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Rehab Continuum Report™

Outcomes
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INSIDE

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Treatment and Billing Scenario Worksheet

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Now's your chance to measure outcomes, make changes before PPS

Flexibility is the key to rehab survival

The federal Health Care Financing Administration (HCFA) may have put the inpatient rehab industry into a long limbo with regard to the Medicare prospective payment system (PPS), but that doesn't mean facilities have had to wait to make any operational changes.

Some rehab hospitals took the past year's reimbursement uncertainty as an opportunity to make changes that could lead to better outcomes and quality, while either helping or at least not harming the financial bottom line.

For example, INTEGRIS Jim Thorpe Rehabilitation Hospital at Southwest Medical Center in Oklahoma City continued to expand and adapt by reassessing its outcomes measurement tools and improving those processes wherever possible.

"[Southwest Medical Center is a] tertiary hospital, and we have all the well-known measuring tools and state-of-the-art benchmarking tools, but these didn't focus on the individual patient," says **Sharon Smeltzer**, MS, director of operations for the 131-bed rehab hospital.

Executive Summary

Subject:
An Oklahoma rehab hospital has revamped management and organizational structure and dress code to shift focus to team cohesion and outcomes measurement and benchmarking.

Essential points:
- ❏ The facility educates physicians and others about the costs associated with services and how to improve quality and efficiency.
- ❏ The hospital started a research and development program that is studying telecommunication services.
- ❏ Each change made in operations is measured according to cost and outcomes.

"We decided we needed to measure exactly what was happening with that patient," she adds.

With that goal in mind and with PPS on the horizon, the hospital restructured its departments, changed the management structure, and changed all of its measurement systems.

"For the next three to five years, a lot of rehab facilities are going to be profoundly challenged because of increasing competition," says **Pam Clark**, PhD, director of research and development for the hospital. "We need to re-examine resource utilization and organizational effectiveness," she says.

One way to improve efficiency is to expand rehab coverage to weekends, which would be expected to lower costs and lengths of stay because therapy would be provided continuously without the typical weekend break.

"We decided to offer consistent therapy no matter what day a patient is admitted," Smeltzer says.

Jim Thorpe Rehab Hospital's changes already have resulted in efficiency and other improvements since expanding to weekend therapy. For total hip cases, the functional improvement measured against patients' lengths of stay improved from 3.38 to 3.46, Smeltzer says. For total knee cases, the improvement was from 3.55 to 3.96. Both the before and after numbers showed the hospital to be more efficient than the regional average of 2.78 for total hip procedures and 3.22 for total knee procedures, she adds.

The expansion to weekend coverage is only one small part of what the hospital did to improve operations and outcomes. Here is a look at some of the hospital's other changes:

• **Restructure management, departments, and even the dress code.** The hospital divided the 131 beds into five departments, placing an interdisciplinary supervisor over each department. Therapists were moved to the same floor as nurses and patients, and physicians now can be reached at nursing stations. "We physically moved all of the staff to the patient floors, which was a major change," Smeltzer says.

Also, the entire staff of more than 500 now is required to wear a uniform to show patients that everyone is part of a team. The uniforms consist of khaki pants and white and blue polo-style shirts stitched with the hospital's logo. Managers and nurses also wear the uniform colors.

Even physicians wear the uniform colors, along with their white coats, at least once or twice a week, says **Al Moorad**, MD, medical director of the hospital. "It's a morale issue for employees, in my judgment," Moorad says. "And having the uniform makes it easier for patients to identify us; it shows that we're all part of one team, on the same level, wearing the same clothes."

Employees now welcome the change, Smeltzer says. "No one likes to be told what to wear, but we've had so much positive feedback since the beginning. Also, we have a committee that occasionally will adopt a new shirt color, so employees feel like they have had definite input on the change."

• **Educate physicians, pharmacists, and others about PPS and costs.** The hospital has created a new team that will help pharmacy staff, physicians, and physician assistants learn about costs. "With PPS, I want everyone to be aware of and educated about everything we do," says Moorad. "We need to do what's best for the patient, of course, and quality of care is our highest issue, but what is the cost per diagnosis, per admission?"

