Maximizing recovery after joint replacement surgery

BY ELINOR ANAN, M.D.

FOR PATIENTS who undergo a joint replacement procedure, there are several post-surgical treatment options: discharge to home or transfer to either a nursing home’s sub-acute program or an acute inpatient rehabilitation hospital or unit (IRH/U). Yet changes in federal health care payment policy and the insurance industry have contributed to a declining number of IRH/Us that treat these individuals.

Kessler Institute for Rehabilitation, however, continues to provide services for appropriate persons within this population when hospital-level rehabilitation is the better alternative. Those suitable for such a program should meet two criteria: having one or more co-morbid conditions that make their post-operative care medically challenging, and having the ability to tolerate the demanding physical and occupational therapy regimen—three hours daily for five days a week.

Confronting Co-morbidities

Most joint replacement patients undergoing rehabilitation have had hip or knee surgery, or, less often, shoulder procedures; some have had multiple joints replaced at the same time. The existence of one or more co-morbidities potentially complicates convalescence. Coronary heart disease is by far the most common condition, and stroke and other cerebrovascular illnesses are second in frequency.

In the IRH/U setting, a physiatrist serves as the attending physician and oversees the patient’s medical and rehabilitation program with visits at least once a day. Additionally, the physiatrist pays close attention to pain management, coordinating appropriate medical care with the therapy schedule to allow individuals to optimally participate in and benefit from their course of rehabilitation. Nurses also help to arrange the treatment plans and medication administration, combining these services with training and a care protocol designed to rapidly restore functional independence.

In addition to physiatrists, practitioners in other disciplines routinely are involved in the patient’s treatment when there is a specific need, including internists, psychiatrists, psychologists and pulmonologists. The core program of intense (continued on page 7)
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Maintaining motivation in challenging times

ADVOCATING FOR PERSONS with disabilities (PWD) requires energy and resolve to overcome the many, often recurring, obstacles. From a historical perspective, rehabilitation initially developed as a field through the impact of wars, medical advances (e.g., antibiotics) and political efforts. Physical medicine and rehabilitation (PM&R) evolved through advocacy by innovative physicians, including our founder, Henry Kessler.

These early advocates understood that PWD were frequently ignored—even mistreated—by the medical community and society at large. Health care advances allowed many World War II troops to survive combat injuries, but often with severe impairments. About the same time, polio epidemics seemingly targeted young, active and affluent people. Both populations’ expectations of functional independence influenced medicine and their communities.

Their motivation, coupled with the physicians’ support, launched the medical rehabilitation team approach. These hospital-based teams concentrated on maximizing patients’ abilities, and events of the times amplified their crusade. The contemporaneous civil rights movement, although focused on race, had implications for PWD. Later, the 1973 Rehabilitation Act and the 1990 Americans with Disabilities Act provided legal footing. At the same time, the nation’s youth were coming of age politically. Their 1960s ethos energized the country around advocacy—opportune for the field’s development.

As Washington accelerated health care investments in the ‘60s, rehabilitation physician-advocates were well positioned within government. Their efforts helped create the National Institute on Disability and Rehabilitation Research, and later, NIH’s National Center for Medical Rehabilitation Research.

As the field grew, its advocacy capacity increased through professional and provider organizations such as the American Academy of Physical Medicine and Rehabilitation, the American Congress of Rehabilitation Medicine, the Association of Academic Physiatrists and the American Medical Rehabilitation Providers Association. Similarly, organizations such as Easter Seals and Paralyzed Veterans of America found common voice through vehicles like the Consortium for Citizens with Disabilities.

As PWD have made significant progress in the civil rights arena, advocates have focused on economic and regulatory barriers to accessing care. Given that Medicare and Medicaid account for approximately 70 percent of inpatient rehabilitation expenditures, current ideological and fiscal struggles threaten the viability of inpatient rehabilitation hospitals or units.

