2011 Program Evaluation Report

2011 Board Program Evaluation Report

It is the policy of the Schreiber Pediatric Rehab Center to review the quality of programs and services annually. Components of the Center's review system include the standardized program assessments, Pediatric Evaluation of Disability Inventory (PEDI), the client satisfaction survey, quality audits and actions by the Professional Advisory Committee (PAC), the Quality Improvement Committee and ongoing follow-up studies and surveys.

Center's Benchmark Performance Goals

The following have been set as benchmark objectives for assessment of the Center's performance:

75% of clients will exhibit progress on the Pediatric Evaluation of Disability Inventory (PEDI) as derived from compared, scaled scores on discharge and/or annually. See Pedi Measurement Chart at the back of this report.

80% of client satisfaction surveys returned will indicate overall satisfaction with services.

80% of agreed upon goals will be obtained.

Pediatric Evaluation of Disability Inventory (PEDI) Program:

The PEDI was selected by the Center in 1995 to measure program outcomes. The system combines elements of adaptive developmental measures utilized in special education and characteristic of functional assessments used in rehabilitative medicines. The functional skill section of the tool is administered to all clients on admission and upon discharge.

The following sections are used to monitor outcome performance at discharge:

A. Functional Mobility Skills

This is a measurement in functional capability of children and is used to monitor Physical Therapy Services**.** (Based upon child's disability/diagnosis, no change could be assigned objective).

B. Self-Care Skills

This is a measurement of changes in daily living skills and is reflective of services provided by Occupational Therapy

C. Social Function Skills

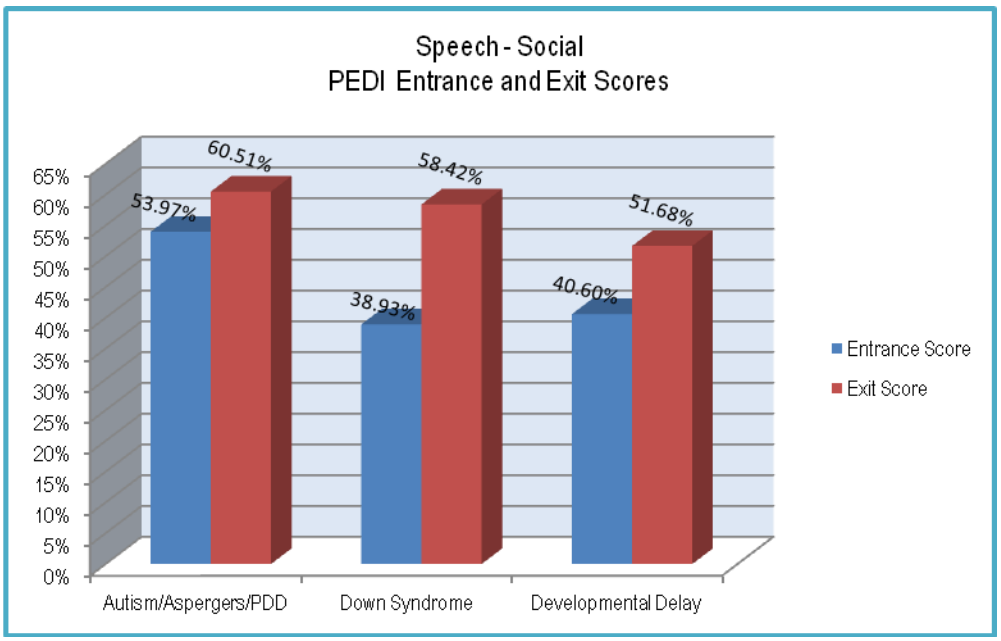
This area measures the child's ability to live with others and changes in cognitive social communication skills. It is used to measure performance of Pre-School and Speech-Language Therapy.

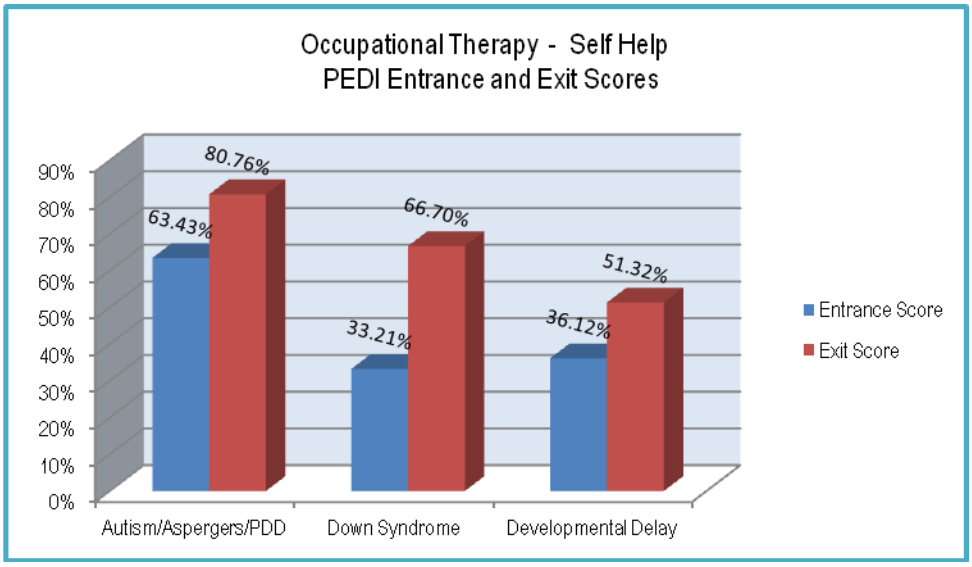
Data collected in the following graphs represent a collection of scores using the Pediatric Evaluation Disciplinary Inventory (PEDI). Social, mobility and self help domains at admissions and discharge for the calendar year January 2011 through December 2011.

