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As Americans grow heavier, problems will arise in rehabilitation facilities

Some rehab facilities have started special obesity programs

Americans' love of fast food and high-calorie snacks has led to a startling increase in obesity in the past decade, and that means rehab facilities and hospitals increasingly are coping with very heavy patients.

Recent research estimates that the number of people who are obese in the United States increased by more than 50% in the 1990s.[1] Also, health care costs related to obesity now are close to $40 billion per year. Some research suggests as many as 27% of Americans are clinically obese, based on their body mass index.[2]

"Our patients in general are getting larger," says **Judy Clementson**, PhD, psychologist with Madonna Rehabilitation Hospital in Lincoln, NE. Madonna Rehab officials noticed that the staff increasingly had difficulty treating patients who were clinically severely obese, defined as weighing more than 400 lbs and 100% overweight, Clementson says. The hospital began a formal inpatient obesity program, which included making equipment and facility changes, as well as providing the staff with inservices on sensitivity issues concerning obese patients.

Executive Summary

Subject:
Obesity is a growing problem nationally that may require rehab facilities to make changes in equipment and staff attitudes.

Essential points:
- ❏ Obese patients may require larger rehab room doorways to accommodate their larger wheelchairs.
- ❏ Rehabs providing aquatic therapy to obese patients may need lifts or other equipment to assist in pulling the heavier patient from the water in the case of an emergency.
- ❏ Exercise equipment, beds, and commodes need to be larger and able to handle excessive weight.

Cape Fear Valley Medical Center in Fayetteville, NC, also began a program to improve the rehabilitation experience for obese patients. "We began by surveying the staff to see what kind of logistic difficulties they had in providing care to obese patients," says **Debra Pedersen**, MS, CCC, director of speech and audiology at Cape Fear. "We took a look at how many patients in the program were over 300 lbs, and we discovered it was a prevalent problem," she says.

In one month, the 78-bed rehab department had five patients admitted who were obese. The 800-bed hospital had a total of 65 obese patients admitted that month.

"So we asked the staff if they had suggestions about what could be done to make their jobs easier in caring for these patients," Pedersen says. "We received suggestions for changing equipment, and several staff members felt we needed to do empathy training because they felt there was a bias against obese individuals."

Obese patients are stereotyped as 'lazy'

For example, rehab staff — like the rest of the American public — believed some of the negative stereotypes about obese people. "One stereotype is that overweight people are very lazy. That's not true at all. The overweight people I've met are extraordinarily productive," explains **Nicole A. Engle**, PhD, clinical psychologist in Chapel Hill, NC, who held an inservice on obesity at Cape Fear. **(See story on creating a more sensitive environment for obese patients in rehab, p. 119.)**

Madonna Rehab and Cape Fear made the following changes to enable the staff to treat obese patients more effectively and easily and to make the facilities more comfortable for those patients:

• **Patient room changes:** Madonna Rehab purchased some extra-wide beds and a lift to assist staff in transferring obese patients who are very weak. "These lifts can handle 750 lbs, and by using them, the staff do not have to physically assist in the lifting, and that makes a difference in reducing staff injuries," Clementson says.

Cape Fear Valley has put together some special rental packages for obese patients. Vendors can quickly provide large beds, walkers, lifts, and other necessary items. Staff also can provide patients with catalogs selling personal products made for larger people, such as larger clothing hangers, Pedersen says.

• **Bathroom changes:** Cape Fear purchased two shower/commode chairs that can hold patients weighing up to 750 lbs. One chair is kept in the pool area, and one is in the rehab unit, where it can be pulled out of storage anytime it's needed.

Madonna Rehab also purchased an extra-large commode, and the hospital remodeled the doorways to the bathrooms by taking off the doors so that extra-wide wheelchairs can fit more easily. "Even though the rooms were standard-sized hospital rooms, with the larger equipment it was very difficult for these patients to use the bathroom," Clementson says. "So in several rooms we took off the doors and purchased curtains that can be slid back and forth across the bathroom doorway."

• **Pool and exercise equipment changes:** "One area of difficulty was that we were not able to provide our aquatics program to obese patients because it might be too difficult to get the person out of the pool in case an emergency arose," says Pedersen. "So we purchased equipment to help us."

Cape Fear bought a head immobilizer and a backboard that can support up to 1,000 lbs. "If a person needs to be lifted out of the pool, the board is heavy enough to lift the person on it," Pedersen adds.