As the relentless cry “we can’t afford it anymore” reverberates throughout government, potential and enacted Medicare cuts—targeting reimbursements for care or access to rehabilitation hospital-level services—imperil medical rehabilitation’s existence. An example is the proposal to reinstate the 75 percent rule. In 2007, advocates invested tremendous resources to enact a law securing the “permanent” 60 percent threshold. Potentially reopening this old policy wound takes advocacy-related frustration to new heights.

Given these onslaughts, how can supporters re-energize? If we continue making moral medical decisions—providing patients with services in appropriate settings with properly trained staff from the outset—we will reinforce our resolve. And, by supporting professional organizations we will meet like-minded people to share work, engage the next generation and celebrate our occasional successes. Looking back at 75 years of progress on behalf of PWD can help us face the battles in the coming years.

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IN MEDICINE, the adage about the pen being mightier than the sword rings particularly true. Beyond today’s technological advances in caring for patients and saving lives, the simple act of proper documentation is one of the most crucial tools in preventing serious, even potentially fatal, errors.

First and foremost among the essential components of documentation is legibility—a seemingly obvious but woefully overlooked detail. In addition, chart notes must be inclusive of all relevant, patient-specific information. History and examination findings should be meaningful, relevant and the foundation for patient care. Examples include medical and family histories; rationale for treatment decisions; administrative matters, such as release of information and consent forms; and detailed admission and discharge summaries.

A Complete Picture
It is especially important that information not be regarded in isolation. Rather, material should be integrated in a meaningful manner such that content provided by different clinicians, within myriad settings and across various time points ties together—painting a picture that is thorough, accurate and informative.

At its most basic level, documentation is a communication tool to support diagnosis, treatment provision and outcome tracking. But it also serves as a multifaceted method for demonstrating medical need, justifying intervention, and assisting a variety of stakeholders, such as third-party payers, in their respective duties.

Among the parties interested in principles of documentation are regulatory and oversight groups, including the Centers for Medicare and Medicaid Services (CMS). For these bodies, documentation plays a central role in assessing whether health care organizations are complying with regulatory and performance guidelines—the need to ensure that hospitals are providing appropriate and effective care.

Standards for Rehabilitation
Rehabilitative care is conducted in multiple environments, including inpatient, outpatient and at-home, by a spectrum of providers—for example, physiatrists, nurses, physical therapists, occupational therapists and psychologists. This underscores the need for documentation that extends beyond general medical components to include functional and rehabilitation needs of the patient. For instance, goal-setting helps the treatment team predict length of stay in acute settings, determine suitability of the plan of care, pursue and achieve meaningful outcomes, and more accurately track progress by informing the use of appropriate measures.

In early 2010, CMS revised its expectations for documentation in rehabilitation. Among these requirements is the inclusion of comprehensive screening evaluations for pre-admission decisions, which must indicate the justification for rehabilitation hospital care. Also, within four days of admission, preparation of an individualized overall plan of care with detailed therapy needs, prognosis, anticipated functional outcomes and discharge destination must be completed. Interdisciplinary team conference documentation should demonstrate progress toward patient care goals, strategies for problem solving, and reassessment of the treatment plan as needed. Finally, documents must reflect the occurrence of at least three face-to-face visits per week by the rehabilitation physician.

Setting the Bar
High standards for documentation in rehabilitation settings are directly related to consistent use of best practices and delivery of quality care; in other words, documentation drives practice. At Kessler Institute for Rehabilitation, this was evident in a recent project to reduce avoidable hospital readmissions. As practitioners were expected to refine documentation of changes in patients’ conditions, more frequent and thorough medical assessment and monitoring occurred, resulting in improved care for patients with a concerning change in condition and a markedly reduced rate of acute care transfers (i.e., hospital readmissions).

