

Rehabilitation

A publication from Kessler Institute for Rehabilitation



An early start to rehabilitation can help avoid complications

◆ Daniel C. Fechtner, M.D.

Rehabilitation following an injury, illness or joint replacement can help prevent deconditioning and muscle atrophy. But timing can be critical. Psychiatrists suggest early intervention to prevent, identify or treat complications that can interfere with the rehabilitation process. And acute care hospitals understand that such interventions can both improve outcomes and shorten stays.

Amputation, stroke, spinal cord injury and traumatic brain injury patients are all at particular risk for complications and could benefit from rehabilitation soon after admission to the hospital. Pressure sores can begin within hours after a spinal cord injury, even while the patient is still in the emergency department. Aspiration pneumonia

or infection can arise within days after admission with stroke or other neurological conditions. These are complications that rehabilitation therapists and psychiatrists manage every day.

Early intervention strategies

Acute care hospitals and rehabilitation hospitals can both develop strategies for ensuring early rehabilitation intervention. There are many diagnostic and therapeutic goals for the first days of an acute stay, and these should include early identification of rehabilitation candidates, early rehabilitation intervention and early transfer to rehabilitation care.

Timely rehabilitation consults are the first step for achieving these goals. Generally, a staff physical or

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Focus on

RehabilitationEDITOR-IN-CHIEF**Bruce M. Gans, M.D.***Chief Medical Officer**Kessler Institute for Rehabilitation*MANAGING EDITOR**Gail Mallor Solomon***Director, Corporate Communications**Kessler Institute for Rehabilitation*EDITORIAL ADVISORY BOARD**Robert Krotenberg, M.D.***Senior Medical Officer**Kessler Institute for Rehabilitation***Samuel Grissom, M.D.***Associate Medical Director**Kessler Institute for Rehabilitation***Steven Kirshblum, M.D.***Associate Medical Director and Director
of Spinal Cord Injury Service**Kessler Institute for Rehabilitation***Bruce A. Pomeranz, M.D.***Associate Medical Director**Kessler Institute for Rehabilitation*MISSION STATEMENT

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Seeing the world of medicine through a patient's eyes

• *Bruce M. Gans, M.D.*

A

fter spending 30 years in physical medicine, I find it easy to forget just how frightening hospitals can be. Our workday world can be a terrifying place for patients and their families, who often find there a nightmarish new reality of limited function or capacity.

Just how scary that can be was brought home to me by two recent experiences. The first was helping a favorite cousin cope with his father's stroke. In our almost daily phone conversations, I heard his bewilderment over treatment options and medical jargon.

What for me, as a physician, was a bread-and-butter situation of a simple stroke was, for my cousin, a life-altering event. "Why can't he talk?" he asked. "When will he be able to swallow? Is he going to die?" I could easily explain the advantages of different care settings and the ideal course of action for rehabilitation management. Instead, he wanted to be reassured that this key relationship in his life hadn't irrevocably changed.

The second experience was even more personal: I myself was briefly hospitalized for a surgical procedure. Suddenly I was the patient, the focus of medicine's technological advances—and possibly the victim of the next medical error.

Two factors about being a patient impressed me the most. One, I was struck by how vulnerable I felt. Even though I was being treated in a world-class institution, I was all too conscious that my well-being was utterly dependent on the skills and professionalism of very busy individuals.

The second and much more positive impression was how important my providers' nonverbal communication was to me. Having physicians spend an extra five minutes of their time, being touched by nurses when they spoke to me, finding aides who maintained good eye contact and a smile instead of staring at the floor or being preoccupied—those were the factors that shaped my experience as a patient and helped calm any fears over what was happening to me medically.

Seeing care through the eyes of a patient is what I've brought back with me to my preferred side of the physician-patient equation. There is nothing "routine" about what has put our patients under our care, and we must help them weather that catastrophe with education, reassurance and understanding.