Madonna Rehab's aquatic therapy pool has steps, as well as a lift that can carry up to 750 lbs. "So an obese patient can be dropped down into the pool for walking and other exercises," Clementson says.

"The aquatic therapy pool is one of the most effective and successful rehabilitation therapies for obese patients, in part because almost all of these patients have joint problems and have developed either arthritis or knee and hip pain as a result of the heavier load on their joints over time," she adds.

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Madonna Rehab also has exercise equipment that can hold 500 lbs, which is 150 lbs more than the typical exercise equipment.

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Are your staff callous to overweight patients?

Psychologists offer tips for improving sensitivity

In an age of increasing sensitivity toward race, gender, culture, disability, religion, and sexual orientation, fat people are the last socially acceptable targets of tasteless jokes, stereotypes, and off-handed cruelty. In fact, making fun of obese individuals is so ingrained in American society that even the most sensitive rehabilitation professionals will engage in the practice, according to two psychologists who are experts on obesity.

Discrimination and derision toward obese people is widespread, even as the population increasingly becomes overweight. For example, last year a San Francisco fitness club chain advertised on a billboard that featured a fierce-looking alien face. The caption read, "When they come, they will eat the fat ones first."

That prompted activists on behalf of obese people to lobby the city to include fat people among the groups protected by discrimination laws, according to a May 9, 2000, article in Reuters news service. So earlier this year, San Francisco's Board of Supervisors unanimously voted to add body size to city laws that ban discrimination based on race, color, age, ancestry, religion, sex, disability, sexual orientation, place of birth, and gender identity. Similar laws exist in Washington, DC, Michigan, and Santa Cruz, CA.

First step is changing staff attitudes

While it may take many years to change the American public's attitudes about weight and obese people, rehab facilities can do something more immediate about changing staff attitudes, suggests **Judy Clementson**, PhD, a psychologist with Madonna Rehabilitation Hospital in Lincoln, NE.

"Because of the stigma in our society, I don't believe an obese person can heal emotionally while there's an undercurrent of blaming them or stigmatizing them," Clementson says. "We see this as a form of sensitivity and diversity training. We make it clear that it's not acceptable to be joking or gossiping or using malicious humor about obese patients."

After undergoing the sensitivity training, the Madonna Rehab staff became aware of unkind remarks, even those made by peers outside of their own hospital, Clementson notes.

For example, the rehab staff had a telephone conference call with peers at another rehab hospital. During the call, the other hospital's staff made some jokes about fat patients and how much of a pain in the neck they were. When Madonna therapists told how they were able to treat some obese patients who entered the hospital in a wheelchair and left the hospital on their own feet, the response was, "You're kidding! How did you manage that? I can't imagine any of ours walking out," Clementson recalls.

"This was very demeaning and done in a collegial way," she adds. The Madonna staff were uncomfortable with the exchange because they no longer talk about obese patients in that manner. "The climate of our unit has really changed so that there's more respect for obese patients, and the assumption now is that they're here because they are medically ill and want to get better," she explains.

Cape Fear Valley Medical Center in Fayetteville, NC, also held an inservice for staff on being more sensitive to issues affecting obese patients.

"I think the general public views obesity as a

will power issue, and people don't recognize that it's not related to will power," says **Nicole A. Engel**, PhD, a Chapel Hill, NC, clinical psychologist who has worked with overweight patients and gave the inservice at Cape Fear Valley.

"For very overweight people, not someone who has a desk job and gains 10 lbs, food is a coping strategy," Engel says. "It helps them with many things."

Clementson and Engel offer the following strategies for teaching rehab staff about becoming more sensitive to the needs of obese patients and how to help obese patients deal with their own shame and other issues regarding their weight:

• **Discuss the causes of obesity.**

"Many of our patients have metabolisms and lifestyles in which their weight doesn't reflect the kind of gluttony that many people might expect," Clementson says. For example, recent research has shown that black women tend to have a lower metabolism than other women when they are at rest. That means they are more likely to gain weight at desk jobs or by spending time in front of the television or a computer.

Genes, viruses may cause obesity

Research has indicated that specific genes and even viral infections could play a role in whether someone is slender or obese. Children who experience physical, sexual, or emotional abuse also may be prone to becoming obese adults.

All of those factors contribute to what has become a societal problem. In American society, there is a great deal of emphasis on fast food, products containing refined sugars, snack foods, and sweetened soft drinks. Researchers are concluding that this type of eating trend has led to a fatter American population.

