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The American Congress of Rehabilitation Medicine (ACRM) and Rehabilitation Research in a Changing Postacute Landscape. The 2007 ACRM Presidential Address

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Postacute rehabilitation is on the threshold of several major changes that have implications for rehabilitation practice and research. The most important of these is the desire of the Centers for Medicare & Medicaid Services to establish a uniform patient assessment method and implement a more setting-neutral prospective payment system across all major postacute settings. The proposed uniform patient assessment instrument will in all likelihood displace the FIM instrument as the industry standard. The rehabilitation research community needs to remain vigilant about the nature, scope, and measurement properties of the proposed uniform patient assessment instrument. A new instrument and setting-neutral payment system may provide new opportunities for service innovation and research. Neurorehabilitation has been one of the strengths of the American Congress of Rehabilitation Medicine (ACRM). ACRM needs to build on this strength and examine more earnestly the rehabilitation interventions and outcomes associated with the increasing prevalence of people with orthopedic and musculoskeletal conditions seen in rehabilitation centers today. ACRM's ability to do so will depend in part on its ability to join forces with other professional and consumer organizations to increase research funding significantly for each of the major federal agencies that currently fund rehabilitation research.

Key Words: Outcome assessment (health care); Prospective payment system; Rehabilitation; Research.

THE WORLD OF POSTACUTE rehabilitation is changing and promises to change even more dramatically in the years to come. In this address, I want to characterize these changes and then outline what they imply for rehabilitation research and what they mean for the American Congress of Rehabilitation Medicine (ACRM) as an organization.

Several major changes are underway. To illustrate, I will mention only 3.

First and most important is the passage of the Deficit Reduction Act of 2005[1] that launched a serious conversation about the future of American postacute care (PAC). Section 5008 of the Act provides for a 1-year ramp-up, starting in 2007, and a 3-year demonstration project, starting in January 2008, to develop and test a uniform patient assessment methodology that will lead to a site-neutral postacute prospective payment system (PPS). The new uniform postacute PPS would replace the 4 separate ones we have now—for (1) inpatient rehabilitation facilities (IRFs), (2) skilled nursing facilities (SNFs), (3) home health agencies, and (4) long-term care hospitals. The soon-to-be implemented demonstration project signals our government's intent to reset the terms of how we assess patients for postacute placement and outcome and how we pay for this care— based more on the needs of the patient and less on the characteristics of the postacute setting in which the patient is placed.

Second is the changing mix of patients coming to postacute rehabilitation across settings of care. Among hospital-based rehabilitation centers, for example, the signature impairment groups include people with stroke, spinal cord injury (SCI), and brain injury—all under the rubric of neurorehabilitation. Yet, up until recently, the fastest growing impairment groups were people with joint replacements and hip fracture—all under the rubric of orthopedic (ortho-) rehabilitation. This change reflects the aging of the population, the increasing numbers of people with joint disease, the rapidly increasing number of people acquiring a hip or knee replacement, and other trends.

Third is the changing distribution of patients across settings of care. From all indications, the "75% rule" has shifted patients, particularly orthopedic, cardiac, and pulmonary patients, away from hospital-based rehabilitation settings to SNFs and other settings. Since 2004 when the Centers for Medicare & Medicaid Services (CMS) reinstituted the 75% rule, the number of rehabilitation units in acute care hospitals has begun to decline after decades of growth.

These and other changes have had downstream consequences that affect choices that newly minted rehabilitation physicians make when choosing a practice setting or subspecialty. In recent years, proportionately fewer rehabilitation residents are choosing an institution-based practice setting doing neurorehabilitation and more are electing a community-based practice setting doing orthopedic rehabilitation, sports medicine, and pain management. A recent survey of graduating rehabilitation medicine residents conducted by the American Academy of Physical Medicine and Rehabilitation (AAPM&R) found that pain and musculoskeletal medicine were the most popular choices for fellowship training and future practice. There was much less interest in brain injury, stroke, and SCI among graduating residents.[2] When asked to identify their top areas of practice, current AAPM&R members listed the following areas: electrodiagnostic medicine, pain medicine, orthopedic rehabilitation, stroke, spinal medicine (apart from

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SCI), and sports medicine (Tom Stautzenbach, American Academy of Physical Medicine and Rehabilitation, personal communication, August 30, 2007). The number of PM&R physicians practicing in neurorehabilitation has not necessarily declined, but newer entrants are selecting other areas of rehabilitation practice. Findings such as these affect the direction of our sister organization, AAPM&R, where increasing attention is being given to issues related to orthopedic and musculoskeletal rehabilitation and pain management in private practice settings.

Some of the trends seen in the United States are not unique. They are seen in other nations that are coping with their own aging populations and postacute systems. They all struggle with the issues of how to assess and place patients and how to pay for their PAC. However unique some of their systems may be, they watch with an eye on how we are trying to sort out these issues. My advice to our international colleagues is not to take us too seriously. Our systems of care can be quite dysfunctional. Take only the best of what we have to offer and forget the rest. More importantly, we need to learn from you.