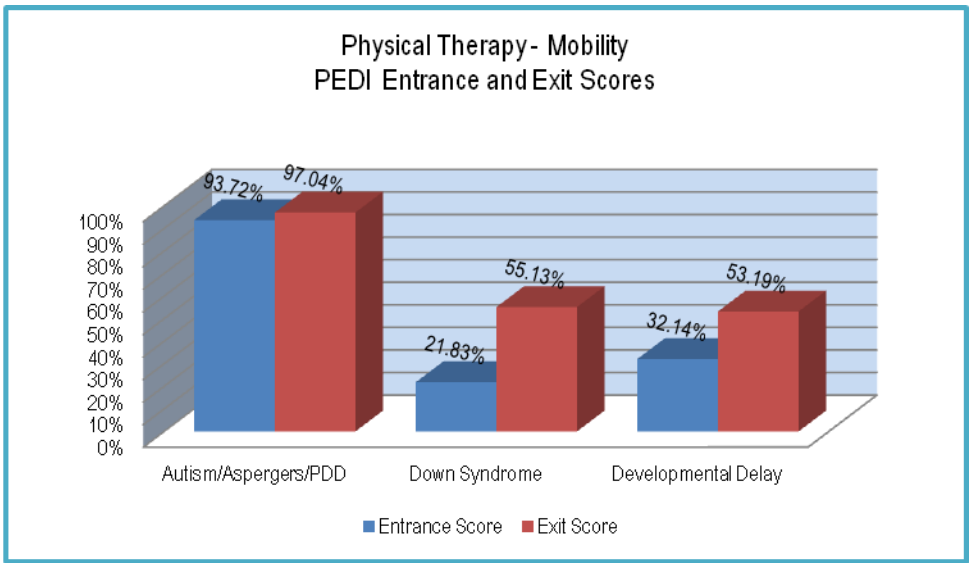
Populations chosen for this year's analysis were represented by the Autism Spectrum, Down Syndrome and Developmental Delay which consist of three of the centers most commonly referred diagnosis.

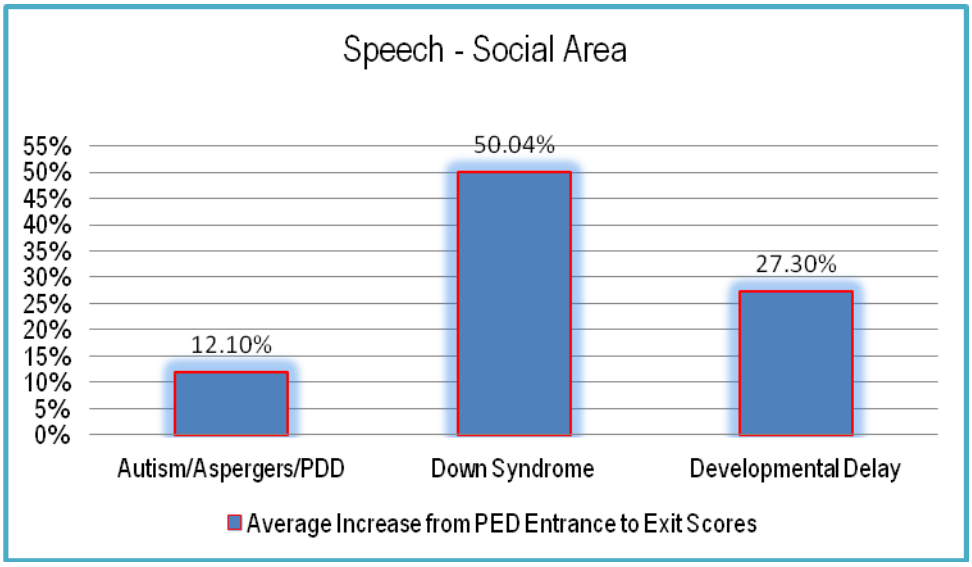
Data analyzed will be used to develop and implement important initiatives within the service delivery areas under the leadership of the Quality Improvement Committee (QI).