Establishment of norms alone, however, is not sufficient to bring about persisting and meaningful improvement; education and training optimize the impact of proper documentation. Furthermore, continuous, systematic chart monitoring through self-, peer, and administrative audits promotes quality control. And while adherence to standards serves as a role model for trainees and colleagues, it also ultimately helps save time, money and even lives.
Best practices for ethical and effective recruitment of clinical study participants

Q&A WITH NEIL N. JASEY, JR., M.D., AND IRENE WARD, P.T., DPT, NCS

PATIENTS ARE the backbone of clinical research, which helps drive advances in risk and prevention, diagnosis, treatment, drug development, and more. Researchers responsible for enrolling study participants face the dual challenge of ensuring that recruitment is sufficiently productive to maintain the viability of the project, and at the same time protecting the best interests of the individuals who may take part. Furthermore, an extensive set of national and institution-specific guidelines dictate what is and is not permissible when asking patients to join.

To help investigators navigate this complex area, Focus on Rehabilitation spoke with Kessler Institute for Rehabilitation’s Neil N. Jasey, Jr., M.D., director of Brain Injury Rehabilitation, and Irene Ward, P.T., DPT, NCS, brain injury clinical research coordinator.

Focus on Rehabilitation: Why is the recruitment process such an important part of clinical science and how does joining a study benefit patients?

Neil N. Jasey, Jr., M.D.: Research influences clinical practice and, conversely, clinical practice shapes research. An investigation that is performed using individuals with certain clinical and demographic characteristics can be more easily generalized to the treatment of larger groups of people with similar clinical and demographic traits.

For investigators, recruitment is key to launching a study and keeping it running in a timely manner. For patients, the process is really their first exposure to the project and members of the research team, so it sets an important tone. It is also the phase in which they first learn how participating might be advantageous. There are many challenges to consider and control for, but the benefits to improving the quality of the care provided far outweigh those challenges.

Irene Ward, P.T., DPT, NCS: And while the participants may not always feel an immediate or noticeable benefit from being involved, my experience has been that individuals are often hopeful

A MODEL FOR THE FIELD

Numerous studies are under way at Kessler Foundation, and one of the most notable is the Traumatic Brain Injury (TBI) Model Systems project, led by Nancy D. Chiaravalloti, Ph.D., and Neil N. Jasey, Jr., M.D., as well as Jordan Grafman, Ph.D., head of the TBI Research Lab at Kessler Foundation. Generously funded by the National Institute on Disability and Rehabilitation Research, these studies are designed to improve the care of individuals with TBI throughout the country. Current investigations are focused on improving cognitive outcomes associated with TBI (for example, memory); developing a measure to better assess quality of life in those who experience TBI; and examining the frequency of sleep disturbance in patients to determine whether intervention on these symptoms is warranted.

For information about these and other active studies at the Foundation, call 973-324-8362 or email info@kesslerfoundation.org.
that their participation will benefit future patients, if not themselves.

**Focus:** What are some essential aspects of appropriate and effective recruitment?

**Ward:** Any study involving human subjects is required to be reviewed and approved by the Institutional Review Board (IRB) prior to its start. The IRB ensures that research participants are treated ethically and safely.

One of the most important yet basic components of recruitment is use of an IRB-approved consent form that states clearly and simply myriad factors. These include the purpose of the study, the expected duration, procedures, potential risks or discomforts as well as possible benefits, alternatives to participating, and the ways in which protected health information will remain confidential throughout and following the close of the project. In addition, financial costs to the participant, payment or other compensation for involvement, and medical therapy for study-related injury must also be discussed during recruitment. It is vital that people understand their right to refuse or withdraw and whom to contact in case of questions or concerns.

All of this information as a whole comprises what is known as “full disclosure” and should be completely explained by the IRB-approved consent form.

**Jasey:** Given the amount of information that needs to be communicated, it is particularly important that clinicians take their time in explaining everything thoroughly. Also, in rehabilitation settings specifically, people are often in inpatient rehabilitation for unexpected reasons, such as stroke, spinal cord injury, brain injury, or orthopedic surgery due to a fall. They may still be adjusting physically as well as emotionally to their new circumstances, and for that reason may feel vulnerable or pressured to participate. It is not unusual for people to need extra time to think about and discuss the matter with their family.

