An Assessment of the Impact of the Medicare Prospective Payment System on Level II Fieldwork

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The health care industry has undergone radical change because of the implementation of the Medicare Prospective Payment System (MPPS). This study is an assessment of the effect of MPPS on Level II fieldwork. Six factors that have the potential to influence fieldwork delivery patterns formed the basis of a questionnaire that was mailed to 23 occupational therapy directors in acute care Wisconsin hospitals. The 21 returned questionnaires were tallied by frequency of response and analyzed to ascertain current practice and changes resulting from MPPS. Findings indicate a strong commitment to professional and technical Level II fieldwork education. Departments reporting a decrease in staff were able to deflect the impact of the reductions by modifying their clinical education programs. Although changes were noted in all of the six identified categories, there was only minimal evidence that they were directly related to MPPS. Monitoring change during the 3rd and 4th year of the transition was recommended.

The implementation of the Medicare Prospective Payment System (MPPS) has resulted in dramatic changes and increased competition in the health care industry. Movement from a retrospective, hospital cost-based system of reimbursement to a prospectively paid, uniform rate of reimbursement by diagnostic category has forced hospitals to examine all programs in terms of productivity and cost-effectiveness (1). Fieldwork education programs are included in this scrutiny. In the past it was sufficient for a program to pay for itself and generate income for the facility. With the implementation of MPPS, the ability of a program to contribute to the early discharge and movement of patients through a vertical system of care have become considerations of critical importance (2). The purpose of this study was to assess the impact of the implementation of MPPS on occupational therapy Level II fieldwork in one state. The resulting information was used to clarify actual changes in fieldwork education programs resulting from the implementation of MPPS.

Literature Review

Several sources have identified probable impacts and implications for occupational therapy practice resulting from the implementation of MPPS. Probable impacts on hospitals include an increased need for computer capabilities and detailed data, a renewed need to reduce costs by decreasing the length of stay and increasing efficiency, reduced wage increases, a need for collaboration among all health care personnel, and increased competition for the limited resources between various hospital departments or cost centers (3). Occupational therapists working in hospitals need to recognize that the current climate of change represents an opportunity for growth and a challenge to identify creative coping mechanisms that will allow departments to thrive within the system (4). To meet this challenge, occupational therapy managers need to learn diagnostic-related group (DRG) budgeting and assure that occupational therapy documentation is compatible with computerized data systems. New hospital-based programs should begin as outpatient services and all new programs, including those developed within existing departments, need to clearly reflect cost and outcome (4).

Method

A review of the occupational therapy literature relevant to MPPS and consultation with occupational therapists knowledgeable in the background and implications of MPPS were used to project six factors that have the potential to affect the delivery of Level II
fieldwork. These are: (a) changes in the number of Level II fieldwork students accepted annually by fieldwork education centers, (b) the amount of time the coordinator of student training at the fieldwork education center spends on student-related activities, (c) the number of fieldwork instructors involved in supervising students, (d) the amount of time the fieldwork instructors spend supervising students, (e) the willingness of the fieldwork education centers to provide an affiliation for “problem” students, and (f) participation in school-clinic educational activities. Eight questionnaire statements were developed for each of the six identified factors and related demographic information. The questionnaire was mailed to the directors of occupational therapy programs in acute care hospitals in Wisconsin that provide a Level II fieldwork experience for occupational therapy students. The resulting data were tallied by frequency of response.

Results

Twenty-one (91%) of the 23 surveyed directors returned the questionnaire. The purpose of the demographic question was to provide a broad assessment of the personnel resources of each department. A majority of the occupational therapy departments employ 11 to 20 full- and part-time persons. Three facilities (14%) reported an increase in staff, and five (23%) reported a decrease. Four (19%) of the eight fieldwork education centers reporting a change in staff indicated that the change was the result of the implementation of MPPS.

Most facilities provided a Level II fieldwork experience for three to four occupational therapy students and one to two occupational therapy assistant students annually. Six (28%) fieldwork education centers will decrease the number of occupational therapy students they accept. These centers were accepting more than three to four students annually. Seven (33%) fieldwork education centers will decrease the number of occupational therapy assistant students accepted annually. These centers also were accepting more than the average number of students per year. Six (28%) of the centers reported that changes in the number of students accepted annually were the result of MPPS. Seventeen (85%) of the coordinators of student training typically spent 49% of their time or less on student-related activities. Four centers (19%) noted a change in the amount of time the coordinator spent on student-related activities, and all four stated that the change was directly related to MPPS.

Thirteen (61%) of the fieldwork education centers reported that four to five staff members were responsible for the direct supervision of Level II fieldwork students. One center (4%) reported an increase and three centers (14%) reported a decrease in the number of staff members who directly supervise students. Two (9%) of these four centers concluded that this change was related to MPPS.

Fifteen (75%) of the student supervisors spent 25% to 49% of their time in student supervision. Six centers (28%) indicated that the amount of time supervisors spent in student supervision had changed since the implementation of MPPS and that this change was directly related to its implementation.

Eleven (52%) of the 21 responding fieldwork education centers reported that they previously had provided a fieldwork education experience for a problem student that needed additional help or special support. These facilities provided an affiliation for one to two of these students annually. Three centers (14%) stated that they would accept fewer of these students, and six centers (28%) indicated that they would accept about the same number of problem students annually. Two centers (9%) noted that the change in the number of problem students they were willing to accept was directly related to MPPS.