In populations such as in Asia, where people are typically lean, there is a general emphasis on eating fish, vegetables, and other foods that are not bought in grocery store packages.

• **Consider the stereotypes and derision aimed at obese individuals.**

"There's an actual anger at obese people, and there's a lot of blaming them for the problem," Clementson says. "Fat people are the last group we can displace our anger and alienation onto."

This contempt for obese people begins in early childhood, she notes. "When kindergarten and second grade students are asked to say what is true about a picture of an obese person, they will say the fat person is lazy, dishonest, and stupid. It's in our culture that you are to blame for your weight."

Other studies of young students show that if they are asked which child would be their friend, and they are shown pictures of a fat child, a child in a wheelchair, children of different ethnic groups, and a child of normal weight, the children invariably select the fat child as their last choice, says Clementson.

Rehab professionals may be familiar with other research in which people with disabilities are asked whether they would trade their disability for a different one. Most respondents — including people with blindness, diabetes, and spinal cord injury — said they would keep the disability they had. The only exception were people whose disability was obesity. Most people in that group said they would trade their disability for something else, including amputation, blindness, or deafness, she says.

• **Treat obese patients for depression and help them improve their self-esteem.**

"There's a lot of shame and issues of self-esteem in obese people, so helping obese people feel good about themselves and helping them to feel empowered is very important," Engel says. "Tackling eating problems and trying to change your lifestyle and change eating patterns, exercise patterns, and coping strategies takes a lot of energy. It's hard to take care of yourself when you're not feeling good about yourself."

Because many obese people have carried the burden of being overweight since childhood, their low self-esteem is ingrained. "They've suffered a lot of teasing and shaming about their body," Engel says.

Obese individuals often have suppressed their emotions to the extent that they may not be aware of their own anger and depression, Clementson says. "Part of a therapy goal is to increase their level of awareness of their feelings," she explains. "But the main goal is to increase their self-efficacy, a belief that you have the ability to cope with circumstances."

Severely obese people often have made multiple attempts to lose weight, and when those attempts ultimately failed, they learned to feel helpless about their obesity, Clementson says. Compounding that feeling of having no control over their bodies, she points out, is the message health care professionals give them: "There's nothing we can do until you lose weight."

Hearing that message, obese patients stop

Clip this guide to facts on fat and obesity

As the American population grows fatter, rehabs will treat increasing numbers of obese patients. Obesity often leads to chronic diseases and conditions that require hospitalization and rehabilitation. Recent research highlights some startling trends and news about fat and obesity. Here are a few facts on the subject:

• An estimated 40 million adult Americans are at least 20% above their ideal body weight.

• As fewer Americans smoke, obesity is becoming one of the most important risk factors for the development of diabetes, hypertension, and cardiovascular disease.

• Clinical researchers now describe overweight and obese individuals by their body mass index (BMI), which is obtained by dividing the weight in kilograms by height measured in meters, squared (W/H^2). Men and women who have the lowest morbidity and mortality risk are those with BMIs of 22-25 kg/m^2. Mortality rates increase substantially when a person is 20% overweight or has a BMI of 27 kg/m^2.

• People who are 60% above their desirable weight, weighing a minimum of 100 lbs more than is healthy, have double the prevalence of all causes of morbidity and mortality.

• Researchers found that a human adenovirus-36 causes animals to gain excessive fat.[1] That leads to speculation that a virus might explain some obesity in humans.

• The food now available to Americans represents a more than 15% increase in food energy per capita than what was available in 1970.[2]

• Americans spent 20% of their food expenditures eating out in the 1970s. By 1992, Americans were spending 38% of their food budget on restaurant food.[2]

• Although Americans increasingly are buying foods with lower fat and oils, they consume nearly 22% more fat and oil than they did in the 1970s because they're eating out more often. Restaurant foods are high in fat and oil.[2]

• Research shows that obese, sedentary women can improve their cardiovascular performance by 13% if they focus on exercising for fitness rather than for weight loss. Those who followed a traditional exercise plan, focusing on weight loss, improved only 5% cardiovascularly.

• Overweight adults are six times more likely than normal-weight adults to develop arthritis in both knees, and obese people are eight times more likely to develop osteoarthritis in both knees.[3]

• Research shows that 22% to 25% of Americans are clinically obese, and 55% are overweight.