Therefore, investigators should make sure patients have their contact information and a copy of the consent form for them to review so that they have adequate time and opportunity to fully consider their decision. The research team also needs to maintain communication with the treatment team, particularly with the patient’s physician, who will likely need to clear the individual for participation.

**Focus:** How does the Health Insurance Portability and Accountability Act (HIPAA) factor in recruitment?

**Ward:** HIPAA dictates standards for maintaining privacy and confidentiality during the recruitment process. Researchers must ask participants for permission to use any protected health information—content that can be readily linked to identities, such as names, Social Security numbers or even email. Protected health information must be de-identified (for example, by using random numbers rather than names to represent patients in databases) and stored in a protected manner (such as an encrypted computer file) for confidentiality.

Only individuals identified on the HIPAA authorization form—for instance, the principal investigator—can have access to this information. A HIPAA authorization form must be signed for a patient to participate in a research study.

**Focus:** What about making patients aware of downsides to participation?

**Jasey:** Any study may certainly carry a potential risk or risks, and whether minimal or major, researchers need to clearly explicate possible dangers during the consent process. The person should be informed of less obvious “risks,” such as cost of transportation if the individual is outpatient and will need to travel to the study site.

**Focus:** What role do patients’ families play?

**Ward:** It is up to the patient as to whether he or she wants to involve family or friends in the decision to join a study. Individuals may wait to consent to participate until they speak with their family. In addition, some people have cognitive or language deficits relating to their injury, in which case a spouse or domestic partner may need to provide surrogate consent.

**Focus:** What are some simple yet sometimes overlooked aspects of ethically recruiting participants?

**Jasey:** Be cognizant of your own communication style. That is, give accurate information but avoid using medical or research terminology, which can be confusing. Provide reassurance that they can withdraw from the study anytime and that participation is strictly voluntary (and will not impact their care, should they choose to decline).

And while it may seem obvious, the same basic courtesies one would expect to be involved in any patient interaction are equally important in clinical research. Be respectful and considerate of their time, always introduce yourself and ask if this is a good opportunity to speak, and don’t forget to thank them.

These may be seemingly insignificant steps, but they send a powerful message that lets patients know how valuable they are to the science, practice and future of medicine.

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WASHINGTON HAS BEEN introducing innovative health care reimbursement models, generating new concerns for physical medicine and rehabilitation (PM&R) providers. With despair about the economy and contention over entitlement programs, some have urged reducing Medicare reimbursement for rehabilitation—even though it accounts for only 1.3 percent of all program expenditures. And despite inpatient rehabilitation hospital or unit (IRH/U) costs being the lowest of all post-acute care institutions, plans are afoot to make disproportionate reductions in this medical sector. Any cuts loom large as Medicare accounts for 55 to 60 percent of the field’s total funding.

Government officials have recommended permanently freezing Medicare market basket updates, superimposing them on Affordable Care Act (ACA)-mandated reductions. Another plan, site-neutral payment, equates IRH/U services with those of skilled nursing facilities. Because rehabilitation hospitals provide vastly different care under very different regulations, this concept ignores their qualitative and quantitative obligations. Additional troubling potential modifications include:

- Potentially extending value-based purchasing to IRH/Us. This would subject them to financial liability for excessive subsequent acute care hospital admissions similar to penalties currently imposed on the latter.
- Prospective Medicaid changes also pose considerable risk for our field. Because most states are struggling with sizable deficits, they use their decision-making latitude to either reduce reimbursements or revise eligibility criteria. Another approach, pushing recipients from fee-for-service benefits into managed care plans, saves money by denying coverage—sometimes after pre-approving it. Unfortunately, states are also instituting RAs, putting providers at profound financial risk.

