FOCUS ON
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Recent advances in prosthetics are putting people back to work

> BY SHAILESH PARIKH, M.D., M.S., AND JOSEPH REDA, CPO, LPO-NJ

Imagine being an automobile mechanic who can no longer grip a socket, or an artist who loses the ability to hold a brush and palette. The fine and gross motor movements of the upper limbs are something most people never think about.

But for individuals with upper-extremity amputations, such capabilities are not taken for granted, especially when it comes to work performance. Fortunately, one particular type of technology is changing the world of prosthetics and helping patients return to their jobs with results that are, in a word, electrifying.

The Body Electric
Body-powered prostheses control limb function using a harness that fastens around the shoulder and upper body, allowing movements, such as shrugging the shoulder, to mechanically activate a prosthetic hook, hand or elbow. In contrast to this, myoelectric prostheses use electrodes that pick up EMG signals generated by muscles selected as control sources. These signals are then transmitted to microprocessors that manage the device’s motors, creating purposeful, active movement.

While traditional body-powered prostheses have helped those with upper-extremity loss perform everyday tasks like pushing, pulling and grasping, myoelectric models are more advanced and facilitate more precise movements. This in turn can help individuals regain vocational abilities.

Although myoelectric limbs are not new, the types of technology available are rapidly evolving. Today’s advanced electric-powered limbs are more sensitive, and capable of detecting signals from weak muscles. Prosthetic hands are now available with an opposable thumb and active individual fingers.

Additionally, the component parts and batteries have become smaller and lighter. Water-resistant features are being developed so that the limb can (continued on page 7)
The valuable role for PM&R in the coordination of care

ESSENTIALLY ALL HEALTH CARE reform dialogue affords marquee status to “coordination of care,” especially that emphasizing cost containment. An article by Berwick and Hackbarth in the April 11, 2012, Journal of the American Medical Association identifies it as one of six categories in which waste can be mitigated; the remaining five are overtreatment, care mistakes, fraud and abuse, pricing errors, and excessive administrative complexity. The lowest estimates of their collective burden exceed 20 percent of all sector expenditures and, in 2011, coordination failures alone cost between $25 billion and $45 billion.

Given these concerns, the current policy climate warrants a close examination of health care system function from prevention through all the subsequent stages. Two phenomena become apparent: the many junctures at which care coordination comes into play and an opportunity for physical medicine and rehabilitation (PM&R) to envision the patient’s total care trajectory.

Both inter- and intrafacility transitions have inherent continuity gaps creating potential safety and quality risks. Whether it is the paramedic relegating responsibility to the EMT who then hands a person over to emergency room nurses; an ER physician admitting the individual to a hospitalist’s service; or rotating shifts of nurses and technicians—each personnel change and patient interaction poses some risk. More to the point, they offer countless ways to inaccurately communicate vital information. Important details can be lost and mistaken observations conveyed.

We in the rehabilitation sector focus on the entire patient journey and are very concerned about the multi-institutional path of complexly ill people. The acute care world does virtually no contingency planning; their decision-making is situational. Too often, they fail to consider patient trajectories until they have stabilized. And discharge planning may begin shockingly late. Physicians rarely contemplate a person’s post-acute care needs until they run up against hospital criteria mandating discharge or transfer. At this point staff may involve the rehabilitation community, either in consultation or as a destination. Because PM&R clinicians consider the entire process, their earlier inclusion would clearly benefit the acute-focused team that, whether because of time constraints or a collective mind-set, administers moment-to-moment care without a long-term strategy.

Continuity then enters a new realm as decision-making rests with patients and their families. Too often, discharge planners offer post-acute options that patients and families find unfamiliar and complex in nature. Lacking guidance and lead time, few people are properly informed or psychologically and emotionally prepared to make immediate yet important decisions. And whereas hospital personnel might prioritize expertise in selecting a post-acute setting, family members may need to also consider facility cost and proximity.