• Soft drinks and other foods, including syrups, table sugar, sweets, cereals, and chocolate milk, with added sweeteners account for 16% of the total calories Americans ingest.[4]

• A 20 lb weight gain in women contributes more to overall physical decline than does smoking. The weight gain will cause problems with routine activities, such as climbing stairs and walking the length of a parking lot.[5]

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speaking up about their pain and physical problems, which increases their feelings of depression.

Occupational therapists and physical therapists can help obese patients gain some successes physically through therapy. As patients become successful at the little steps, they will gain independence and become better able to manage their pain, Clementson suggests. "After they become physically stronger and are able to do more independently, including improving their grooming and hygiene, their self-esteem increases."

• Make malicious humor and gossip unacceptable in the rehab climate.

Obese individuals typically are very aware and sensitive to jokes and derision about their appearance. "We found early on that this group of patients knew everything that was being said and done," Clementson says. "They overhear a lot, so it's obviously a part of staff training to maintain discretion and confidentiality."

She often tells rehab staff that because of an obese person's early history, he or she will notice, hear, and be hurt by offhand comments or jokes

that employees assume they didn't hear. "Another part of staff training has been that in one or two rare instances, we have had staff members who, because of their own histories, have had very strong negative reactions to this patient group, and I really think that's much more common than we like to think," she says.

• **Explain how personal hygiene problems often occur in obese people.**

Obese people sometimes have body odor that's difficult to control even though they may bathe as frequently as normal-weight individuals, says Clementson. "If you're on the nursing staff or therapy staff and have to have close physical contact with an obese patient, it can be difficult."

For example, nurses and other staff have gone into a few patients' rooms and immediately suggested the patients shower. "The fifth time that happens in one day, it's very hurtful," says Clementson.

To prevent staff from inadvertently hurting patients' feelings, the hospital assigned one person, an occupational therapist, to be in charge of obese patients' hygiene. That way, nurses know not to ask about showers because they know the personal hygiene issues are being addressed. ■

Aphasia center offers more therapy choices

Center takes multidisciplinary approach

Post-inpatient treatment for the more than 1 million Americans with aphasia often fails to provide them with hope of regaining their ability to communicate with others. Insurance carriers fail to recognize that aphasia is a chronic condition that sometimes requires lifetime treatment.

"The way we treat people with aphasia right now in this country is by giving them a week or two of [outpatient] therapy, and then saying that's it. I believe there are many aphasia patients who need ongoing therapy for years," explains **Steven Small**, MD, PhD, director of the University of Chicago Comprehensive Aphasia Center at Schwab Rehabilitation Hospital & Care Network in Chicago. Small also is a professor of neurology at the University of Chicago.

Clinic provides assessment, therapy

The 125-bed rehab hospital's new aphasia center provides a comprehensive program of assessment and therapy for aphasia patients with a goal of helping them make improvements beyond those possible if they were left to fend for themselves, as sometimes happens after discharge from an inpatient facility.

"What we do that's most different from other places is we've instituted a multidisciplinary evaluation approach," Small explains. "Each patient is seen by three primary care providers."

Most of the aphasia center's patients have had strokes, but patients with dementia, brain cancer, brain tumors, multiple sclerosis, and traumatic brain injuries also might qualify for the aphasia clinic.

Small, who is a cortical neurologist, is one of the three team members. The others are **Amy Usher**, MS, CC-SLP, a speech-language pathologist, and **Elizabeth Pieroth**, PsychD, a staff psychologist who specializes in neuropsychology.

The aphasia center opened earlier this year but has not yet collected specific outcomes data. Anecdotal evidence suggests that patients who are a few years post-stroke have improved in their communication skills because of the center's treatment, Usher and Pieroth say.

"One way we're seeing improvements is through family members coming in and letting us know they are very happy because the patient is initiating more speech at home and the patient is more intelligible and more verbal," Pieroth says.

Here are the main components of the center's aphasia program:

Executive Summary

Subject:
Schwab Rehab in Chicago opened an aphasia center that treats patients with a multidisciplinary team and comprehensive approach.

Essential points:
- ❑ The aphasia team consists of a neurologist, a neuropsychologist, and a speech-language pathologist.
- ❑ Team members hold consensus meetings to discuss each patient's case and set treatment goals particular to a patient's deficits and strengths.
- ❑ Patients are treated in individual and group therapy sessions, and their family members are educated about aphasia and the reasons behind the patient's behavioral problems.

• **Comprehensive evaluation:** Small, Pieroth, and Usher evaluate patients referred to the center. Small assesses patients' sensory problems, as well as cerebellar problems. The sensory problems include whether patients have the ability to feel their hands and legs and know where they are in space. These problems also encompass motor skills, weakness of the mouth or palate, weakness of hands, and coordination difficulties.

