge of using it to influence policy makers to create reimbursement systems that will support appropriate treatment efforts.

**Acknowledgments**

We thank Jim Intagliata, PhD, Kathy Okkema, MBA, OTR/L, and Ruth Ann Watkins, MBA, OTR/L, for editorial assistance.

**References**