The education will take the form of meetings with physicians, lectures by various members of the team, and meetings with pharmacists, who help keep physicians up-to-date. The team will keep track of various diagnoses, looking at incidence rates, co-morbidity issues, and complication issues, then compare these to national averages.

Physicians will do their part by filling out weekly time studies and reviewing trends and costs. Part of the education will involve teaching physicians and nurses to look at costs over a long term, as in the costs of complications if certain precautions are not taken.

COMING IN FUTURE MONTHS

- Improve your infection control program
- Provide scoliosis screening as a community service
- Starting Pilates therapy could build a niche market
- Develop comprehensive interdisciplinary pathways
- Focus on staff and patient education to improve outcomes

For example, the hospital will use a protocol for all spinal cord injury patients. The protocol will address the possibility of a complication called deep venous thrombosis by having physicians order a baseline bilateral venous doppler study of the legs of all spinal cord injury patients. That will be done regardless of the patient's age, Moorad says.

"We're instituting a very active anti-thrombotic protocol to prevent blood clots in their legs, and what we also will do is follow these patients and repeat these doppler studies depending on the patient's length of stay," he adds.

The hospital also asks physicians to continue the same program when patients return home. "If you have a lower incidence of deep venous thrombosis, then you cut down on lots of morbidity and mortality from complications," Moorad explains. "And we think if you do these things and spend the money on the front end, then you will save a lot of money in the end and provide better patient care."

Physicians have been very receptive to those sorts of protocols and changes, which are suggested rather than mandated, Moorad says.

• **Expand research and development.** Rehab facilities may need to expand research and development (R&D) to stay ahead of cost and service trends. "In order for Jim Thorpe to become nationally recognized, we need to concentrate on research and development," Clark says. "I've spent a lot of time traveling around the United States and meeting with professionals from the top 10 rehab facilities, and what I realized is that most — if not all — have research and development departments."

One of the hospital's first R&D projects involves using telecommunications technology to provide speech and language therapy to children in a rural community about 150 miles from the rehab facility. **(See story on telemedicine program, at right.)**

The hospital received a $900,000 grant in 1997 from the Health Resources and Services Administration for rural telemedicine to provide specialty services to medically underserved communities.

• **Measure outcomes and costs associated with each change.** With new measurement systems, the hospital can show physicians how their own patients' morbidity and mortality rates compare with the hospital's average and how they compare with national benchmarking numbers, Smeltzer says.

"We have all of our state-of-the-art financial measurements interfaced, and they're hooked up on a big system that is rehab-specific," she explains. "So we can show physicians the areas where they can make changes, and then they're very willing to make those changes."

By the same token, physicians, therapists, and other staff can use those statistics to demonstrate productivity and outcomes and to ask managers for changes to procedures and processes.

Outcomes measurement also is a morale booster when the data show staff how the hospital already is performing better than regional or national averages in some areas, Smeltzer says. ■

Providing speech therapy through telemedicine

Rehab facility helps improve its speech outcomes

Telemedicine can be used as a way to expand a rehab facility's continuum of care and services, but it's also useful when a facility wishes to provide rehab therapy services to underserved communities.

For instance, INTEGRIS Jim Thorpe Rehabilitation Hospital at Southwest Medical Center in Oklahoma City developed a telemedicine program that provides speech therapy to rural students who otherwise would have to compete for the little time available from the area's only speech/language pathologist.

The community of Hugo had one speech pathologist providing therapy to 60 students from pre-kindergarten through high school.

Executive Summary

Subject:
Telerehabilitation provides rural school children with speech therapy services that otherwise would not be available or would be less intensive.

Essential points:
- ❑ A pilot program had positive outcomes and was quickly expanded.
- ❑ Eleven students received a total of 450 speech therapy sessions over nine months via telerehabilitation technology.
- ❑ Telerehabilitation also can be used to provide follow-up care to spinal cord injury and other patients.