The University of Chicago's aphasia program focuses on communication as well as overall quality of life.

Usher begins her evaluation by giving the patient a battery of tests, including the Boston Diagnostic Aphasia Examination, the Apraxia Battery for Adults, the ASHA-FACS, and the Boston Naming Test. "Those are in addition to some other informal testing measures," she says.

Pieroth assesses patients' cognitive abilities and their general emotional and affective states. She administers various neuropsychological tests, depending on a patient's level of functioning. For example, a patient who has had a stroke on the left side of the brain, affecting the person's right side of the body, may be unable to speak or use the dominant hand for writing or drawing. Pieroth wouldn't give such a patient any tests that required writing or drawing.

With some patients, the tests might be visual; with others, they are verbal. The assessment tools include a visual spatial processing test, a visual memory test, and a problem-solving test that has no verbal requirements.

• **Consensus meeting:** Small, Pieroth, and Usher meet after completing their evaluations to discuss the patient's deficits and potential outcomes. The roundtable discussion also may include the patient's referring physician or other doctors.

"We talk about the main problems the patient has and what sorts of things we might do to help the patient," Small says. "We don't restrict our attention to the issues of getting the patient's speech back, although communication is the most important thing, but we also look at the patient's quality of life, including the patient's ability to have a job, talk with family members, and feel comfortable at a party."

The team decides whether the patient needs to be referred for vocational training, substance abuse counseling, or other therapies.

"We then come up with modified goals and recommendations," Usher says.

The consensus meeting is one of the big advantages to the aphasia center, Small says. Each member of the trio evaluates the patient differently, and together they come up with treatment strategies a one-sided evaluation would have missed.

"We think that all sorts of cognitive skills can impact both the language disorder itself and possible treatments," Small says.

That's why Pieroth's evaluation is important, he adds. "If someone has a good visual memory, for example, then the therapist might be able to use therapy that has visual aides or visual material."

Pieroth also could highlight a patient's problems with depression or other psychological problems stemming from the patient's emotional reaction to the illness. "It's known that patients who have depression after a stroke don't have as good a rehab outcome as people who don't," Small says.

Alternative communication tools explored

• **Individual therapy:** Usher typically meets individually with patients once a week. She works on some of the speech goals that are specific to that patient, with the ultimate goal of improving functional communication. "We work on the basics and provide stepping stones," she says. "I may train a patient how to use an alternative form of communication, like a communication board."

She also teaches patients specific communication skills, using gestures, and works with them on their ability to name objects and develop increasingly complex speech.

• **Group therapy:** Usher leads an aphasia communication group once a week. The group's goal is to improve functional communication based on verbal skills, gestures, and pictures. "We encourage any sort of successful communication skills so it's a more natural environment for patients, as opposed to working with them one-on-one," she explains. "And they can also assist each other, asking other participants to repeat things, and asking questions, and helping other people to convey their message."

• **Psychological treatment and education:** Small estimates that more than half of the stroke patients also suffer from depression. "It's a very big problem, and we do have a very comprehensive evaluation of that issue, and we recommend to patients' physicians that they consider drug

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therapy for depression when we think it would be helpful," Small says.

Some patients and/or their families are referred to Pieroth for therapy to help them with depression and other emotional problems related to their illness and difficulty in communicating with others. However, for patients with language difficulties, therapy for depression sometimes is impractical.

Pieroth also educates family members about aphasia, stroke, and brain injury. "I explain why it effects their language, and I talk a lot about behavioral issues because some of the behavioral problems are related to neurological insult, and some are related to affective reaction to injury, such as frustration in not being able to communicate. Family members don't understand how that plays out and how it really affects the person," she explains.

Pieroth may begin by meeting with the patient's caregiver and asking about the caregiver's concerns about changes in the patient. "We don't know the patient before the stroke, so it's important to get the family's understanding of the changes they've noticed, both affective and personality changes," she notes.

Sometimes family members will say the patient is being stubborn and not behaving as expected. The true problem is that the patient has difficulty understanding what is being said and may have indicated a "yes" answer to a caregiver's question, when the truth is the patient doesn't have a clue about what has been asked.

"People can falsely believe the patient understands them, and so it becomes very frustrating for the patient and family member if things don't work out as expected or if the patient doesn't respond as the family member desires," she says.