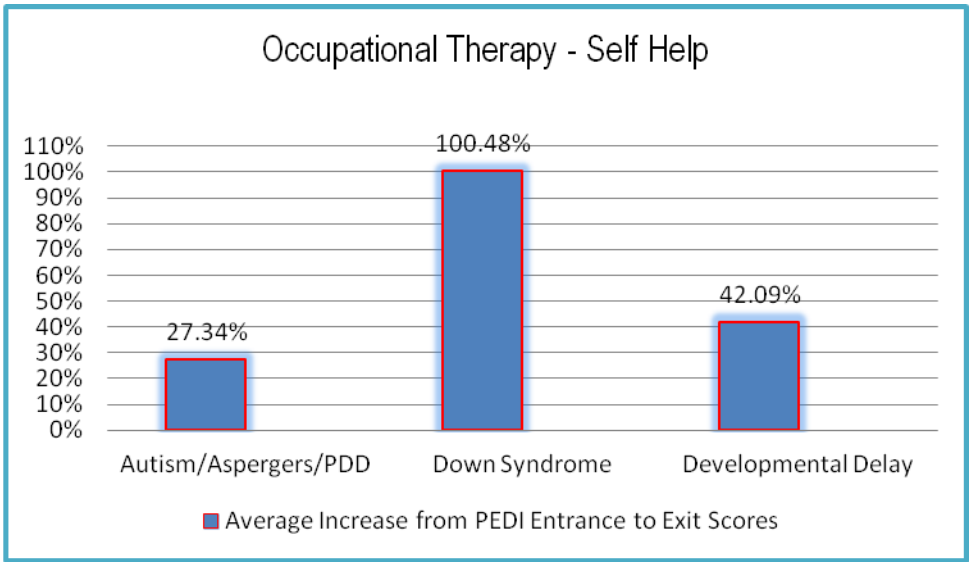
Below is the data that was analyzed comparing admission versus exit scores, average increase or decrease from admission versus exit scores, and finally, what percent of the population showed improvement based on these scores.