Initially, rehab hospital representatives approached the Hugo school district, asking its administrator if the district had any need for allied health services that the rehab hospital could provide. The administrator suggested the hospital check with Hugo Elementary School, whose officials expressed a need for a speech therapist. The hospital applied for and received a $900,000 three-year grant from the federal Health Resources and Services Administration.

Earlier in the process, however, the hospital sought buy-in from its own therapy staff. "What we did was develop stakeholders for telemedicine before getting the grant, and part of the stakeholders are therapists," says **Pam Clark**, PhD, director of research and development at the hospital. Staff buy-in is crucial to any new program's success, Clark adds.

The next step was to engage the school staff and community into accepting and supporting the program. Toward that end, the hospital held a community open house to show teachers, nurses, and others how the telemedicine technology worked.

"We explained that we'd like to do a pilot program for five weeks, a research and development demonstration," Clark says. "We said, 'This is what it is, and do you want us to come and help the speech therapist?'"

School employees and the community agreed with the plan. They were aware that the speech therapist had too high of a caseload, and they were in danger of losing her due to burnout.

Pilot program involves five students

The pilot project involved five students at Hugo Elementary School. The rehab facility set up a two-way interaction television monitor with high-quality definition. "It's like watching Dan Rather on the nightly news with less than a second delay," Clark says.

A speech pathologist based at Jim Thorpe Rehab Hospital met with students at the elementary school. The therapist assisted the students with their communication and articulation skills, meeting with each student twice a week for five weeks. Each session lasted 45 minutes.

The pilot program demonstrated patient satisfaction and student improvements in speech skills. The speech improvements were assessed based on pre-therapy functional improvement measurement scores based on what the parents, teachers, and the rural speech pathologist observed before and after the five-week program.

After the pilot program concluded, the school and hospital made a contract to continue the program for one school year for 11 students. "That significantly decreased the caseload of the speech pathologist in the rural community," Clark says.

The program also provided the 11 students with more intensive speech therapy. Some of those students had moderate to severe articulation deficits, and a few had developmental-delay retardation. Previously, some of them had received only 30 minutes of group speech therapy per week.

Before beginning the therapy via telecommunications, the speech pathologist drove to the Hugo school and explained to the students, their parents, and their teachers how the program would work.

The speech pathologist met with students via telecommunications a total of 450 times during a nine-month period. She also met weekly by teleconference with the Hugo speech pathologist. The outcomes proved effective: Of the 11 students, three no longer require any speech/language therapy, and the others have improved.

Also, the Hugo speech pathologist was able to spend more time with her remaining students, enabling them to receive more intensive therapy.

"We helped to enhance the quality of services the other students received, and we also helped with the morale of the speech/language pathologist in that community," Clark says.

The Jim Thorpe speech pathologist was designated to the telemedicine project but also spent some hours each week doing documentation and providing coverage for the hospital's inpatient pediatric program.

Clark says the program is being expanded to 12 students for this school year. The school is being reimbursed for the speech therapy through the Oklahoma Health Care Authority, so some of the rehab speech therapists will be reimbursed.

The program's success prompted some other rural schools to contact the rehab facility about occupational therapy, neuropsychology, and educational inservices for teachers. "We have gotten a call from other school systems asking if we have a psychologist who can work with a family or child, and we say, 'Yes, we have other allied health professionals who could do this,'" Clark says.

(Continued on page 137)

REHABILITATION
OUTCOMES REVIEW™

Teach staff how to count units billed per HCFA change

Develop competency program for reimbursement

One of the more important quality issues a rehab facility will face in the current environment has to do with staff's understanding of billing issues and reimbursement.

That's not to say staff should be entirely fluent in prospective payment system (PPS) terminology and methods, but it will improve a rehab facility's efficiency and outcomes if therapists and other staff understand how their services translate into reimbursement dollars.

After the Health Care Financing Administration (HCFA) implemented changes in how rehab facilities count billed units of therapy, Ingham Regional Medical Center rehab department in Lansing, MI, began an extensive staff education program on the subject. "We went to ground zero to teach staff how CPT [current procedural terminology] codes work, the Medicare fee schedule, how things are defined, such as what is 'whirlpool' and what are 'therapeutic exercises,' and we turned it into a competency," says **Teresa Vinson**, MPA, PT, rehab supervisor for the 20-bed rehab facility, which is part of a 241-bed acute care hospital.