There are new programs on the scene. The ACA-mandated public insurance plans will establish essential health benefits. Recently, the administration announced its intention to base each state’s program on its biggest insurers, permitting tremendous variation among them. Experience suggests that this could create a new population of inadequately covered people—upward of 25 million. Other innovations such as Accountable Care Organizations, the bundled payment initiative and medical homes may dramatically alter some medical landscapes by the financial incentives to divert referrals from IRH/Us.

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Soon, the Supreme Court will judge the health care law’s constitutionality. If it hands down an adverse ruling, we will face the worst scenario imaginable: diminished benefits, a reduced number of insured individuals, decreased reimbursement and increased regulatory burden. Whether Congress introduces new major Medicare and Medicaid reductions or just allows the $1.5 trillion in sequestration cuts to go into effect, the financial impact threatens the viability of smaller, rural IRH/Us—jeopardizing a third of our capacity nationwide.

Our priority is providing the best health care in a cost-effective way. Some ACA proposals incentivize care coordination—clearly not well done in today’s world. All PM&R patients can benefit from earlier identification, improved transition management and enhanced continuity of care.

Although the new rules and constructs are daunting, they also present opportunities. Now is the time to partner with bundlers, home health agencies and nursing homes to create networks for directing patients into the right settings; educate our existing and prospective referral sources; explore affiliating with traditional competitors; and, on behalf of persons with disabilities, advocate to Congress, the White House and Medicare.

Most important, we should support responsible change that preserves rather than dismantles fundamental values and services. If we work with the broader health care community, we can rationalize care instead of competing for it. It’s the only way to meet these challenges, and now may be our best opportunity.

**BY BRUCE M. GANS, M.D.**
Recovery after joint replacement surgery
(continued from page 1)

physical and occupational therapies is delivered in a coordinated manner through daily team huddles and weekly team conferences.

As a result of these high-level practitioners collaborating in a multidisciplinary fashion, the typical length of stay for patients is as short as seven to 10 days. In contrast, the national statistics for length of stay for people cared for in a skilled nursing home program are typically 20 to 30 days—two to three times the duration in an IRH/U environment.

Specialized Therapies
The goals for elective replacement—namely relieving pain, regaining joint efficiency and improving function—require tailored post-operative rehabilitation. Patients who convalesce at home are usually limited to three sessions of physical therapy weekly, and those in skilled nursing homes typically receive 45 to 90 minutes a day. Compared with these alternatives, an IRH/U’s rigorous regimen of physical and occupational therapies results in both shorter stays and greater degrees of functional recovery.

While physical therapists concentrate on restoring or preserving range of motion, strength and mobility, occupational therapists focus on recapturing activities of daily living—dressing, bathing and toileting. They teach the proper use of adaptive devices such as walkers, crutches, canes and commodes, as well as proficient transfers in the bedroom, bathroom and car. An IRH/U will also provide additional therapeutic services including recreation therapy to guide individuals in activities that support motor and reasoning skills while enhancing their emotional well-being, and speech and language therapy to help with articulation and swallowing difficulties for patients with relevant co-morbidities.

Preventing Complications
Beyond offering therapeutic resources, an IRH/U stay is valuable in avoiding post-operative complications.

Orthopedic surgery and prolonged immobility place individuals at high risk for deep vein thromboses (DVT)—most often in the legs and pelvic region—a third of which travel to the lung and become pulmonary emboli. Pulmonary embolism is associated with a mortality rate as high as 40 percent, so it is extremely valuable to provide preventive care and close surveillance for any incipient thrombosis formation. Acute rehabilitation hospital staff are alert for DVT signs and symptoms, and they assist patients with moving about, a key protective measure. Inpatient rehabilitation hospitals should have Doppler ultrasound technology readily at hand to immediately detect the condition and speed early diagnosis if a thrombosis does develop.