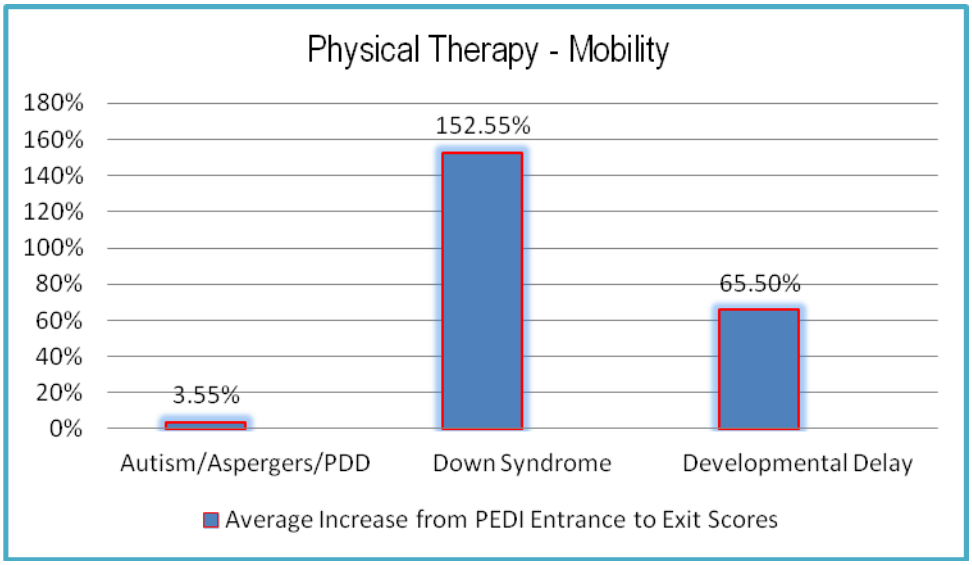


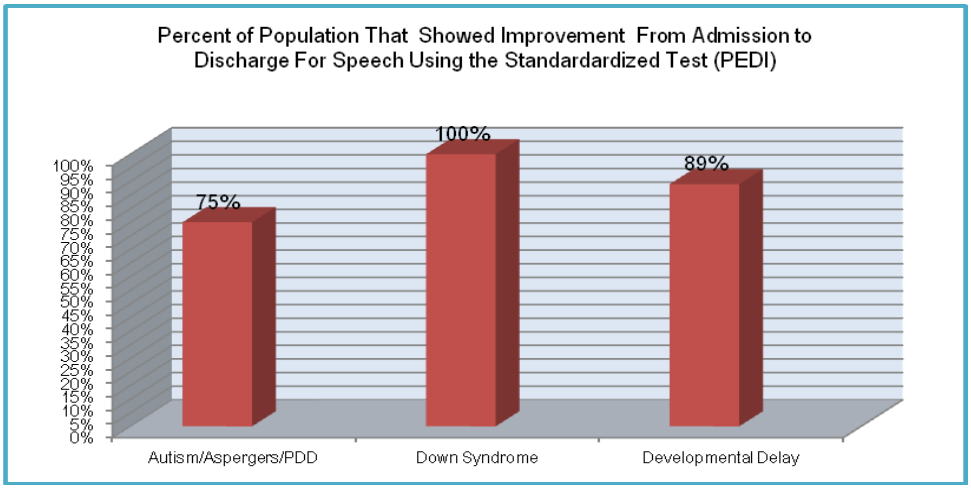

Occupational Therapy - Self Help
PEDI Entrance and Exit Scores
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
63.43%
80.76%
33.21%
66.70%
36.12%
51.32%
Autism/Aspergers/PDD
Down Syndrome
Developmental Delay
Entrance Score
Exit Score

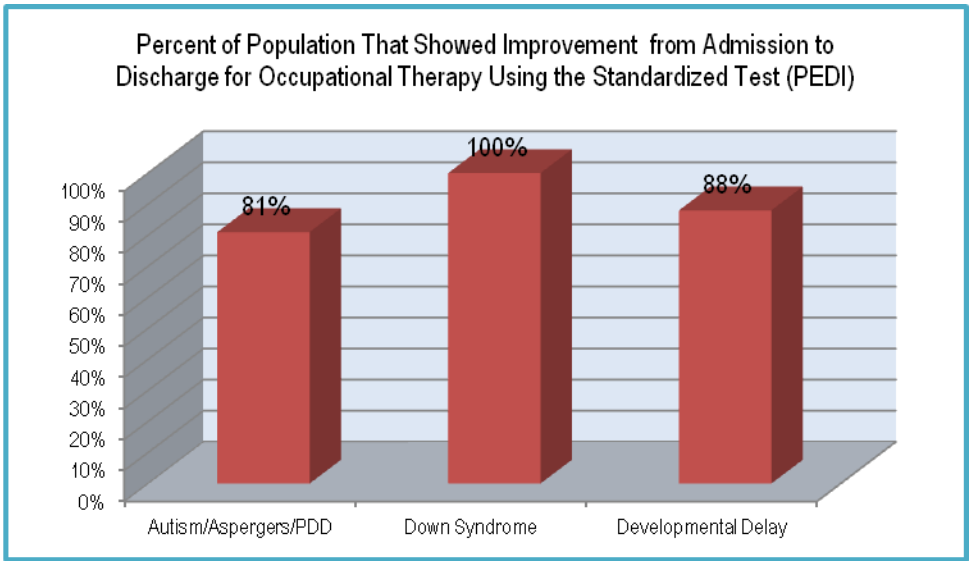

Physical Therapy - Mobility
PEDI Entrance and Exit Scores
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
93.72%
97.04%
21.83%
55.13%
32.14%
53.19%
Autism/Aspergers/PDD
Down Syndrome
Developmental Delay
Entrance Score
Exit Score


Speech - Social Area
55%
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
12.10%
50.04%
27.30%
Autism/Aspergers/PDD
Down Syndrome
Developmental Delay
Average Increase from PED Entrance to Exit Scores


Occupational Therapy - Self Help
110%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
27.34%
100.48%
42.09%
Autism/Aspergers/PDD
Down Syndrome
Developmental Delay
Average Increase from PEDI Entrance to Exit Scores


Physical Therapy - Mobility
180%
160%
140%
120%
100%
80%
60%
40%
20%
0%
152.55%
65.50%
3.55%
Autism/Aspergers/PDD
Down Syndrome
Developmental Delay
Average Increase from PEDI Entrance to Exit Scores


Percent of Population That Showed Improvement From Admission to Discharge For Speech Using the Standardardized Test (PEDI)
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
75%
100%
89%
Autism/Aspergers/PDD
Down Syndrome
Developmental Delay


Percent of Population That Showed Improvement from Admission to Discharge for Occupational Therapy Using the Standardized Test (PEDI)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
81%
100%
88%
Autism/Aspergers/PDD
Down Syndrome
Developmental Delay

In addition to PEDI ouitcomes, as a condition of our United Way funding, the center must report every six months, outcomes for the programs that are funded by the United Way. The programs funded in part by the United Way are: Physical Therapy, Occupational Therapy, Respite Care, Social Skills, and the Pre-school STARS program. The oucomes report is attached to this program evaluation report.