Occasionally, family members will respond to their frustration by becoming verbally abusive, yelling at the patient, and arguing. Pieroth teaches them better coping strategies.

She also shows families how to identify the signs and symptoms of depression in the patient. For example, patients may tend to isolate themselves because of their inability to clearly communicate, and Pieroth explains that this is a common sign of depression in aphasic patients.

"They may sit in a room and watch TV and avoid other people," she adds. "Look for warning signs of depression, such as sleep disturbance, appetite disturbance, and other indicators."

• **Reimbursement:** The medical and speech pathology treatment typically is covered by insurance companies and Medicare, but the psychological evaluation and treatments usually are not reimbursed. Even so, Small says this component is an essential part of the overall program.

"It's very frustrating, and we need to educate insurance companies," Pieroth says.

The aphasia center started outcomes research on its comprehensive treatment approach, looking at patients' quality of life, language improvement, and cognitive improvement, she says.

Ultimately, a body of research that shows improvements among aphasia patients through a multidisciplinary approach could help convince payers to reimburse for this type of treatment. ■

Government study compares FIM, MDS-PAC

HCFA contractors have begun collecting data

Although no one can say for certain that Medicare will switch rehab patient classification systems until the prospective payment system (PPS) proposed rule is published, it's clear the government is seriously considering a change.

The Health Care Financing Administration in Baltimore funded a nine-month project to evaluate the Minimum Data Set-Post Acute Care (MDS-PAC) for use in classifying cases into case mix groups in inpatient rehabilitation PPS. The study will compare MDS-PAC with the Functional Independence Measure-Functional Related Groups (FIM-FRGs).

Fifty facilities nationwide started to collect data in September. On all Medicare, non-HMO admissions, the rehab sites will collect both MDS-PAC and FIM data at admission for all patients with stays beyond three days in an eight-week period.

"The purpose of the study is to see if the two instruments classify patients into the same payment cells," says **Joan Buchanan**, PhD, a lecturer in health care policy at Harvard Medical School in Boston. Buchanan is the study's principal investigator. The project is a collaborative effort by Harvard Medical School, Rand Corp., and Sargent College of Health and Rehabilitation Sciences at Boston University in Boston.

"There already are costs attached to payment cells, so if the two systems don't classify cases in the same way, there's potentially an issue of fairness of payment to hospitals or access to patients," Buchanan says.

Study to examine consistency

The study will determine the following:

- How accurate is the MDS-PAC for use in classifying cases into case mix groups under the inpatient rehab PPS?
- How does the MDS-PAC compare in validity, reliability, and consistency with the FIM?
- Do the FIM and MDS-PAC code comorbidities accurately?
- Does the MDS-PAC provide an opportunity for better groupings in future classification work because of its additional data?

The study's design will address psychometric issues to ensure that institutions across the country are calibrating to the same set of norms and to obtain the most reliable data. Three calibration teams visit each participating institution, spending 2.5 days at each site and rating at least four cases using both the FIM and MDS-PAC systems.

The project is scheduled to be completed by March 31, 2001. ■

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WI facility starts golf program to fill niche

Golf rehab easy to provide, brings extra income

Sports injuries frequently occur among weekend athletes, who sometimes are treated by physical therapists for injuries. While many preventive programs may not be financially lucrative for most amateur sports, golf is an exception.

To fill that niche, Howard Young Medical Center's rehabilitation facility in Woodruff, WI, began a golf-specific exercise program earlier this year. "If someone is going to spend $1,000 to $1,500 for a pair of clubs, they'll spend $160 to make sure they're swinging them right," says **Jonathan Ekhoff**, ACT, a certified athletic trainer for Howard Young Medical Center.

Ekhoff, who plays golf, attended three different golf seminars to learn proper technique and training. The seminars included information on how to evaluate a person's golf swing, how to evaluate a golf swing from a biomechanical perspective, how to treat people with golf injuries, how to prevent those injuries, and how to help a golfer improve balance for better performance.

Three-tiered program targets golfers

Armed with additional knowledge, Ekhoff established a three-pronged golf exercise program. Within the first four months, he sold 12 golf exercise packages and received about 40 phone calls. The new program creates a small but growing market niche for the rehab facility and helps Ekhoff enhance his own billable services. It also provides a much-needed community service in the area, which is known for its golf resorts.

"It's a very functional program, and it doesn't take an lot of extra time out of the day to provide it," Ekhoff says.