Our ability to provide support is particularly critical, given how many of our patients have a hard time processing the information we need to give them. Our willingness to spend the time they need and our efforts to communicate—through our demeanor, as well as our words—can have a big impact on their therapy.

We need to extend that support as well to their family members, who sometimes become anxious in the face of such frightening changes. As tough as those interactions can be, we must make the extra effort to reach out to people struggling with panic and grief—feelings they inevitably experience before they can see the hope we offer and begin to reap the benefits of the care we provide.

How electronic aids to daily living can empower patients with spinal cord injury

♦ *Jill Garcia, M.S., OTR, and Terrence C. Carolan, M.S., P.T.*

After a spinal cord or brain injury, patients often feel their lives are over. In fact, with the help of powerful assistive devices, all patients can gain some degree of control and quality in their lives. Electronic aids to daily living (EADL) programs are designed to determine which devices will give individuals the greatest possible amount of independence. EADL devices bridge the gap between a patient's level of function and his or her environment.

The Kessler Institute for Rehabilitation EADL program serves patients with severe spinal cord injury (C6 or C7 or higher) and may soon expand to include other diagnoses such as traumatic brain injury. The program helps patients set specific goals, then determines ways to achieve them using the appropriate technology. A dedicated assistive technology suite provides a quiet environment to assess and instruct patients on the use of devices in one-on-one therapy sessions. Environmental control units (ECUs) in patients' rooms are used to control lights, televisions, call bells and other devices for training in a real-life environment.

The ECUs allow patients with little or no arm or leg function to control any number of appliances, such as telephones, doors, televisions and DVD players. The units have switches that can be turned off and on with infrared beams, ultrasound waves, or pneumatic pressure generated by sipping or puffing into a tube. Other switches are controlled by subtle movement, such as raising a cheek or elevating an eyelid. Other ECUs "learn" the patient's voice and allow him or her to activate appliances and lights by voice.



Today's electronic technology enables patients with spinal cord injuries to control their environment in ways that were undreamed of just a generation or two ago.

Another mission of the program is to stay up to date on new technologies and assistive devices. Vendors provide product information and demonstrations regularly and therapists in the EADL program attend annual courses and classes in the field. Frequent in-service presentations on EADLs are given for staff.

Patient training in the use of the assistive devices is provided by physical and occupational therapists and also integrated into the therapy regimen. Program therapists communicate with the therapy team on what devices the patient is working with and which muscle groups need exercising in order to use the devices. The patient may be learning to use a voice-controlled computer that will enable him or her to return to work. Individuals may also learn to use a cell phone with buttons that have been built up with pegs of wood, so less assistance will be required after

returning home. Mainly, however, EADL improves the quality of life for individuals who would otherwise have very limited function. One type of device, for example, uses switches to allow a patient to turn the pages of a book forward and backward.

Finally, because electronic assistive devices are often expensive and not covered by insurance, the program also seeks to help patients locate funding for them.

The EADL program offers exciting options for patients and allows them to focus on what they can do, rather than what they cannot do.

Jill Garcia, M.S., OTR, is an occupational therapist at Kessler Institute for Rehabilitation. She can be reached at jgarcia@kessler-rehab.com. Terrence C. Carolan, M.S., P.T., is a senior physical therapist at Kessler Institute for Rehabilitation. Readers may contact him at tcarolan@kessler-rehab.com.

Acupuncture gains a believer—and a practitioner

One of the world's oldest medical techniques is making new inroads in rehabilitation

It is an ancient technique dating back thousands of years, the Oriental art of using fine needles to diagnose and treat medical conditions.

But acupuncture is now finding diverse new applications in modern rehabilitation to treat pain, relieve side effects from other therapies and help stroke patients regain function. Robert Krotenberg, M.D., Kessler's senior medical officer, recently explained to *Focus on Rehabilitation* why he's become not only an advocate of the venerable therapy, but a practitioner as well.