Target Treatment Goals

Another area monitored to evaluate services in conjunction to the PEDI is the number of target goals achieved. A team composed of parents, outside consultants and the Center's therapy staff establishes treatment goals. The data is based on a random sampling of written goal plans in charts of discharged clients during 2011. All four service provider areas monitor performance. The target performance is 80%. The following is outcome data for the past seven years:

Areas of Service	2005	2006	2007	2008	2009	2010	2011
Physical Therapy	85.2%	95.7%	94%	96.6%	96%	85%	89%
Occupational Therapy	83.3%	82.9%	86%	93%	94%	90%	90%
Speech-Language Therapy	95%	94%	91%	97%	97%	97%	95%
Pre-School	86.3%	75.3%	86%	92%	91%	91%	92%

Productivity

Productivity for Schreiber Pediatric Rehab is calculated using the actual numbers of billed hours divided by the number of hours available for billing (hours available for billing is net of vacation, sick time, time off to attend conferences, etc.). The expected level of actual hours billed versus available hours is 65%.

The goal of 65% was established in 1997 and considered appropriate due to the population of children that we serve (one-to-one), and the reimbursement sources.

The Center's goal is 65%. The productivity levels per department and facility over the past seven years are as follows:

Center's Productivity Percentages							
Areas of Service:	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Physical Therapy	63.7	55.3	57.0	60.4	56.4	61.0	62.5
Occupational Therapy	60.7	56.2	54.3	63.5	60.4	64.4	67.4
Speech-Language Therapy	62.3	62.5	62.7	62.5	60.7	63.7	67.0
Facility Average	62.2%	58.1%	57.4%	62.1%	59.3%	63.2%	65.6%

	MH/MR Referrals 2005-2011						
	2005	2006	2007	2008	2009	2010	2011
January	33	25	35	39	32	39	9
February	39	32	32	39	28	46	15
March	25	36	40	40	41	39	27
April	34	11	51	51	37	20	26
May	25	24	25	25	23	31	18
June	33	31	22	22	19	17	22
July	15	16	24	24	29	21	21
August	41	23	36	36	24	36	28
September	41	32	26	46	36	24	17
October	22	29	38	38	40	32	21
November	23	33	32	19	36	27	9
December	15	29	25	32	24	13	23
Total MH/MR Referrals	346	321	405	411	369	345	236

	Total Referrals 2005-2011						
	2005	2006	2007	2008	2009	2010	2011
January	94	52	79	77	91	112	50
February	73	47	61	72	108	78	69
March	33	61	79	60	88	94	88
April	51	43	68	85	98	79	67
May	44	68	87	38	65	85	53
June	53	52	67	48	49	65	88
July	29	47	108	55	67	59	80
August	69	58	61	80	67	118	71
September	69	59	50	74	86	97	59
October	51	70	71	91	81	89	57
November	48	84	58	47	79	59	55
December	40	65	46	77	51	52	56
Total Referrals	654	706	835	804	930	987	793

Recreation Programs

Schreiber Pediatric Rehab center offers a variety of recreational programs throughout the year. We offer programs in the fall, winter, spring, and summer. The center for the 2011 year has seen 803 participants in the year ranging from age 3 to 21years old. Our most popular program is Camp Schreiber last year along we served 217 participants in a 5 weeks program. The kids that participate in Camp have a day filled with gross motor activities, arts and crafts, and cooking classes. Every day is a different theme day and the activities are planned around that theme. The kids while at camp also swim twice a week in our indoor pool. Other popular programs are the Top Soccer program which is an adaptable soccer program for kids with special needs. The soccer participants learn ball handling skills and drills. The Bowling program is another popular program which offers the participants a fun and comfortable environment for them to socialize with kids their age.

American Red Cross adaptive swim lessons are offered in our therapy pool for children of all disabilities and children with in the community. With our special program the kids learn in a private setting, and then either placed in a semi-private lesson or moved into a community swimming program.

The Schreiber programs continue to expand and grow each year. Some programs are not offered for a year and then are brought back maybe the next year to give the families a variety in programming.

Programs	2006	2007	2008	2009	2010	2011
Teen Camp					16	20
Hoops	N/A	5	N/A	N/A	N/A	N/A
Top Soccer	34	14	22	8	32	18
Kids In Motion	20	18	N/A	N/A	N/A	N/A
Waterworks-Open Swim	N/A	17	17	N/A	0	8
Swim Lessons	78	136	98	118	131	75
Preschool Gym		70	60	50	60	60
Bowling	53	18	47	60	40	35
Social Skills	15	16	11	21	25	9
Teen Scene	109	113	152	168	118	82
Camp	134	157	152	159	185	217
Preschool Camp			26	32	22	12
Fishing Mini camp	N/A	N/A	N/A	N/A		N/A
Golf Mini-Camp	9	N/A	N/A	5	N/A	N/A
Karate	32	24	24	24	25	144
Respite	310	224	161	139	101	N/A
Music Therapy	9	N/A	N/A	N/A	N/A	N/A
Floor Hockey	N/A	N/A	4	N/A	N/A	N/A
Little Stars	N/A	N/A	12	N/A	N/A	N/A
Easter Hunt	134	165	69	135	168	254
Total	**943**	**977**	**829**	**919**	**923**	**934**