The rehab services department gave staff therapeutic procedure guidelines and modalities along with the CPT codes for the various therapy procedures. Here's how the educational and competency program works:

- **Assess the need for a competency program.** Rehab supervisors initially thought they could update staff about reimbursement changes through a staff memo. "Then, as we started learning more about how charging and reimbursement works, we realized that our staff as a whole doesn't have an understanding of the intricacies of billing," Vinson says. So they decided to create a complete competency program about billing and reimbursement.
- **Give staff a handout with guidelines.** Supervisors gave the staff a three-page handout that included some of the HCFA requirements and definitions for terms such as "unit." It also included examples of how to calculate minutes and charges, and it broke down some of the guidelines, offering examples of what is and is not reimbursed by Medicare. **(See information in handout, p. 135.)** They also gave staff a chart that explains what billable time is. **(See billing chart, below.)**

When determining billable time:

	IT IS....	IT IS NOT...
HP/CP	Billable Counted in total treatment time	A service we provide. A statistic we track via charge sheets Documented
Calculation of Time	Pre and post delivery services. The time counted begins when the therapist or an assistant under the supervision of a therapist is delivering therapeutic services. The patient should already be in the treatment area and prepared to begin treatment.	The time actually spent in the delivery of the modality requiring constant attendance and therapy services.
Calculation of Time	The time spent if two therapists or a therapist and assistant are required to treat the patient simultaneously. In other words, 15 minutes of treatment by two professionals is one billable unit. We are investigating how this impacts co-treatment between disciplines.	The time counted is the time the patient is treated.
Calculation of Time	Rest time -- even if therapeutic	Education -- safety, exercise program, joint protection, etc.
Billing of Time	A charge for each type of intervention provided.	A reflection of total time the patient is treated. It is documented with a start and end time **OR** a start time and a total treatment time.

• **Explain why a competency program is needed.** Supervisors explained how the recent changes in Medicare billing created the need for staff to learn more details about how to calculate billable hours. To communicate that need, supervisors told staff, "This isn't just making life more difficult for you as a therapist, this is protecting your license and protecting the hospital to make sure we follow these guidelines," Vinson recalls.

• **Create a competency tool.** Using a fee schedule form, a CPT code book, and other information, Vinson and outpatient supervisor Heidi French, PT, spent six weeks developing the competency tool. "We had turned it into a worksheet, and there were 18 different treatment scenarios," Vinson says. "We tried to encompass outpatient medical rehab scenarios that would apply to all staff."

The result was a five-page tool, which the supervisors gave out at a quarterly rehab meeting, asking staff to complete the worksheet by the next staff meeting. **(See example of billing competency tool, inserted in this issue.)** It takes about 30 minutes to complete. After the staff finished the competency tool, supervisors reviewed it and answered questions at a staff meeting. ■

Billing and charging competency

(Editor's note: Ingham Regional Medical Center's rehab department has created a competency program for staff on Medicare billing and reimbursement. These guidelines explain some of the definitions and terms to therapists and other staff.)

The Health Care Financing Administration (HCFA) has provided clarification on counting units that has erupted into a professionwide (PT, OT, and SLP) discussion about how to charge for services. The objective of this competency is to instruct staff in the current billing guidelines provided by HCFA. Each staff member will complete a test on patient scenarios to ensure we all interpret the guidelines in the same manner.

2000 CPT Code Changes

1. Debridement. We can now bill for active debridement. Code G1069 will be added to our chargemaster in the near future. G1069 is the HCPCS code for removal of devitalized tissue, without anesthesia. This can be done by using high pressure jets, scissors, or scalpels and/or scrubbing with gauze. This charge does not include application or removal of bandages or topical agents. This is an untimed code and can be billed one time/visit.