FOCUS: What sparked your interest in acupuncture?

KROTENBERG: My wife had chronic neck problems for 15 years and got little relief from traditional therapies. I finally asked a physician here who is certified in acupuncture if she could help—and after only three treatments, my wife hasn't had a problem since.

I became a believer and decided to get trained myself. I'm now the fifth physician here at Kessler to be certified in acupuncture, out of a physician staff of 30. That's an unusually high ratio.

FOCUS: What conditions do you treat with the procedure?

KROTENBERG: We use it primarily to treat a whole range of pain syndromes—pain resulting from trauma, auto accidents, broken bones or chronic back pain. Patients who opt for acupuncture often don't want to take stronger medications than they're already on, so they use it to complement pain medications. Some patients who prefer a less systemic treatment for pain will get acupuncture as an alternative.

Also, in the past we received a federal grant to study the effectiveness of acupuncture for different conditions. One trial that we had a keen interest in, because we treat so

many stroke patients, looked at how effective acupuncture was for patients with swallowing problems as a result of stroke.

Our research—and the data that were subsequently published—clearly supported the use of acupuncture for dysphagia, so we are now one of only a very few facilities that offer it to stroke patients. In patients who have swallowing problems, we use acupuncture in addition to the head position techniques and food consistency modification that are the standard of care for dysphagia.

We also use acupuncture for other conditions for which it's been recognized as effective: vomiting and nausea, particularly nausea associated with chemotherapy and other medications; and facial pain, including trigeminal neuralgia. Studies also support its use in treating post-operative pain.

FOCUS: Are more patients now asking for the procedure?

KROTENBERG: In inpatient rehabilitation, its use is driven more by our physicians, who are aware of its benefits and offer it to patients. On the outpatient side, patients here in the community have heard we offer acupuncture, so they come in specifically for treatment—usually for pain—that isn't tied to any form of rehabilitation.

FOCUS: Why does it work?

KROTENBERG: We now have a better understanding of what happens physiologically in the body when



When acupuncture helped his wife overcome neck pain, Robert Krotenberg, M.D., decided to learn the technique.

acupuncture is administered.

Studies have shown that various pain modulators—such as endorphins, enkephalins and other neurochemicals—are secreted in response to acupuncture stimulation at specific anatomical sites we call “points.” Certified acupuncturists typically work with several hundred different points throughout the body.

These substances have an opioid-like effect and can reduce pain. Also, these neurochemicals affect parts of the central nervous system that are linked to involuntary body functions and sensation.

FOCUS: How extensive is the scientific evidence behind acupuncture?

KROTENBERG: Studies clearly support its effectiveness. At the same time, it's hard to design a classic scientific study—one that's randomized and double blinded—for acupuncture, because trial participants can't “ignore” an acupuncture needle the way they can unknowingly take a

How an ethics committee resolves disagreements about what's right

♦ Philip J. Driscoll, Jr., FACHE

placebo in a blinded pharmaceutical trial.

There have been “sham” acupuncture studies where the control group is given needles that aren't placed directly in acupuncture points—an intervention that can still stimulate a placebo effect. But studies have found that the placebo response in acupuncture trials is identical to that found in studies on traditional medications. The science certainly doesn't support the idea that acupuncture is all placebo.

The National Institutes of Health has issued a consensus statement about acupuncture. It also established the National Center for Complementary and Alternative Medicine, which supports research into acupuncture, as well as into other types of therapy. I'd say the majority of insurers now cover acupuncture treatments.

FOCUS: Is physical medicine more open to such complementary therapy than other specialties?

KROTENBERG: I think so. Physical medicine in general takes a broader view of medical care and already incorporates a variety of therapies, such as massage and stimulation.

Because we help patients regain function in all areas of their life, we need to take a more holistic, multidisciplinary approach. That leads rehabilitation physicians and allied professionals to be more open to alternative approaches than other specialties, which might be more entrenched in strictly outcomes-based medicine.