IRH/Us should have protocols in place to prevent and monitor for hip joint dislocation after a hip replacement procedure. Further, wounds are vulnerable to infection, especially in patients with diabetes, so checking wound status and closely managing diabetes are important preventive services to be offered.

Taking the Next Step
The inpatient rehabilitation goal is to discharge people home rather than to continue on to a skilled nursing home. To do so, and in preparation for discharge, each patient’s case manager will ascertain that all necessary equipment—specialized beds, mobility assistive devices, shower or tub seats, and the like—is ordered and delivered to the home. The case manager also schedules outpatient therapies.

For individuals who have had a joint or joints replaced, especially those with co-existing illnesses, the benefits of IRH/U care are measured by superior clinical outcomes that are achieved more quickly than in other settings, and by more complete joint function with complication-free recoveries.

JOINT ACTION
According to the Centers for Disease Control and Prevention, hip and knee replacements are among the most common U.S. surgeries. The predominant underlying cause is osteoarthritis—affecting 50 million Americans from 2007 through 2009. Arthritis prevalence is expected to rise because of the nation’s aging and increasingly obese population.

Not surprisingly, current trends project that during the next two decades, hip procedures may surge 175 percent and knee surgeries 600 percent.

In the 2007 National Health Interview Survey, an evaluation of adults with arthritis indicated that 47 percent had one or more co-morbidities—the four most common being:
• Heart disease: 24 percent
• Chronic respiratory conditions: 19 percent
• Diabetes mellitus: 16 percent
• Stroke: 7 percent

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The future of prescribing for pain management in the digital age

BY JOSEPH P. VALENZA, M.D.

Electronic Prescribing

Electronic prescribing refers to sending computer-based prescriptions from the point of care directly to a pharmacy, promoting accurate, readable and error-free communication, according to the Centers for Medicare and Medicaid Services (CMS). Seen by CMS as an important part of improving the quality of patient care, this technology is a key element in the government’s initiative to establish a national electronic health information system. Nationally, more than 90 percent of retail pharmacies now are receiving e-prescriptions.

A Special Case

Requirements for e-prescribing are fairly straightforward for most drugs, but controlled pain medicines are a special case. Were these medications treated no differently than antibiotics, hackers potentially could intervene and divert prescriptions, compounding an already pressing public health problem. The number of Americans 12 and older abusing pain relievers in 2009 increased by 20 percent compared with 2002, according to the Substance Abuse and Mental Health Services Administration.

In June 2010, the Drug Enforcement Administration (DEA) revised its regulations so that practitioners have the option of e-prescribing controlled substances. The regulations also allow pharmacies to receive, dispense and archive e-prescriptions. Currently, the information technology industry is developing and testing applications implementing DEA requirements, and therefore, controlled drugs still are handled with traditional methods.

Control Measures

Preliminary information suggests that to defend against hackers and other security breaches, medical providers will be required to use simultaneously two out of three distinct means of positive identification: (1) a password, (2) a biometric marker or (3) a physical object unique to that prescriber, known as a “token” and recognizable by a computer interface. The federal program should reduce abuse and diversion of prescription medications, as well as improve the ability to overview all drugs currently used by a patient.

Unknown is whether the e-prescribing of pain medications will lead to increased physician anxiety about law enforcement officials scrutinizing prescription of controlled substances. If so, this might exacerbate the serious problems linked to the undertreatment of pain. In the context of rehabilitation medicine, several recent studies have shown poor acute pain management to be associated with delayed ambulation, shortened or missed rehabilitation sessions, decreased quality of life, increased cost of care, and potential progression from acute to chronic pain.

Preventing abuse and diversion of controlled substances is extremely important. E-prescribing is another tool that should help reduce some of the risk of prescribing controlled substances, allowing clinicians the use of these medications to enhance their patients’ functional recovery. Once appropriate technology for these drugs is ready for use, Kessler Institute for Rehabilitation will implement it for the benefit of its patients.

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