Ekhoff advertised the program at local health fairs, in the local newspaper, and, most importantly, through contacting local golf clubs and golf pros. "Golf pros think it's great because they know it's not interfering with their teaching lessons," he says. "It's supposed to benefit golfers who are taking lessons, and I like to work with golf professionals."

For example, Ekhoff can work with a golf pro during a lesson, provided the client has requested the service and the golf pro is amenable. "If this

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person needs to make a bigger shoulder turn, and the golf pro says, 'You can do it this way and this way,' I can say, 'To enhance that even more, you can stretch out this way.'"

Ekhoff envisions that once the program is better established, it will be a good referral source for golf pros, and the pros will refer clients to him. He plans to encourage the more serious clients to take advantage of having a golf lesson attended by an athletic trainer, and Ekhoff would make all the arrangements for an extra fee. The program is divided into three packages:

❑ **Red package:** In this one-time bargain-basement golf exercise program, the client receives all the training in a two-hour session. "I set you up on a home exercise program, show you how to do the exercises, and give you copies of the exercises," Ekhoff says. The package costs $90 and includes a videotape of the golfer's swing and an analysis of what can be improved.

❑ **White package:** So far, this has been the most popular package, Ekhoff says. Clients can choose four, eight, or 12 sessions. They meet with Ekhoff twice a week, so the instruction lasts two to six weeks. "For the first session, we go through the evaluation and videotape their swing at a driving range," he explains.

In the second session, Ekhoff analyzes the tape. In the third, clients work on stretches, strengthening, and golf drills. The fourth through 12th sessions repeat and emphasize the stretching and exercises. "The benefit of doing it eight or 12 times is that you get that information repeated over and over in your mind, and you get feedback from me as to whether you are doing it correctly," he says.

The four-session package consists of four hours and costs $160. The eight-session package is for eight hours and costs $280, and the 12-session package is for 12 hours and costs $360.

❑ **Blue package:** This package has 20 or 30 sessions. "The difference between the blue and white packages is that I put you on a comprehensive strength and endurance program with the blue package," Ekhoff says. "This program includes overall fitness, and you will improve golf and lose 15 or 20 lbs or whatever you need."

Ekhoff will include fitness training on stationary bikes or treadmills, incorporating these activities into the golf exercise program. The 20 sessions, totaling 20 hours, cost $700, and the 30 sessions, totaling 30 hours, cost $900. ■

Hospitals offer rehab within wellness centers

Programs for diabetes, heart, lung patients offered

Hospital systems increasingly are opening medical-model wellness centers, creating opportunities to expand outpatient rehabilitation programs. Two new wellness centers offer a variety of rehab services for patients with chronic illnesses. Between them, the centers provide services to patients with musculoskeletal problems, diabetes, cardiac disease, and pulmonary disease.

At the same time, wellness centers provide the community with a fully equipped fitness facility staffed by health care and fitness professionals. The centers are an important addition to a hospital's continuum of care, transitioning some sick patients to the community and providing the community with disease-prevention opportunities.

Regional Rehabilitation Center of Pitt County Memorial Hospital of University Health Systems of Eastern Carolina in Greenville, NC, planned its 52,000-square-foot wellness center, named ViQuest, for several years before its summer 2000 opening.

"We look at this center as a part of the continuum of health care," says **Wanda Bennett**, MS,

Executive Summary

Subject:
Hospital-owned wellness centers give rehabs an opportunity to provide more services and a multidisciplinary continuum of care.

Essential points:
- ❑ Wellness centers offer outpatient services for patients with musculoskeletal problems.
- ❑ A wellness center can provide aquatics therapy.
- ❑ Patients at wellness centers may benefit from fitness sessions held in the same facilities used by healthy members.

OTR/L, administrator of outpatient rehabilitation services for the hospital. "We've been able to set up a program to transition patients to a wellness environment," Bennett says.

ViQuest houses some of the hospital's outpatient rehabilitation services, including a general orthopedic program, return-to-work program, cardiopulmonary rehabilitation, and sports medicine. The center's staff include hand therapists, physical therapists, occupational therapists, exercise physiologists, registered dietitians, recreational therapists, health educators, aquatic therapists, nurses, aerobic instructors, child care providers, and a medical director.

Centers can fit community's needs

Wellness centers can be tailor-made to suit a particular hospital's and community's needs. "There really was a huge need for a wellness center," Bennett says. "We have fitness clubs in the area, but many times those clubs aren't meeting the needs of our patients, who are less than fit."