Readers may e-mail Dr. Krotenberg at rkrotenberg@kessler-rehab.com.

Every day, health care providers face ethical dilemmas that have far-reaching effects on their patients' lives. While acute care questions generally revolve around life-and-death decisions—such as whether to continue or cease life support—in the rehabilitation setting, patients are more medically stable. More often, the challenge in rehabilitation care is to balance what the care team thinks is best for the patient versus what the patient wants to do.

Consider, for instance, the dysphagic patient who demands solid food, even though the team knows that the risk of aspiration would be high. Or the stroke patient who wants to go home when the team knows she does not have the ability or support to do so safely. Or the spinal cord injury patient who wants to continue rehabilitation after the team determines that his potential has been reached.

These are the types of ethical challenges that must be resolved each day in the rehabilitation setting. Generally, the patient, family members and care team negotiate and strike a compromise solution on their own. If no meeting of the minds can be reached, however, Kessler patients and staff members can turn for help to the ethics committee, which has representatives from all four Kessler sites. The committee includes physicians, psychologists, nurses, therapists and administrators, who meet quarterly—or more often if needed—to help the patients and practitioners tackle the ethical gray areas that arise.

The committee emphasizes educating its members, as well as all staff members. Everyone is urged, for instance, to know the difference

between a “difficult” patient and one who actually presents a thorny ethical issue that requires consideration. Staff members are also encouraged to see the committee as a hands-on resource that anyone can turn to. In-service presentations for all employees are given, and informational material is distributed to keep staff up to date on industry perspectives on medical ethics. The committee members also learn about state and federal laws on patients' rights and review medical ethics literature for guidelines and broad theories. Generally, though, cases must be decided individually.

Although the patient nearly always has the right to decide, each case is different. The patient who continues to insist on returning home too early may be discharged. The patient who wants to continue rehabilitation treatment beyond the point of benefit will most likely not be allowed to continue. As for the dysphagic patient who wants solid food, it is improbable that the hospital would have to provide a potential danger just because the patient insists. This is a typical question for the ethics committee, however, and one not covered by broad ethical theories.

The committee, which reports to the medical executive committee, must also determine the level of need for its services. The committee therefore asks for feedback from all staff members to ensure it is meeting those needs. And as committee members identify trends in the types of problems brought before them, they continue to seek effective resolutions.

Philip J. Driscoll, Jr., FACHE, is vice president of administration at Kessler Institute for Rehabilitation. Readers may address correspondence to him by e-mail at pdriscoll@kessler-rehab.com.

The brave new world of the 75 percent rule

♦ Bruce M. Gans, M.D.

It is almost a year since the new 75 percent rule from the Centers for Medicare and Medicaid Services (CMS) went into effect. As you may now know, the May, 2004 rule revised the classification criterion used to determine whether hospitals can be considered inpatient rehabilitation facilities for purposes of Medicare payment. Unfortunately, despite CMS's extensive review of the rule, the final regulations, in their present form, still fail to address the scope of rehabilitation services today and potentially jeopardize access to and treatment options for certain patient classifications. Notwithstanding the new rules, Kessler will continue to take the lead in advocating change and in further educating CMS and our lawmakers about the evolving role of inpatient rehabilitation facilities in treating complex patients.

There have been a number of recent developments in this respect. Language included in last year's Omnibus Appropriations Act, for instance, defers penalties rehabilitation facilities would be required to pay for noncompliance until the Government Accountability Office (GAO) releases its study on the impact of the 75 percent rule. This study is due soon. Also, the National Institutes for Health (NIH) has formed a panel to determine what research is needed to define the appropriate setting to rehabilitate certain diagnostic populations including cardiac, pulmonary and joint replacement patients.