2. Whirlpool. We will maintain our whirlpool (WP) charge, but delete our special WP charge. WP should not be used as a single modality but as a precursor to other forms of treatment for the enhancement of that treatment. Examples include:

• to warm tissue as a precursor to exercise;

• to cool tissue to reduce pain and swelling, therefore improving the quality of exercises;

• to clean a contaminated dirty wound, which is not the same as debridement; this is the cleaning of drainage or foreign material that may be contaminating the wound and could cause an infection;

• to remove bandages that have become embedded and stuck in the wound;

• to debride/remove devitalized tissue.

3. Group therapy. CPT code 97150 has been the focus of debate between HCFA and therapists. There is significant controversy on how this code should be used. It is our stance that the group therapy code will be used in this manner:

When the therapist or assistant is responsible for the treatment of more than one patient at a time, the group therapy code will be used for that patient not receiving one-on-one treatment from the therapist. For example, Patient A is exercising on the upper-body ergometer, while Patient B is receiving manual therapy treatment from the therapist. Patient A will receive a group therapy charge during that time the therapist is one-on-one with Patient B. Patient B will receive a manual therapy charge for that one-on-one treatment.

4. Manual therapy. All manual therapy techniques have been lumped together under manual therapy code 97140. This code covers myofascial, muscle energy, mobs, manipulation, manual traction, and manual lymphatic drainage. Continue to specify what technique was used in your notes.

5. Orthotic fitting/training. This code cannot be used in conjunction with gait training unless two separate areas are being treated. This must be clarified in your documentation.

To determine what to bill the patient:

1. Determine the total time the patient was treated.

2. Separate out untimed treatment minutes and timed treatment minutes.

3. Translate the total time treated into the corresponding units.

4. Charge for the services that take the longest time.

WHAT IS A UNIT?

1 unit = 8-22 minutes	5 units = 68-82 minutes
2 units = 23-27 minutes	6 units = 83-97 minutes
3 units = 38-52 minutes	7 units = 98-112 minutes
4 units = 53-67 minutes	8 units = 113-128 minutes

* **Example A:** If 24 minutes of neuromuscular re-education and 23 minutes of therapeutic exercise were furnished, then the total treatment time was 47 minutes, so only three units can be billed for the treatment. The correct coding is two units of neuro re-education and one unit of therapeutic exercise, assigning more units to the service that took more time.

* **Example B:** If a therapist delivers five minutes of US, six minutes of manual techniques, and 10 minutes of therapeutic exercise, then the total minutes are 21, and only one unit can be paid. Bill one unit of 97110 (the service with the longest time), and the clinical record will serve as documentation that the other two services also were performed.

* Examples taken from the Michigan Medicare B Bulletin, April 2000. ■

Need More Information?

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Balancing expansion with cost-cutting measures

*(Editor's note: **Judy Waterston**, chief executive officer of Schwab Rehabilitation Hospital & Care Network in Chicago, offers some examples of how a large rehab hospital attends to quality improvement issues while continually offering new services and staying abreast of the changing financial climate in the rehab industry. Schwab Rehab has 125 beds, including 30 subacute beds, and is affiliated with Sinai Health System, also in Chicago.)*

RCR: *Rehab Continuum Report* recently wrote about a new cancer rehab program and a new aphasia center at Schwab Rehab. Schwab has a number of other new programs, as well. How does your rehab hospital maintain a balance between putting resources into starting new ventures and trying to find ways to make existing services more efficient while improving quality?

Waterston: In order to grow, an organization must be able to balance efficient and effective operations with the creation of new programs and services. New programs, which are key to Schwab's future growth and viability, are a way to increase volume while meeting the needs of the patients and communities we serve. If an organization is stagnant, it will die. We are an organization in transition, learning to adapt to an environment which is constantly changing.

RCR: Health care organizations often pride themselves on their successful efforts in improving quality and increasing customer satisfaction. But in at least some health care industries, the staff and time dedicated to quality improvement has been cut back because of financial constraints imposed by the Balanced Budget Act of 1996. Do you see this occurring in the rehab industry, as well?