Implementing coordination projects and bundled payment initiatives creates both a need and an opportunity for physiatrists and other PM&R staff to help reform health care delivery. For if we can engage much earlier in a person’s care episode, we can provide a missing but critical component—a long-term perspective so essential when caring for those with complex, continuing needs.

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Matters of the mind: Cognitive rehabilitation’s effects on dementia

BY KELLY A. KEARNS, PSY.D.

REHABILITATION IS OFTEN mistakenly thought of as providing a cure for a given disability or injury. But by definition, it involves helping individuals achieve optimum well-being despite the presence of physical problems or functional deficits, not necessarily to achieve disease-free states.

This distinction is particularly relevant for those who are diagnosed with neurodegenerative disorders such as Alzheimer’s disease and other types of dementia, where symptoms may never remit and inevitably become worse over time. For these patients, living a full, healthy life is still relevant and, thanks to cognitive rehabilitation, still possible.

Understanding the Problem
The focus of rehabilitation for a person with dementia is on optimization of functioning and enhancement of quality of life for both the patient and family. This cannot be accomplished, however, if treatment is concentrated solely on the primary disability while ignoring the dementia. Individuals with dementia have many complex challenges, ranging from cognitive decline; swallowing difficulties; psychological disturbances, including depressed mood; social impairments; mobility problems; and increased likelihood of falls.

Furthermore, most patients also face issues related to the normal aging process, such as comorbid medical illnesses. The complexity of these needs underscores the importance of using a holistic and interdisciplinary approach to care, with the inclusion of geriatricians, physiatrists, neurologists, neuropsychologists, pharmacists and multiple rehabilitative therapists. Rehabilitation settings are typically designed to address such complicated needs and provide multidisciplinary staff, making dementia care both necessary and viable.

Treatment can be addressed on an inpatient or outpatient basis, depending on the extent of the primary disability as well as the progression of the dementia. A plan that addresses everyday, personally relevant problems—for example, keeping track of personal belongings—will prove the most useful. Broader goals focused on helping individuals resume previously enjoyed activities, adopt new pursuits or increase social contact are also particularly beneficial.

Since symptoms are progressive, it is imperative that goals be easily modifiable to be consistent with the disease trajectory. For instance, early to-moderate dementia rehabilitation may focus more on teaching compensatory memory strategies, engaging the person in conversation, providing stimulating activities, enriching the environment and managing problematic behaviors like aggression. In contrast, therapy for later stages may need to shift the focus to maintaining mobility or reducing pain.

A final essential element of rehabilitation is involvement of the family and/or caregiver. An emphasis on instruction allows for generalization of learned information from the hospital setting to the home or community environment. Also, this step creates a collaborative relationship between the patient, family and treatment team.

Person–Centered Care
The Dementia Program at Kessler Institute for Rehabilitation is designed to assist individuals with dementia or mild cognitive impairment in utilizing their preserved abilities to optimize well-being. Led by a neuropsychologist, the interdisciplinary team consists of speech therapists, occupational therapists and a nurse case manager. The priority is providing care centered on the person, employing evidence-based techniques in the areas of cognition, behavior management and socialization.

Additionally, treatment requires caregiver instruction and significant involvement, ranging from 50 percent to 100 percent, depending on the patient’s needs. The program is limited to four weeks and designed to supplement other therapeutic activities, with the aim of developing a functional maintenance plan. Referrals to community and other resources are provided. During the program, occupational therapy may address home/community safety issues, wandering, disorientation, environmental modifications, stress management, identification of meaningful activities, fall prevention, and health and wellness. Speech therapy will assist in teaching communication and memory strategies. With a dedicated focus on setting personalized goals and monitoring achievements, the Dementia Program offers these individuals the same important opportunity that all patients at Kessler are entitled to—the opportunity to maintain quality of life.

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An inside look at a successful program to reduce acute care transfers

Q&A WITH BRUCE POMERANZ, M.D., MMM, AND PASQUALE FRISINA, PH.D.