A quick fix is unlikely

Even if the GAO report favors the perspective of inpatient rehabilitation hospitals, this will not neces-

sarily compel CMS to change the current regulations, nor will panel findings from the NIH have an immediate impact on Medicare policy. However, these reports and panel findings should help both the lawmakers and rehabilitation hospitals meet a consensus on which patients are most appropriate in hospital-level rehabilitation.

In the meantime, we must ensure that we are in strict compliance with the current Medicare regulations. This may mean some tough new choices. Rehabilitation hospitals may now have to say no to

Notwithstanding the new rules, Kessler will continue to take the lead in advocating change and in further educating CMS and our lawmakers about the evolving role of inpatient rehabilitation facilities.

patients who, if admitted, could push facilities below this year's 50 percent threshold.

In addition, alternative care strategies will need to be found for those patients we will now have to decline in accordance with the new regulations. Some facilities will be able to create alternative programs, while others may have to refer patients to competitor facilities. We will need to ensure that these alternative care settings have the same service obligations and quality benchmarks as rehabilitation hospitals, while also being subject to comparable standards and accountability requirements.

Hospitals will now also need to make sure that they are properly categorizing admitted patients. Physiatrists must play a leadership role in establishing proper coding

and patient classification practices and fully document in their notes both the needs and conditions of patients.

Ways to make our point

We must continue in our leadership position, with our colleagues, to educate CMS and lawmakers on the appropriate criteria for patients who need to be in rehabilitation hospitals in order to advocate change and to enable these hospitals to best address all patients' needs.

We should also begin identifying patients who, in our opinion, are being harmed by the policy change in limiting their access to care in our hospitals. We should also strive to promote professional judgment and consensus. For example, the American Academy of Physical Medicine and Rehabilitation is currently preparing guidelines to determine medical necessity standards. These guidelines will help determine which patients belong in rehabilitation hospitals and to assess those criteria being used by insurers or facilities. They will also serve to promote uniform guideline procedures throughout the field.

By and through these continued efforts, Kessler will continue to assume a leading role, in conjunction with our peers, in promoting the best interests of our patients and our hospitals and advocating appropriate change so that we can continue to best address all of our patients' rehabilitation needs and the evolving scope of rehabilitation services in the 21st century.

Bruce M. Gans, M.D., is chief medical officer of Kessler Institute for Rehabilitation. Readers may direct e-mails to him at bgans@kessler-rehab.com.

How early should rehabilitation begin?

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occupational therapist sees patients who may be candidates for rehabilitation. Since most acute care hospitals do not have a physiatrist on staff, an outside clinician may be called in. These early consultations are crucial and can help determine when rehabilitation should start, which is often on day one of the illness or after the accident. The therapist or physiatrist is also able to evaluate patients and assess the level of impairment, providing input that is invaluable for developing care and discharge plans. Evaluations can also identify those patients who would benefit from care in an acute rehabilitation hospital following discharge. The physiatrist or therapist may team up with other advocates, such as doctors, social workers, case workers and therapists, to facilitate the earliest possible transfer to rehabilitation.

Little things that mean a lot

Acute care settings, regardless of the level of rehabilitation care they are able to provide, can also help avoid medical complications and shorten lengths of stay by introducing rehabilitation therapy early. Simply seeing that the patient sits up in a chair every day and walks as soon as possible can greatly help to avoid complications. This is especially true for patients who have extended stays in acute care.

Rehabilitation hospitals can also implement strategies to ease the way for early intervention and patient transfer. Kessler Institute works with acute care hospitals within its geographical area to develop and use diagnostic-specific protocols that expedite early rehabilitation and patient transfer. Upon every admission to participating hospitals, the protocol is triggered and the patient is reviewed for rehabilitation needs. These protocols open the lines of

communication between acute and rehabilitation facilities. They have also helped to shorten stays in acute care, as some joint replacement patients are discharged to rehabilitation as early as day one post-op.