Waterston: Time dedicated to quality improvement is very important. As health care providers, we must prove to our patients, payers, and the communities we serve that we add value. Our customer service and clinical outcome scores will show that we do.

RCR: What is one example of a simple quality improvement measure begun at Schwab Rehab that has had a big impact on the hospital's services, operations, or customer satisfaction?

Waterston: At Schwab, we have undertaken several quality improvement initiatives over the past year. We've looked at nursing response time, outcome measures, and patient accessibility to care. This last initiative focused on improving the hospital's appointment scheduling processes for Schwab inpatients who are being discharged into one or more of our outpatient therapies. Our efforts on this initiative have impacted numerous areas within the hospital, helping us to develop more efficient and effective discharge and outpatient scheduling systems.

RCR: How important have outcomes measurements been to a rehab facility's goals, and do you

think this is becoming more or less important under the prospective payment system (PPS)?

Waterston: Outcome measurement under PPS will be very important. We have to be able to prove that our rehab interventions improve patient outcomes functionally. Under PPS, we will need to show our patients' outcomes justify the dollars spent on rehab care.

RCR: Health care organizations have tried to look at the glass as half full in recent years, many saying that they have improved quality in some areas by cutting patients' length of stay (LOS) and becoming more efficient in other ways. Can the managed care reimbursement cuts in rehab patients' LOS really be turned into a positive clinical outcome, and how is this possible?

Waterston: With the advent of managed care and other changes in reimbursement, organizations have been forced to partner with community agencies to identify alternative ways to care for our patients once they are discharged from the hospital. We also learned to think outside the traditional health care box, realizing that acute inpatient rehab isn't the end-all, but rather part of a continuum of care which includes many options for patients needing inpatient and outpatient rehab care.

RCR: Many of the recent managed care and PPS changes mean that some rehab disciplines have lost jobs, seen salary cuts, and otherwise faced career uncertainty; at the same time, those employed in the industry are expected to do more work in less time. How does Schwab Rehab maintain a happy or at least a content staff atmosphere in spite of these industrywide changes?

Waterston: I believe the key to change is communication. Frequent communication by management to all levels of the staff can go a long way in keeping them informed and reassured on what is happening throughout the organization. Communication between staff and management is also a way to plan ahead so that you can be successful as reimbursement and the delivery of patient care begins to change. Empowering staff to identify patient care solutions is also another way to keep them interested and involved.

Finally, I also believe that maintaining the hospital's focus on patients is paramount. Utilizing data, planning for the future, and piloting patient care studies are different ways to be innovative in creating the future of rehab. We are not victims of external forces, but rather instigators of change for the improvement of patient care. ■

Need More Information?

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- **Al Moorad**, MD, INTEGRIS Medical Director, and **Sharon Smeltzer**, MS, Director of Operations, can be reached at the same address. Telephone: (405) 644-5200.

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Telemedicine programs could include pharmacy and nursing consultations, as well as other therapies, she adds. "They took advantage of our speech therapy, but this year we hope we will be used for other specialty services as well, and we would like to set up contracts with other schools as well."

The rehab hospital could provide telemedicine services to rural communities and schools that are near Hugo Elementary by having those schools provide transportation to the school, where the dedicated equipment is in place.

Providing follow-up care

Another offshoot of the program is the hospital's ability to use telerehabilitation to follow post-acute stroke or spinal cord injury patients who do not have access to community services, Clark says.

"We've done studies with a physical therapist who works with patients who were discharged to their home communities and who then go to a rural hospital to receive outpatient therapy," she explains. "The physical therapist at Jim Thorpe then provides guidance and counseling through telecommunications technology."

The hospital has been exploring the use of inexpensive home-based units that could work on analog phone lines. That way, a physical therapist can observe the caregiver making patient transfers and watch patients during exercise programs to assess how well they're doing those activities.

"We have a research team currently evaluating different outcomes measures, and we're basically just at the beginning of using this technology," Clark adds. ■

Care managers help improve quality of care

Rehab patients benefit from seamless care

When a trauma patient first enters the 360-bed Gundersen Lutheran Medical Center of La Crosse, WI, and is admitted to the intensive care unit (ICU), the patient is assigned a care manager who stays with the patient until he or she is discharged from inpatient rehabilitation.