EARLIER THIS YEAR Kessler Institute for Rehabilitation was honored to receive the 2012 Excellence in Quality Improvement Award from the New Jersey Hospital Association. The recognition was for a Kessler initiative that focused on acute care transfers (ACTs) and was the only distinction given to a post-acute organization for a program that enhanced both health care quality and patient outcomes.

The Kessler effort was developed and implemented as a proactive risk assessment (PRA). PRAs, a Joint Commission requirement, are intended to bring about better outcomes for at least one high-risk process and ultimately to increase patient safety. The PRA was established in the first quarter of 2011 (January–March), and one year later (quarter one of 2012) the ACT rate had significantly improved by 18 percent overall. There were also significant decreases across each Kessler campus when compared with the start of the PRA project in 2011 (see figure). Additionally, the largest change in transfers to date has been observed in the stroke population, which saw a 22 percent drop from last year.

To gain insight into implementation of the program and the impact it has had, Focus on Rehabilitation spoke with Bruce Pomeranz, M.D., MMM, medical director at Kessler and chief quality officer for rehabilitation for Select Medical, and Pasquale Frisina, Ph.D., Kessler’s director of Research & Quality Management.

Focus on Rehabilitation: Why are ACTs important to quality and outcomes?
Bruce Pomeranz, M.D., MMM:
Intrinsically, the mission and purpose of rehabilitation is to restore functional independence while providing high-quality medical care that prevents adverse events, returns individuals to health, reduces the risk of recurrence and integrates people back into their home and community setting. Fewer transfers improve the effectiveness of patient care and have the added benefit of reduced cost.

Pasquale Frisina, Ph.D.:
ACTs are important to both the patient and stakeholders. The Centers for Medicare & Medicaid Services (CMS), insurers and other payers like to see a low ACT rate because each transfer adds to the economic burden.

Focus: How is a person affected when his or her rehabilitation is interrupted by a hospital readmission?

Pomeranz: The event places an individual a step back in the progress toward recovery. Both patients and caregivers will commonly express concern when transfers occur. Sudden discontinuation of the rehabilitation program tends to impede functional progress and is emotionally discouraging.

Focus: What trends in ACTs were being tracked prior to the PRA?

Pomeranz: Historically, Kessler ACTs appeared to trend in conjunction with patient acuity. In 2002, with a case-mix index (CMI) of 1.07, ACTs were at about 11 percent. However, as the CMI increased in 2010 to 1.32—high numbers mean greater acuity—the ACT rate increased to 15 percent. Furthermore, information from 2010 showed that ACT rates at Kessler, independent of acuity, were above our established benchmarks.

Focus: What methods are used in the program?

Frisina: Six Sigma methodology was utilized to proactively develop the PRA plan. Initially, the multidisciplinary team was challenged with the fact that historical ACT data was not truly quantitative. With this in mind, we created a mandatory Case Audit Transfer form that would explain the reason for every ACT and allow for the collection of both qualitative and quantitative data that can be analyzed at the aggregate and individual case levels. While the team prepared for resistance to this new documentation requirement, we were pleased to achieve nearly 100 percent compliance.

MISSION POSSIBLE: 2013 QUALITY SUMMIT

In spring 2013, Kessler Institute for Rehabilitation and the Inpatient Rehabilitation Division of Select Medical will host a national Quality Summit focusing on improving patient safety and quality outcomes. This program is thought to be the first quality summit dedicated specifically to the field of medical rehabilitation. It is anticipated that the summit will establish a baseline definition for safety and quality indicators, review public policy issues, and share analytic methods and techniques. Participants will discuss studies on clinical applications and outcomes from both a population-specific perspective as well as their applicability to the general population. Trends in advanced evaluation methods and preventive care will be highlighted. The summit, still in the planning phases, will be held in Washington, D.C.
Pomeranz: Details on ACTs are now tracked according to the physician and nursing unit involved. Information on physicians caring for different patient populations is adjusted for medical complexity. Both physicians and nursing units get a nonpunitive monthly score card that compares their ACT rates to others within the organization. This has heightened awareness among the clinical staff and identified opportunities for training and quality improvement.