While musculoskeletal problems were a big concern for Pitt County Memorial Hospital, other hospitals have different priorities.

For example, Cape Fear Valley Health System in Fayetteville, NC, recently opened a wellness center called HealthPlex, which features special programs on diabetes management, cardiac rehab, and pulmonary rehab.

Hospital officials wanted to move those types of services to a wellness center climate to give patients a sense that they are away from the clinical, sterile hospital environment, says **Marcie Justice**, MS, executive director.

The 65,000-square-foot facility also has clinical space devoted to physical therapy, sports medicine, and occupational therapy. Its staff include physical therapists, occupational therapists, a vascular health exercise physiologist, a risk reduction exercise physiologist, a psychologist, a diabetes nurse, a cardiac nurse and physiologist, and a pulmonary nurse and physiologist. There also are two contract dietitians and a fitness staff of 35.

Here are some of the wellness centers' features:

- **Orthopedic therapy:** ViQuest treats patients who have suffered musculoskeletal injuries, including hand and back injuries, whether they resulted from work, sports, car accidents, or other causes. "These include athletes who are injured and need to compete," Bennett says. "Or it could be a weekend warrior who overdid it a little bit and may need some therapy services."

- **Cardiac rehab:** Cape Fear's HealthPlex has designed a rehab program for people with heart disease, including those who have had a heart attack, bypass surgery, or angioplasty. Physicians refer patients to the program for three months of treatment using a multidisciplinary approach. The cardiac team includes a nurse, psychologist, exercise physiologist, and dietitian.

Cardiac patients visit the wellness center three times a week to be educated and to exercise under supervision. The cardiac team sends regular progress reports to the patient's physician. Once patients complete the 12-week program, which is covered by Medicare and other payers, they can enter a maintenance program. The maintenance program is an out-of-pocket expense, costing $45 a month. For that fee, they may visit the facility three times a week to exercise. They can attend

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any of the wellness center classes on cardiac disease. Patients who need additional guidance from a cardiac specialist can receive it at the center.

• **Return-to-work program:** The Pitt County rehab center's WorkReady program includes training on how to prevent injuries, as well as job safety visits to local companies. Since part of the hospital's outpatient rehab facility has moved to ViQuest, the wellness center has become part of the continuum of care for WorkReady clients.

"At the wellness center, participants are working in that environment," Bennett says. "So if we have a person with a back injury, we start them at a level they can handle and train them to return to the level they need for work by having them work on our equipment and in the warm water pool."

Once WorkReady clients complete the traditional therapy, the rehab staff continue to train them and make recommendations for how they might transition into ViQuest's environment for a continuation of their work hardening treatment.

The WorkReady program also features prevention education and work site visits. "We do assessments regarding ergonomic set-ups and have rehabilitation programs that are part of it," Bennett says.

• **Diabetes program:** Cape Fear's diabetes program has moved to the wellness center, where clients are taught how to manage their disease within two or three sessions, lasting about four hours. This program, recently affected by Medicare cuts, originally offered eight hours of education in two half-day sessions, Justice says.

"Our nurses are certified in diabetes, and we have a dietitian and assistance from an exercise physiologist," she says.

The program teaches patients about taking insulin properly, checking blood sugar levels, and following a better diet and exercise regimen. The exercise physiologist may offer patients guidance in selecting an exercise program.

• **Aquatic therapy:** ViQuest has three swimming pools, including a lap pool, a warm water therapy pool, and a whirlpool. The program offers pool classes, as well as therapy programs with warm or cool water. Participants learn strengthening skills, endurance skills, and practice range of motion techniques. "Some of the specialty programs that use aquatics therapy are back rehab, chronic pain, and sports medicine," Bennett says.

HealthPlex has a warm water pool set at 88 degrees and a lap pool at 82-84 degrees. The pools are available for recreational swimming, as well as aquatic therapy.

• **Pulmonary rehab:** The HealthPlex program is similar to its cardiac therapy program. "Basically, it's set up like cardiac but is designed for people who have pulmonary disease, whether it's chronic lung disease or emphysema," Justice says. "Patients are referred by a physician; they come to the hospital for a couple of weeks, and then they come out to the HealthPlex to be integrated into the wellness center environment."

"That's one thing that makes us so different from other wellness centers," she explains. "Pulmonary patients are exercising on the exercise floor with the center's healthy members."

When patients exercise around healthy people, Justice says, their confidence gets a boost and they can become more focused on becoming well. ■

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