The care manager role, particularly having one care manager follow a patient through each medical setting, is crucial to the quality of care in the rehab facility, says **Linda Wieczorek**, BSN, CRRN, staff nurse on the hospital's 17-bed rehab unit.

"The care manager is serving patients to make sure all their needs are met," Wieczorek says. "Previously, we had a care manager in ICU, then when the patient transferred to the medical or surgical floors, there would be a brand new care manager, and then when the patient arrived on the rehab unit, there would be another care manager."

That resulted in communication problems and other issues because the patient and family continually had to explain their concerns and difficulties to staff, Wieczorek explains.

To solve those problems, Gundersen Lutheran Medical Center started the continuous care management program several years ago as a way to provide continuity of care to ICU patients and their families. **Cathy Bly**, BSN, one of the two nurse care managers, works with patients who have suffered from a spinal cord injury, brain injury, or other type of trauma. "Everybody is

Executive Summary

Subject:
Rehab care managers can follow patients from the ICU to discharge, providing greater care continuity and helping increase patient satisfaction.

Essential points:
- ❑ Care managers assess patients' personal and physical needs.
- ❑ When patients are transferred from the ICU to acute care or to rehab, the care manager is there to help the family adjust and to explain the family's particular needs to the new staff.
- ❑ Care managers also provide some follow-up care when patients are discharged from rehab.

Care managers support therapists, nurses

Care managers serve as partners in rehab

Rehab facilities and hospitals that have a care manager providing continuity of care to patients also will benefit from the care manager's support to rehab staff.

For example, at Gundersen Lutheran Medical Center in La Crosse, WI, care managers attend staffing meetings and provide support to all areas, including neuropsychology, occupational therapy, physical therapy, speech therapy, and dietary.

Care manager **Cathy Bly**, BSN, works closely with the rehab team to answer questions they may have about patients or serves as a liaison between the family and staff. Bly says she has become identified as the nurse who understands rehab issues and who provides support to rehab staff and patients.

The care manager also serves as a partner with rehab nurses, says **Linda Wieczorek**, BSN, CRRN, staff nurse on Gundersen's rehab unit. "We work together and fill in those blanks that are specific to the rehab nursing needs of the patient," she says. "We talk nearly every day."

Bly explains to Wieczorek and other rehab staff about patients' specific needs and histories. "This saves families from having to retell their story," Wieczorek adds. The care manager also is a liaison between rehab team members and the physician. "Cathy grabs doctors if need be and gets all my questions answered, and then she comes to me with all the information that she's gathered, and she gives that to me," Wieczorek explains.

That allows her to focus on the patient's care needs rather than spend time tracking down information from the doctor and other staff. Wieczorek doesn't need to be the patient's sole emotional support in rehab because the care manager has time to provide emotional sustenance. "There are times when a patient is telling you things, and you're thinking, 'Oh my goodness, I wish I had the time to spend with you and meet your emotional needs, but I have four more people I have to get to.' But Cathy has more flexibility and has established a relationship with the family through their tragedy, so there's a special bond there." ■

unique, and it's important for us to know what kept a patient comfortable at home and what strategies worked at home so that we can provide a less threatening environment for that patient," she says. That's Bly's job — to find out what a particular patient needs and to communicate those needs to the staff in ICU, acute care, and rehab.

The hospital hasn't measured outcomes since beginning the continuous care management program, but Wieczorek says the anecdotal evidence suggests it helped the rehab facility reduce lengths of stay and improve quality in patient care. "It has been real positive for patients to have a trusted person right with them through their recovery," she says. Also, rehab staff benefit from having one person they can contact if they need to give the patient's doctor or family some new information about the care plan.

Here's how the program works:

1. The care manager assesses patients after ICU admission. Bly completes a tool called the Functional Health Patterns Assessment based on what she learns from the family of new patients. When a patient is able to answer questions, she will confirm the family's answers with the patient.