Focus: What other outcomes have been impacted?
Pomeranz: We were very encouraged to see two other measures have improved favorably: the rate of patient discharge to the community and functional status as determined by the Functional Independence Measure (FIM). The change in FIM, from admission to discharge, has shown an exciting proportional increase in both FIM and community discharges.

Focus: Were there any other benefits observed as a result of the PRA?
Pomeranz: Several unanticipated benefits were noted after implementing the Case Audit Transfer forms. The information provided detailed insight into the issues and clinical decision-making surrounding transfers and helped to identify additional opportunities for improvement. The forms also served as a framework to guide clinical practice. By having to complete them, clinicians learned to articulate their thinking and ensured that the proper steps were taken to achieve expert diagnostic assessment and management prior to transfer. Clinical leaders meet and review the forms to investigate gaps and opportunities. Lastly, the more complete data has allowed for a comprehensive analysis of outcomes and trends.

Frisina: The PRA was rolled out in a sequential fashion, adding one campus at a time with the West Orange campus last. Between the robustness of the data analysis and the results from each campus, the model appears to be generalizable, which means that it has external validity. This provides the opportunity to expand the concept to other facilities and raise the bar for health care to meet a new level of quality.

Focus: Is there any new legislation that will impact patient outcome programs?
Pomeranz: The Affordable Care Act has established a quality reporting program that applies to rehabilitation hospitals. Starting in autumn 2012, quality data related to acquired pressure ulcers and catheter-associated urinary tract infections must be periodically submitted to CMS. Data related to acute care transfers and hospital readmissions will continue to be indicators of increasing interest to a broad spectrum of stakeholders.

Focus: What are the next steps?
Pomeranz: This program heightened awareness of the need for excellent clinical assessment, treatment and documentation when a patient develops a concerning medical condition. With that in mind, we just implemented a program for documenting baseline mental status evaluations for all individuals within the first couple of days of admission. This allows us to quantifiably evaluate changes in mental status to utilize for clinical decision-making and to provide valuable information to receiving institutions when transfer is necessary.

Frisina: Our findings should be made available to other health care providers as a model to improve patient care. We would like to have our work published and would be proud to know that we have established a new benchmark of parameters for the safety of patients in rehabilitation centers.

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Bundled payment initiatives: Health care from a business perspective

BY BRUCE M. GANS, M.D.

THE CENTERS for Medicare & Medicaid Services recently awarded both standard and advanced (Pioneer) accountable care organization (ACO) designations to several dozen entities nationwide. As a health care reform mandate, this highly anticipated model is becoming a reality.

In a separate program, Medicare’s Center for Medicare & Medicaid Innovation (CMMI) has invited providers to respond to its bundled payment initiative (BPI). Respondents must propose approaches based on whether the services provided are acute and/or post-acute, and on payment—retrospective adjustment or prospective fee.

From the number of submitted letters of intent, the agency anticipates being inundated with final applications. Although these projects only involve Medicare fee-for-service patients, the health care industry is exploring such innovations for other payers as well.

Encouraging Efficiency

As a specialty, physiatrists must determine their role in these bundled systems, and as a field, the nation’s 1,100 inpatient rehabilitation hospitals or units (IRH/Us) must also find their niche. Because 900-plus units belong to existing or potential ACOs, these “insiders” will ideally organize their respective care delivery systems to maximize their clinical contribution.

The more than 200 free-standing rehabilitation hospitals vary in their relationships with referring institutions. Roughly half are owned, operated or joint-ventured by a hospital or health system, and the rest are independent. These latter IRH/Us may partner with, but not be part of, any provider system. Both free-standing types must educate their referral sources about identifying which patients will need rehabilitation, the ideal transition time and the appropriate rehabilitation venue. Deploying physiatrists into acute care settings, such as emergency rooms or intensive care units, early can facilitate these determinations.