Quality Improvement Activity

A. Barriers to Service

Several barriers to service were identified and resolved in 2011.
The Social Service Department, which receives all requests for evaluations, noticed that when calling families whose children were on the waitlist for an evaluation appointment, many families did not call back. As much as 50% of the children who were on the waitlist for PT, OT, or ST evaluations, did not make an appointment for an evaluation. The scheduling process was then streamlined for the client to be given an actual evaluation appointment date and time when they first called the Center, even if it is a few months wait.

Another barrier was the frequent failure of the Center's main electronic doors. The doors were installed in 1981. During 2010, the doors started to experience an increased failure rate. In 2011, the failure rate increased further when the new vendor was unable to obtain parts for the doors. New automatic doors were installed in November 2011.

A barrier we encountered was when a family is referred for service at the Center but when billing reviews their insurance information, an evaluation is denied by the family's insurance carrier. This happened twice in 2011. Each family was offered information on Medical Assistance. If the child does not qualify for the MA program, a sliding scale fee is offered to families. If the family does not want to pay, the Social Worker will refer the family to another provider. A follow up call is made to families to determine if they need any other assistance.

In one instance in 2011, a child was residing in Lancaster with a host family, and was unable to obtain insurance in this country. Services were provided to the child free of charge due to the nature of the circumstances.

B. Multidisciplinary Case Review

A meeting is held upon therapist request to discuss the care plan or other issues (health, social, etc.) of up to four or five clients. Those in attendance include the Medical Director and representatives from each therapy discipline involved with the client. The meeting results in recommendations of how to better serve the clients. In addition, multidisciplinary meetings are held bi-annually and annually for Early Intervention and IU Preschool Special Education clients with parents participating as team members.

C. Discharge Follow-up

In 2011, the board requested that families be surveyed upon discharge. Starting in April, 222 surveys were mailed out to families, and 26 were returned, so the Center had a return rate of 11.7% of the surveys mailed to families. Surveys are not sent to families that are referred not seen (RNS), one time consults or were discharged for attendance issues. Of those responding, 100% reported in being satisfied to - extremely satisfied with Schreiber's services. One of the suggestions that came up was for Schreiber to provide behavioral services however, this is not something that management felt could be provided at this time, because we do not have a psychologist on staff. Another suggestion was regarding the phone system being substandard. Due to the suggestion, and previous suggestions regarding an automated system by other

parents, an automated phone system was put in by E-Communications at the end of October 2011.

In reviewing our discharge analysis for 2011, the number of children who were discharged from services was 783. The majority of these children were discharged (24%) because they reached age appropriate goals/maximum benefit of goals were achieved. Twenty percent (20%) of children were discharged because of a family decision, such as the family being happy with the progress, or other financial obligations of the family (too much money for gas or co-pays). Eleven percent (11%) of children was discharged because of an inability to contact the family. Since that was a fairly high percentage, families are now asked each time they come into the office if their address, phone number, email and insurance information has changed. Four percent (4%) of the children were discharged for attendance reasons.

D. Continuing Education

The center places a high emphasis on continuing education and professional development of its staff members and continually moves toward improved areas of service delivery. Training logs for all therapy staff are kept by department. There are several mandatory trainings now required for Early Intervention therapists, which includes a mandatory 24 hours of training in Early Childhood in the program year. Trainings we require staff to participate in include: CPR, First AID, Fire Safety, Universal Health Procedures, Cultural Competence, Mediation, Transition Training, Procedural Safeguards, Mandated Reporting and Behavior Management which all staff must participate in.

The following continuing education costs data was available:

Continuing Education and Certification Costs Per Employee				
2007	2008	2009	2010	2011
$349	$375	$360	$369	$565

Other Significant Events

A. CARF Re-Accreditation 2011

The center was not successful in receiving its fifth three-year accreditation from The Commission on Accreditation for Rehabilitation Facilities (CARF). Instead, we received a one-year accreditation which is set to expire December 2012. After some deliberation, it was decided that the center would try again, in 2012, for another three-year accreditation. The Carf task force immediately began the process for a new three-year accreditation. We fully expect a successful survey.

B. 5010 Compliant 2012

The center at the beginning of 2012, successfully converted from HIPAA 4010 to HIPAA 5010 with very little difficulty. We are now HIPAA compliant for the transmittal confidential information associated with billing electronically.