Rehabilitation hospitals can also expedite early patient intervention and admission by ensuring continuity of medical care, especially for patients who are not yet fully stable. Kessler Institute meets patients' medical needs by providing daily physician visits, well-trained registered nurses and certified rehabilitation registered nurses and a full array of ancillary services, such as laboratory, imaging and dialysis services. Inpatients who require oxygen, intravenous medications or dialysis can all be managed by the medical staff.

Overcoming barriers

Despite the benefits of early rehabilitation, common misperceptions can prevent it. Patients and even health care providers may mistakenly believe that a patient who is actually a good candidate for therapy is too sick, too weak or too old to benefit from a rehabilitation regimen. At Kessler, rehabilitation patients generally receive three hours of therapy each day. But for patients who require it, therapy can be progressive, starting slowly and gradually building to a full schedule. In addition, patients can be transferred to the rehabilitation hospital shortly after diagnostic testing is completed, medical treatment has started or surgery has been per-



Today's acute care hospitals understand that an early start to rehabilitation often can be the key to both better outcomes and shorter stays.

formed. Patients must no longer need continuous monitoring (e.g., telemetry), and must be able to build up their exercise tolerance within a week. That means that most patients from a medical or post-operative unit are considered well enough for inpatient rehabilitation care.

It is important to recognize that whether patients are admitted to inpatient rehabilitation on day three or day ten after an illness or injury, a course of rehabilitation therapy will help them reach their goals and return home. The main objectives of early intervention, however, are to minimize muscle atrophy and loss of exercise tolerance, avoid complications that can interfere with rehabilitation and start the physiologic and functional recovery.

Daniel C. Fechtner, M.D., is director of stroke rehabilitation at Kessler Institute for Rehabilitation. He can be reached at dfechtner@kessler-rehab.com.

Switching to a new billing and scheduling system

♦ Roseann Tambone

State-of-the-art rehabilitation hospitals require state-of-the-art computer systems that integrate seamlessly with the various clinical areas. In January 2005, Kessler Institute for Rehabilitation introduced a new billing/scheduling system to meet its current and future information technology demands, including electronic medical records, unbundled billing and sophisticated scheduling programs. After months of investigation, MISYS Healthcare Systems with Tiger software was selected for its capabilities and proven reliability in physician groups across the country.

One indispensable capability was unbundled billing. In the past, hospital billing was combined with professional billing and it was difficult to obtain a clear picture of what insurance carriers were paying for professional services. Now patients can clearly see the charges for physician services versus hospital services. Separate psychology charges can also be identified by patients and administrators.

Another crucial capability of the new system will allow physicians to use hand-held units for recording electronic patient data at the bed-



side or in the physician office or psychology suite. This capability will be implemented in the near future. Doctors can then download the data into the computer. This electronic medical record helps prevent data-entry errors caused by hard-to-read handwriting. The system also helps doctors code for services, with the use of computer prompts that guide or correct the coding process.

The new scheduling component also represents a major advance. In the past, lengthy screens required the user to enter complete patient information at each visit. Now such screens have been eliminated and each patient has one account number that is used for all outpatient visits.

To facilitate the change, an entity wholly owned by Kessler Rehabili-

tation—Kessler Professional Services—was formed to select and implement a new billing/scheduling system. A 15-member team of doctors and administrators attended manufacturer product demonstrations for three months. Then team members voted based on system capabilities and ease of use. Soon after, training sessions were held for key staff, who in turn trained other staff. During the ses-

sions, patients were registered and charges were entered. Invaluable support was provided by staffers specializing in information technology with expertise in implementation and hospital applications. They were on site throughout December and for the critical period just after implementation. Both the old and new systems were in use for one month before the January 1 launch.

Implementing a massive information system change in a way that is virtually seamless for users and patients is a major task. But the new system's flexibility has demonstrated that the pains of transition were well worthwhile.

Roseann Tambone is executive director of professional services for Kessler Professional Services. She can be reached at rtambone@kessler-rehab.com.

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