Broadening the concept of the “episode of care” is essential for a successful bundled payment model. By accepting responsibility for more than a patient’s institutional experience, providers are accountable for treatment consequences over an extended period. This forces them to superimpose a long-term strategy on acutely focused clinicians and systems. Although complex conditions requiring lengthy treatment receive larger payments, such hospitalizations also have more intrinsic variability, complicating expenditure prediction. Longer episodes, including post-discharge convalescence, encourage more comprehensive planning and require extensive care coordination. In contrast to our existing system’s “every silo for itself” mentality, BPIs assume responsibility for all settings, promoting efficient resource use from the outset.

Because disease treatment and recovery can extend beyond a hospital discharge, it is unclear whether these payment models will promote a sufficiently long perspective to influence the care of our particular patients. Since the majority of costs occur during the institutional period, it is a rational starting point for bundling experiments.

In a different view of accountability, Medicare’s value-based purchasing program has intensified acute care hospitals’ interest in avoidable readmissions. Although the financial penalty applies only to a few conditions as yet, the hospital community is generalizing this approach as a broad quality control measure. Rehabilitation hospitals’ performance in this regard should enhance their value to the acute care world.

Continuing Care Hospitals

Another mandated innovative model, the continuing care hospital (CCH), offers promise. Although still theoretical, it is slated for introduction in 2013 as a Medicare demonstration project.

As a specialty, physiatrists must determine their role in these bundled systems, and as a field, the nation’s 1,100 inpatient rehabilitation hospitals or units must also find their niche.

From a referring provider’s perspective, the CCH simplifies care decision-making by offering all three levels of hospital-based post-acute service: rehabilitation, long-term acute, and skilled nursing. The relative ease of coordinating with and budgeting for this model should make it especially appealing to ACOs and other bundled payment recipients.

Medicare’s bundling models—ACO, BPI and the upcoming CCH—hold substantial potential for medical rehabilitation. In an ideal world, providers would share responsibility throughout an entire episode of care, institutional and beyond. Financially incentivizing this approach may make it a reality and, in the process, highlight the value of rehabilitation. Notably, these models will demonstrate with fresh clarity that acute and post-acute providers are interdependent—that they need each other to optimize the economics and the quality of health care.
Recent advances in prosthetics are putting people back to work
(continued from page 1)

function in damp or dusty conditions. Advances in terminal devices have given patients the power to hold objects that are heavy as well as the finesse to lift lighter items without damaging them.

With newer technology, control programs allow clinicians to fine-tune the prosthesis by adjusting the amplification of the EMG signal needed to activate it. Older devices only permitted regulating the sensitivity of the surface electrodes. In some new prostheses, several different grasp patterns can be programmed into the hand.

Continuum of Care
It is best if the physiatrist can be involved from the earliest stages in planning for a patient’s amputation. Having familiarity with the latest prosthetic advances allows him or her to provide critical input to surgeons on the optimal amputation level that will maximize residual limb function—and enables the patient to benefit from the newer designs.

Patients at Kessler Institute’s Amputee Rehabilitation Program work closely with their treatment team to learn about the different options that are available. Selection is tailored to the most appropriate features for the person’s individual lifestyle and vocational goals—a process that helps to build confidence in the ability to perform necessary skills. A carpenter, for example, can benefit from unique terminal devices that better aid with holding a hammer or other tools required in the trade.

Recipients then participate in a program of occupational therapy where they use biofeedback to learn how to control the EMG signals that operate the system and become oriented to its functional benefits and limitations. After receiving the prosthesis, individuals will return to occupational therapy to further optimize its use.

A Success Story
In a recent case that involved a crush injury to the left arm just below the elbow, a Kessler physiatrist consulted with the patient’s surgical team prior to amputation to ensure the best possible outcome. During his rehabilitation at Kessler, the individual was first fitted with a body-powered prosthesis but then advanced to a myoelectrically-controlled powered model.