ACRM AND HOSPITAL-BASED REHABILITATION

For better or worse, ACRM has been linked closely with the academic and hospital-based segments of the rehabilitation industry. ACRM's members come disproportionately from such settings. If you look closely at the institutional affiliations of ACRM board members and leaders, you will note that they come disproportionately from the top 20 rehabilitation facilities ranked in *US News & World Report Best Hospitals* in 2007.[3] As a matter of fact, of the 10 highest ACRM member–contributing facilities, 7 are also in the Top 10 *US News & World Report* list. In short, the more members a facility contributes to ACRM membership, the more likely the facility is to be ranked in the top 10, 20, or 25 facilities. As every researcher knows, association is not causation—and most know well the weaknesses of the *US News & World Report Best Hospitals* list (and there are other facilities that should be on this list and are not)—but I do believe that participation in the scientific endeavors of a national organization such as ACRM does contribute to a facility's reputational score in rehabilitation.

The more highly ranked facilities also tend to be sponsors at our annual meetings. They are also more likely to have residency and other training programs. This is no coincidence. These institutions are deeply committed to advancing the field. They bring a deep sense of public service that extends well beyond excellence in patient care. Our nation owes these facilities and others like them a real debt for the spirit of public service and commitment to research and education. Without this commitment, our field cannot advance.

Many of the listed institutions are brand-name legacy institutions and bring a distinct institutional culture to American PAC. Their existence depends in part on a postacute payment system that has recognized this legacy as an important segment of the American postacute landscape. As we move toward a more setting-neutral patient assessment and payment system, some of the boundaries that distinguish this group of facilities from other settings of care may begin to blur, although hospital licensure, accreditation standards, and other criteria will maintain some of the system's distinct features.

IMPLICATIONS FOR REHABILITATION RESEARCH

Frankly, I see enormous opportunities in a more site-neutral patient assessment and payment system. Placing patients in narrowly defined PAC boxes never made sense to me when their needs and capacities shift over the course of their rehabilitation. If implemented, I believe a more site-neutral system can begin a new era of service experimentation and innovation that is more tailored to the natural history of the recovery process.

I hope that such a system will unleash a quest for best practice based on sound research. Whether we get there will depend greatly on how the federal government and other payers structure the payment system to incentivize providers to advance the state of care. If we develop a payment system that is based on patient needs at admission and risk-adjusted outcomes at discharge and follow-up (pay for performance)—along with a full risk-adjusted outcome disclosure system, providers will scramble to figure out how best to achieve these outcomes to be the best in their class. A well-structured payment and outcome disclosure system is worth a thousand randomized trials, much like a picture is worth a thousand words. Today's research questions, such as whether SNF- or IRF-level care is better, will become moot. Instead, we will seek to determine what combinations of resources over time lead to better outcomes. These kinds of questions are not easily answered by randomized trials in a changing practice environment but by research methods that can identify practice patterns that are most strongly associated with patient outcomes.

The linchpin for a new postacute system is the uniform patient assessment instrument. It will drive all other downstream changes in PAC—payment systems, information systems, referral systems, quality monitoring, and outcome systems—to name just a few. Getting there is a huge lift. Each of today's main postacute settings is deeply vested in its own patient assessment tool. Each tool represents years of development, arises from a distinct professional and institutional culture, and reflects additional years of investment in information systems technology, database development, training, and quality monitoring systems. Retooling all of this is no easy task. There is much to be said for building on the best of what each system of care provides now. My fear, however, is that in doing so, CMS will try to please all and satisfy none. The great risk is that we will develop an unwieldy one-size-fits-all tool that tries to cover all the bases. CMS needs to avoid the mistake it made in 2000 when it developed the Minimum Data Set (MDS) for PAC care based on a single legacy tool—namely, the MDS for skilled nursing. This instrument had limited relevance to other settings of care where nursing home "residents" were never a part of its traditional patient mix. The field wisely rejected this alternative.

Once a new instrument is designed and implemented, we may have to live with the new tool for the next 2 decades or more. And once instituted, this is not a piece of postacute infrastructure that many will want to revisit anytime soon. We may be stuck with it—unless CMS makes a real commitment to update and refine the tool as we gain experience with it and as new information technologies enable us to achieve new economies of use. The developers of the instrument assure me that the instrument will be modular, robust, and amenable to change as new measurement technologies evolve. By simply building on current tools, I am concerned that we are not taking full advantage of computer-adaptive testing technologies that can assist us in developing instruments that are more comprehensive but also more efficient to administer and thus more generalizable to the wide range of patients seen across PAC settings including outpatient care. I wish that CMS had taken this route—although I am told that many postacute facilities remain paper-based and simply lack the information technology platforms needed to support such advances in measurement. By aiming our measurement tools to the lowest common