C. Medicaid

Currently, there are approximately 2,000,000 Pennsylvanians and their families that are part of the Commonwealth's Medicaid Program. The program itself funds medical coverage not just for the poor, but the disabled, and those that lack adequate medical coverage. At Schreiber alone, the majority of our clients that are covered by the Medicaid Program do not fall into the category of "poor." Many of the children that we see are classified as disabled, meaning they qualify for coverage on that basis, and as such, family income is not used as a determining factor.

Pennsylvania's Medicaid program is subcontracted out to various companies that are charged with managing costs for the Commonwealth. Each company has its own set of policies and guidelines that providers are expected to adhere to.

Schreiber Pediatric Rehab Center, since the Commonwealth's switch to the managed care organizations (MCOs) have worked with all three; AmeriHealth Mercy, United Community Health Plan (formerly Unison) and Gateway. As of 2010, two new managed care organizations have entered the Lancaster area. They are the University of Pittsburgh Medical Centers (UPMC) and Aetna Better Health.

As a result of increased paperwork requirements and problems with reimbursements, Schreiber elected to leave Gateway and add University of Pittsburgh Medical Centers (UPMC) as its third Medicaid provider. This change took place during the spring of 2011. Gateway enrollees were informed of the change three months in advance of when the actual change was to take place. Many of our Gateway enrollees were able to make the change with very little difficulty. However, there were a few whereby families could not make the change primarily due to their primary care physician and some specialist which did not accept UPMC. ***These families were referred to other providers.***

Rates are negotiated between the managed care organization and the providers using the Commonwealth's Medicaid base rate plus a percentage over that base rate. For instance, one of the managed care organizations reimburses Schreiber Pediatric Rehab Center 115% of the standard Medicaid rate for services that are provided to its enrollees. As an example, the base Medicaid rate for one unit of physical therapy is $16.25. Schreiber was able to negotiate a rate of 115% of the Commonwealth's Medicaid rate. Schreiber's reimbursement for the one unit of physical therapy becomes $18.69. The negotiated rates vary among the managed care

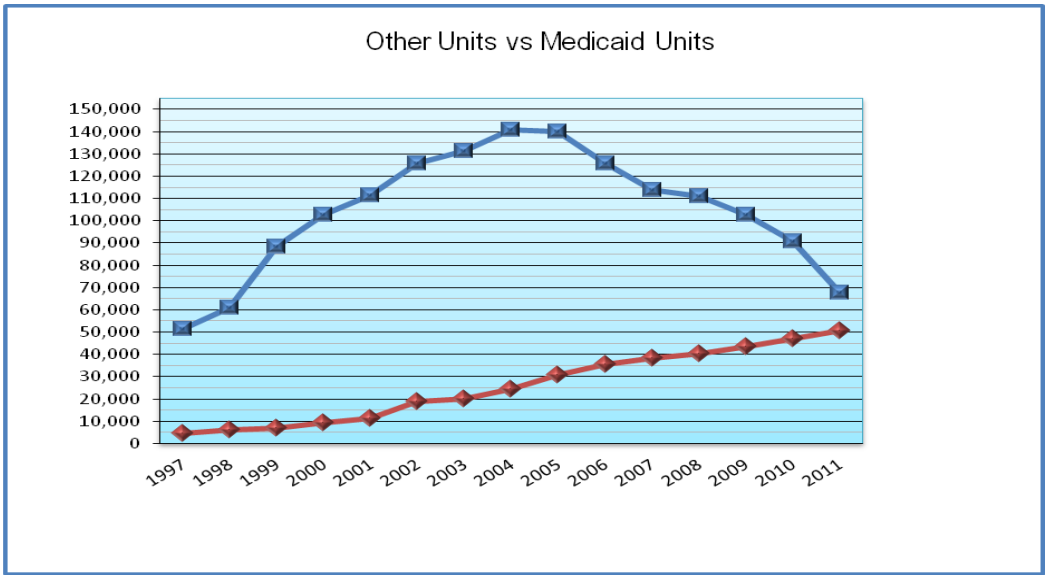
organizations. While one managed care organization may pay us 115% of the Medicaid rate, another may pay as high as 125 - 130%. In any event, the rate of reimbursement does not cover the cost of providing services. Also, rates are not adjusted upwards on an annual basis. We must negotiate with the managed care organization for any type of an increase.

Since 1999, services provided to Medicaid recipients have grown substantially, and they now have become a significant base of clients that Schreiber now serves. The increase was the direct result of primary insurance carriers denying coverage for specific disorders not considered medically necessary or "not a covered benefit." As a result, many families have relied on Medicaid to cover certain conditions not covered through their primary insurance. In 1997 the number of medical assistance units of service was 4,666, which accounted for 8.29% of all units of service generated. Now, approximately 311 children have as their only source of coverage one of the Manage Care Organizations (Medicaid). Another estimated 342 children have both a primary and as a secondary, one of the Managed Care Organizations (Medicaid); UPMC, AmeriHealth Mercy or United Community Health Plan. It's estimated that at least eighty percent of all children that are covered by their parent's insurance policy through their employers have as a secondary, one of the Managed Care Organizations (Medicaid). Because of this, Schreiber cannot collect co-pays from these families with Medicaid as their secondary. ***Co-pays are submitted to the Managed Care Organizations, and we are not reimbursed for the full amount of the co-pay (see the Highmark scenario below*).*** Families that have large deductibles through their insurance carrier, those deductibles for services must be billed to Medicaid.