He discovered that no single prosthesis or terminal device allowed him to accomplish all the tasks required for home, work and leisure activities. As a result, he was provided with two systems: a traditional body-powered limb that has both a hand and a hook, and a myoelectric prosthesis that has i-Limb™ technology and an Otto Bock Greifer. Having access to these four hand options has provided him with greater freedom and flexibility by offering alternatives that can best match a specific task.

While regaining everyday functioning is of obvious importance, preserving one’s vocational abilities is of equal value. Work fosters independence, self-esteem and a better quality of life. Patients often derive great satisfaction from being able to return to gainful employment and from carrying out their job responsibilities. This in turn helps to restore an important sense of productivity and normalcy to their lives.

Clearly, the benefits of myoelectric technologies extend beyond helping to fulfill day-to-day needs. By offering an opportunity to carry on with one’s occupation, these exciting devices are helping treat people from the inside as well as the outside.

BIONIC BREAKTHROUGH
The human hand is among the most complex anatomical structures in the body, with 39 muscles controlling 27 bones. Mirroring this complexity, advanced prosthetic devices using microprocessor-controlled hand technology are offering more lifelike options.

With this development, each individual digit contains its own motor, powertrain and load system—allowing every finger to articulate independently and bend at the natural joint with greater versatility. This in turn facilitates an impressive variety of specific and nuanced movements necessary for numerous vocations and activities, such as typing with greater precision, gripping and turning a key, holding a credit card or using an iron. Furthermore, use of software that communicates with the hand through a Bluetooth connection allows the devices to operate wirelessly.

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How expanding programming can meet the evolving needs of patients

BY LORAN VOCATURO, ED.D., ABPP (RP)

DEVELOPING CLINICAL programs through a comprehensive multidisciplinary team model provides an evidence-based approach to target specific patient needs. It establishes a mechanism to maintain quality and effectiveness, and encourages clinical specialties among staff.

Furthermore, tailoring services to the unique requirements of particular diagnostic groups is an essential way for inpatient rehabilitation hospitals or units (IRH/Us) to differentiate themselves from other levels of care, such as skilled nursing facilities. These steps also allow organizations to proactively comply with changes in rules defining IRH/Us.

With these benefits in mind, the following strategies can help in developing new programs to meet the evolving demands of the population.

Adopt a comprehensive approach to patients. Not long ago IRH/Us questioned their capacity to treat medically complex conditions. But advances in medical and surgical interventions made it possible to expand stroke and brain injury programs to include cases of multiple comorbidities, such as hypertension and diabetes. Similarly, IRH/Us have gained the capacity to address the needs of cardiac patients by partnering with acute care hospitals and placing cardiologists, pulmonologists and subspecialists on staff.

This “whole-person” framework also benefits joint replacement patients and others who may have comorbidities, such as obesity. Incorporating a targeted weight loss and management program could help reduce associated risk factors.

Combine interventions from existing programs. For example, 50 percent of those with spinal cord injury will have a concomitant brain injury. Specialized treatment could promote recovery from both simultaneously.

Recognize changing demographics. As the population grows older, IRH/Us should provide neurocognitive treatment for people with memory problems related to normal aging. Dementia programs focusing on compensatory strategies and environmental and behavioral interventions could foster independence and provide family support.

Look to recent legislation. IRH/Us must respond to new laws. For example, many states now require that all public schools institute a system for the early identification of sports concussions. An outpatient program could target student athletes and others who might otherwise go undetected.

Evaluate new technologies. The future of rehabilitation must include the evaluation and incorporation of the latest innovations. Through research and clinical trials, IRH/Us should strive to improve rehabilitation potential, outcomes and quality of life.

Consider the patient’s perspective. Shortened inpatient stays can cause multiple challenges for patients and families. IRH/Us must provide a continuum of care to address ongoing needs. People with traumatic brain injury, for example, can perceive returning to a job as a distant goal.

Behavioral strategies, family education and cognitive rehabilitation can be a bridge, giving support until a person is able to work.

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