Seventeen (80%) of the fieldwork centers have participated in the local educational council (Wisconsin). Sixteen centers (76%) reported participation in individual school meetings for fieldwork educators, and 14 (66%) have provided lectures and in-class presentations to students. Although a majority of the fieldwork education centers that participated in school/clinic educational activities have continued their involvement in at least one of the three identified activities, decreases were reported in all areas. There was a 19% decrease in Wisconsion attendance, a 23% decrease in attendance at individual school meetings, and a 28% decrease in the number of lectures and in-class presentations. Three centers (14%) reported that the change in level of participation in school/clinic educational activities was directly related to MPPS.

No attempt was made to identify patterns of practice prior to the implementation of MPPS. Thus, comparison data were not available. This may be a limiting factor in future investigations since it will not be possible to trace changes in practice from the period immediately before the implementation of MPPS through the 4-year transition period. An additional limitation to the usefulness of the data was that the wording of the questionnaire statements regarding the time spent supervising students did not provide a
clear indication that the change represented an increase or a decrease in supervised time.

This study was restricted to occupational therapy fieldwork education programs located in acute care hospitals in Wisconsin because the study was conducted during the 1st year of the transition from a hospital cost-based system to a national DRG rate. In the 1st year of the transition, hospitals were reimbursed at 75% of the hospital cost base and 25% of the regional DRG rate (1). Thus, it was too early to look at large samples. Opportunities for identifying nationwide trends should occur in the 3rd and 4th year of the transition.

Discussion

Changes in Level II fieldwork were reported in all of the identified categories. Findings indicated that there will be fewer opportunities for students to receive clinical education in acute care hospitals. However, this trend should be counterbalanced as hospitals move toward providing vertical systems of care and opportunities for clinical education develop in rehabilitation units, outpatient services, and home health. Supervisors and coordinators of student training spent a substantial amount of time in caseload and service management responsibilities that are not related to fieldwork education. Finding acute care hospitals that are willing to accommodate students with special needs will remain difficult. Lastly, the total involvement of fieldwork education centers in school/clinic educational activities has been reduced.

There was minimal evidence that the changes reported in Level II fieldwork programs were directly related to MPPS. Only eight (38%) of the 21 responding fieldwork education centers indicated that changes in Level II fieldwork were directly related to the implementation of MPPS. Six centers (28%) acknowledged that implementation of MPPS was directly responsible for changes in the number of students trained and the amount of time fieldwork instructors spent supervising students. Four centers (19%) noted that changes in the amount of time that the coordinator of student training spent in student-related activities were directly related to MPPS. Three centers (14%) indicated that decreases in the levels of participation in school/clinic educational activities were the result of MPPS. Two centers (9%) concluded that the implementation of MPPS was directly related to reductions in the number of problem students that could be accommodated annually and the number of staff members responsible for supervising Level II fieldwork students. Three facilities were in the process of developing in-hospital rehabilitation units. These units have the potential to contribute to a department’s ability to maintain a viable fieldwork program and are an example of the positive effects of MPPS. Thus, although it is clear that several occupational therapy departments were strongly affected by MPPS, a majority of the respondents did not attribute changes in fieldwork education programs to its implementation.

It was apparent that, in addition to the identified factors that have the potential to directly affect Level II fieldwork, several indirect factors also could influence the delivery of occupational therapy fieldwork education. The ability of the individual acute care facility to reposition itself in the health care marketplace has a significant impact on the resources available for clinical education. Occupational therapy departments in hospitals that have formed alliances with other segments of the health care industry to develop vertical systems of care and that have clearly defined and pursued their target markets are not experiencing the same constraints as departments located in smaller, less proactive facilities.

Another factor that may affect occupational therapy clinical education is the trend in acute care hospitals toward realigning individual departments into a single, multidisciplinary rehabilitation or physical medicine department. Resources for clinical education may be controlled by an allied health professional who may or may not share occupational therapy’s strong commitment to fieldwork education.

Conclusion

Several conclusions regarding current practice may be drawn from the survey results. First, the most significant conclusion is that a majority of the occupational therapy departments surveyed continue to have an ongoing interest in providing a fieldwork education experience for Level II students. Findings indicate an equal commitment to maintaining and preserving fieldwork education programs for professional and associate level students. However, the effect of this commitment on Level I fieldwork should be assessed since Level I fieldwork often is valued less by fieldwork educators than Level II fieldwork, primarily because of its short duration and limited return to the facility. Changes in the types of experiences and supervision available to Level I students have the potential to affect their preparation for Level II fieldwork and could result in the need for additional supervision and time spent in teaching clinical skills during the Level II affiliation.

Second, the five departments that experienced a decrease in staff were able to deflect the impact of these reductions on Level II fieldwork by modifying their clinical education programs. These modifications reflected the needs, values, and resources of the individual departments and did not follow a discernible pattern.

Third, MPPS is to be phased in over a 4-year period. This study provides information on current practice and changes in the delivery pattern of Level II fieldwork resulting from the 1st year of the transi-
tion. In each of the next 3 years, reimbursement rates for Medicare patients will move farther away from the hospital cost base, until in the 4th year of the transition most hospitals will be reimbursed at a national DRG rate (1). As this progression toward a single, national rate of reimbursement occurs, more stringent controls and constraints on programs may emerge. Therefore, continued monitoring of fieldwork education programs is recommended, particularly during the 3rd and 4th year of the transition, to identify national trends.

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References