There are many issues that deter many for profit entities from becoming involved with the Managed care Organizations. As mentioned previously, the biggest deterrent to working with Medicaid is the level of reimbursement and not to mention the fact that we are not permitted to collect co-pays. Also, billing for Medicaid is redundant and very time consuming. Because Medical Assistance is considered the payer of last resort, we must bill a family's primary insurance first, then submit a claim, along with the "explanation of benefits" which will state, "not a covered benefit" to one of the managed care organizations. This must be done for every visit despite the fact that benefits may be exhausted or it is not a covered benefit. In the past this has caused significant delays with reimbursements which had caused a strain on cash flow.

The chart below illustrates that while other service units are declining, Medicaid service units continue to climb.

The Department of Public Welfare for 2012, is considering having families whose child is disabled and is on Medicaid pay co-pays for services rendered in order to reduce the cost of the program. As of yet, the level of co-pays have yet to be determined.



D. Billing Audits

The Finance Department in fiscal 2008, began performing billing audits as a way of determining that billing statements accurately reflect the services that were billed for and that the amount billed was accurate.

On a monthly basis, each biller selects at random patients from the previous month whereby billing sheets are reviewed checking for units of service and the amount billed which is then traced to the twelve week goal plan. As of August 2012, there have been no discrepancies based on our review.

Schreiber Pediatric Rehab Center

Program Data

January 1, 2011 - December 31, 2011	
Number of work days:	251
Number of Patients	3,011
Number Full Time Therapists	30.05
Number of Patients Per Full Time Therapists	101.63
Number of Patient Visits	***33,783***
Avg. Number of Patient Visits Per Day	135
Number of Service Units Per Patient Visit	2.75
Number of Service Units Per Day	***517.1***
Patient Visits:	
Physical Therapy	8,787
Occupational Therapy	12,409
Speech Therapy	10,724
Pre-School/Social Work	1,883
Total Visits	***33,803***
Service Units:	
Physical Therapy	28,551
Occupational Therapy	43,804
Speech Therapy	33,453
Pre-School/Social Work	23,986
Total Units	***129,794***
Number of Service Units Per Patient Per Annum	123.75
Avg. Number of Visits Per Patient Per Annum	45
Home Visits Analysis	
Therapy Units	34,138
Travel Units	15,915
Ratio Therapy/Travel	***1.00: .47***
Discharge/Admission History	
Patient Beginning Balance @ 1/1/2011	3,054
Plus: Admissions	778
Less: Discharges	(783)
Net Patients @ 12/31/2011	***3,049***

Schreiber Pediatric Rehab Center
INCIDENT / ACCIDENT / VARIANCES
ANALYSIS REPORT
January 1, 2011 to December 31, 2011

There were a total of twenty-four (24) incidents reported for the year versus forty-seven (47) incidents reported the previous year.

Breakdown analysis

Individuals involved were:	Clients	10	41.7 %
	Visitors	5	20.8 %
	Volunteer	0	0.0
	Employees	5	20.8 %
	Day Care	3	12.5 %
	Nurse	1	4.2 %

Location of incidents was:

Physical Therapy gym	3	Occupational Therapy gym	3
Reception area	1	Lobby & parking lot	2
PreSchool	2	Hallway	2
Client home	2	Camp	0
Offsite	4	Pool	0
Day Care	3	Speech Dept.	0
Playground	2		

Factors related to events were:

Fall/slip – 6	Scratch - 1	Tooth injury - 1
Seizure – 1	Bite – 0	Head injury - 2
Incorrect technique - 0	Aggressive behavior - 0	Face injury – 2
Exposure to disease - 0	Improper supervision by parent – 0	Leg injury - 2
Suspected abuse/neglect (non-staff) – 0	Client emotional concern - 1	Back injury – 2
Inappropriate supplies – 0	Disruptive behavior – 0	Arm injury - 2
Theft – 1	Stomach pain - 1	Shoulder injury – 1
Burn - 1		

Outcome Status – There were seven (7) events that were referred for treatment: five to hospital and one ambulance called for nurse of client.

Severity of Injury - There were two (2) workers compensation claims but did not result in any time off from work.

Conclusion/Recommendation - Significant decrease compared to prior year. Noted was closer supervision needed when performing challenging tasks to prevent client slips and falls.

Analysis conducted by: Christina Kalyan and Lisa Gilert
Members, Safety & Risk Control Committee