That tool, which takes about 10 minutes to complete, gives Bly an overview of the person's life, including questions about how the patient eats and sleeps, elimination issues, who the patient's supports are, how the patient copes with problems, overall health issues, and spiritual aspects of the patient's life. "This gives us a pretty good picture of the patient," Bly says.

She uses the information to create a more comfortable environment for the patient. For example, if a patient enjoys a certain television show, Bly will write this into the care plan, so hospital and rehab staff can remind the patient when that show is on. The same strategy is used to find music and other activities the patient enjoys.

During the most traumatic and intensive part of a patient's hospital stay, Bly meets with patients and their families about twice a day. She typically checks in with the family and patient during the mornings and then again in the afternoons.

"Sometimes, the families are so overwhelmed with the big words and complexities of the medical equipment that they want someone to decipher

what is happening," Bly says. "So I sort of become a communication link."

Likewise, if a physician has told the patient and family something they don't understand, Bly checks with the physician to get a clear answer for them. She also meets daily with dietitians, social workers, chaplains, and other disciplines to discuss the patient's care. **(See story on how care managers support other rehab staff, p. 138.)**

2. The care manager develops relationships with the patient, family, and staff. Soon, patients and their families begin to trust Bly and see her as their advocate and liaison. "They begin to trust my judgment, and things move smoother for them," she says. She is, in effect, a buoy in an ocean of uncertainty for parents of young people with brain injuries. "I've shared a period with them when we don't know if their son or daughter is going to live or die, and consequently, we often become buddies in this tragedy," she explains. "I know what the families are going through, and I can give them some encouragement."

Another stressful time is when the patient leaves the ICU and is moved into another area of the hospital. The family and patient sometimes are frustrated because they suddenly have to start all over meeting a new staff of nurses. Bly provides some continuity in their experience, because she will be with them whether they have moved to acute care or directly to the rehab unit.

Since Bly became a care manager for traumatic injury patients, she's often convinced the rehab team that certain patients do not need to be transferred from the ICU to acute care before entering rehab. "We can transfer a patient directly from ICU to rehab so the patient and family don't have an intermediate stop. For the cases where that has happened, it has worked out very well."

She convinces the rehab team that some patients will not have medical problems too complex for the rehab unit to handle. The rehab team has grown to trust Bly's judgment and usually follows her suggestions. "I've had 100% success with the ones I've sent over to rehab," she says. "I know the work that's involved, and I don't want to see someone fail." She also paves the way emotionally for rehabilitation patients. "Within a day or two, if we have a patient who is going into rehab, I start to get the staff psyched. I commit to my patients, and I want the staff to like them as much as I do."

3. The care manager provides unique services to patients. Care managers work very closely with patients and their families and therefore have some opportunities to provide services that are out of the ordinary. "I try to see each patient as being unique and try to get the things that person specifically needs," Bly says.

For example, one of her patients was a grandfather, so she made sure he received some photos of his new grandchild. Another patient was a from a foreign country and needed to return home after his injury. Bly made phone calls to airlines to check their weight limits on baggage and packages and then, along with volunteer help, assisted the man in packing his belongings in boxes that were under the 70 lb limit. The hospital even sent someone with him on the plane trip because he needed assistance with his wheelchair.

"There aren't any specific boundaries to what you can do with this job," Bly says.

She also prepares patients and their families for rehabilitation and the subsequent changes to their

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lives. "I educate the family of what to expect, like if they need ramps or 24-hour supervision. This way, it's less overwhelming for the family to deal with the patient's disability because we've been talking about the changes from the start."

Early on, she provides families with manuals on head injury and spinal cord injury. The families have plenty of time to read them and ask her questions as the patient progresses.

4. Care manager provides follow-up care. When patients are discharged, Bly calls their homes to see how things are going. She also sees them when they come in for appointments. "This is a plus with the families because, if you've been with them for an extended period of time, they like to see you again," she says.

If a patient is readmitted to the hospital or rehab unit for any reason, Bly is automatically identified as the care manager. That, again, provides the family with reassurance and gives the patient an added dimension to the continuity of care. ■

Need More Information?

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