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INSIDE

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PPS and other rehab industry changes will make patient education more vital

North Carolina facility develops patient book

As rehab facilities try to improve patient outcomes while reducing costs and length of stay, they'll realize what the home care industry has known for the past couple of years: Patient education is crucial to clinical and financial success.

This means that it's not enough to hand patients and their families a batch of written materials and expect them to learn most of what they need from that. Rather, rehab facilities will need to develop comprehensive educational programs that are multidisciplinary and diagnosis-specific. That is the conclusion reached by managers of the University of North Carolina (UNC) Health Care Rehabilitation Centers in Chapel Hill. The 30-bed rehab facility is developing an ambitious educational program that will coordinate all educational materials, including those for staff, patients, and community members, in a multidisciplinary fashion.

"Education has been one of our major initiatives over the last few years," says **Susan Evers**, MPH, administrative director for the department of physical medicine and rehabilitation.

"We've developed an education committee and educational rehabilitation pathways," Evers says, "and we're giving staff more training in

Executive Summary

Subject:
North Carolina rehab facility makes patient and staff education a top priority as the industry prepares for the prospective payment system and other changes.

Essential points:
- ❏ Education efforts often are left to the various departments instead of being coordinated in a multidisciplinary, cohesive manner.
- ❏ It's a good strategy to create a patient education notebook for patients to use during their rehab stay and after being discharged.
- ❏ A comprehensive employee orientation manual will guide efforts to assess staff's competency.

crisis management."

Prior to the new program, each department conducted its own patient and staff education, often overlapping and sometimes missing important aspects, says **Stephanie McAdams**, MA, CCC-SLP, education coordinator.

"In addition, while we were doing community outreach and community education projects, they weren't as extensive as we wanted them to be, so we had to beef up things there as well," McAdams says. **(See story on community educational events, p. 144.)**

The educational program has resulted in new patient manuals, filled with information that helps patients navigate the rehab facility, find community resources, and learn about their particular injury.

Here are some of the different aspects of the new educational program:

• **Form an education committee.**

The committee comprises representatives from all disciplines, including a physical therapist, occupational therapist, speech-language pathologist, recreational therapist, social worker, nurses, neuropsychologist, rehab physiatrist, rehab technician, physical therapy assistant, and occupational therapy assistant.

• **Assess existing educational materials.**

Everyone on the committee brought existing educational materials from their department to the first meetings. Then the entire group reviewed and assessed each piece of material.

"They gave their opinions by writing comments, explaining their dislikes and likes for a particular item," McAdams says. "The educational items that most people didn't like were discarded."

These discarded items usually included educational materials that had some virtues but were not cohesive or could be easily replaced with better quality materials.

Committee members also brought in new educational material to suggest adding it to the revised program. Once the committee agreed on a consensus of items, the package was brought to the hospital's education department for approval and subsequent purchase.

• **Develop a patient information manual.**

The rehab facility's goal is to make sure patients receive all necessary educational materials prior to discharge, Evers says.

In response to this goal, the committee developed an educational notebook for patients. Various materials and information are collected in a three-ring binder, and the information is specific to the patient's diagnosis.

Committee members broke into smaller teams to develop materials for patients in three groups: spinal cord injury (SCI), traumatic brain injury (TBI), and stroke. Educational binders directed toward patients with other diagnoses will be completed later, but those three were the priority diagnoses, McAdams says.

• **Divide patient binders by information sections.**

The binders are divided and indexed by section. For example, there is a section with general hospital information, a section that identifies the patient's rehab team, a section dealing with medical issues, and one that discusses cognitive issues. There are separate books for the specific diagnoses, including SCI, TBI, cerebral vascular accident (CVA), amputation, orthopedics, and coronary artery bypass graft.

Beginning this month, the rehab facility will distribute these notebooks to patients when they are admitted. Patients and their families will keep these notebooks with them throughout their stay, and will be able to take them home. Additional materials, such as discharge instructions, will be added as necessary.

• **Make changes according to patients' needs.**

In conjunction with the educational improvement process, the rehab facility assessed its patient satisfaction survey data to see if they offered any clues about what information patients thought they needed.

"A couple of years ago when our satisfaction surveys came back, one area that was low was that people didn't feel like they were provided

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with information about community resources," says **Becky Binney**, MEd, TRS, CTRS, senior recreational therapist.

"So I developed a continuous quality improvement project that tracks the educational books we're putting together," Binney says.

The CQI project involves having the education committee put information related to community resources into the patient binders. The committee will then see if patient satisfaction results improve, Binney adds. Those results should be available sometime in 2001. **(See story on educational CQI project, p. 145.)**

• **Produces patient orientation video.**

The rehab facility, using the hospital's audiovisual department, made a nine-minute video that orients new patients and their families to the facility.

"We wanted to modify our initial orientation to the rehab center," McAdams says. "Before the video, the orientation was done verbally and with written materials, and we wanted to augment that."

The video guides patients and families through the entire rehab process, beginning with initial admission, continuing with an introduction of the rehab team and examples of specific roles of each team member, and ending with discharge planning and rehab continuum.

'Patient is central character'

Other features include rehab scheduling, community re-integration activities, daily conferences and training, and a look at the goal-setting process and how this is focused on the family's needs.

"The patient is the central character in the entire process," McAdams says.

Before creating the video, the education committee looked at sample videos from other rehab facilities and hospitals, again discussing what they liked and disliked.

"We wrote an outline and had team members give input," she explains. "Then we made that into a script and started shooting the video footage."

• **Create an orientation manual for new staff.**

A new committee, slightly different from the first education committee, was formed to create the staff orientation manual. This committee also was represented by all disciplines.

The committee brought in orientation manuals used by the various disciplines to review.

"We were interested in what the other disciplines were doing and thought it would be good for everybody to know," McAdams says. "This doesn't replace the general department orientation, but supplements it."

The new manual is in the form of a booklet, and it has an orientation checklist. It includes specific competencies for rehab items, such as a handicap van competency and rehab evacuation competency.

Staff education occurs on Internet

It's set up partially as a self-learning tool, and also will have training observational competencies. "We have portions of it on the hospital Web site and hope to get a larger share on the hospital Web site so the parts that can be self-learned are," McAdams says.

Each discipline was strongly involved in establishing discipline-specific education, and each new employee will receive orientation for all members of the rehab team. All employees will receive the new orientation manuals, including nursing students, medical staff and residents, nurses, therapists, psychologists, and therapy assistants.

"This helps to give staff a better understanding of what all team members are doing and what their roles are on the unit," McAdams says.

The staff orientation manual is continuing to be revised, but here are some examples of information included in it:

— rehabilitation center's scope of service, mission statement, and admission criteria;

— visiting hours and how to provide exceptional customer service;

— team meetings / family conferences / rounds;

— phones and paging systems, information security, and hospital abbreviations;

— domestic violence intervention program;

— utility systems - basic staff response;

— medical gas shutoff, evacuation procedures, bomb threat, infection control, and latex allergies;

— age appropriate competencies;

— body mechanics / transfers / evacuation techniques and restraint policy;

— rehabilitation documentation, including documentation policy;

— protocols, including neutropenia, neurological assessment, pressure relief, skin integrity, total hip protocol, and oxygen therapy;

— equipment, such as use policy, equipment

descriptions, Hoyer lift, Miami J Collar, Hill-ROM bed, Vail bed, vital signs monitor, pulse oximeter, defibrillator, and others;

— competencies and quizzes on fire safety, bomb threat, swallowing / aspiration, customer satisfaction, transfer competency, and others. ■

Educational events aid community, staff training

Facility taps into local resources to do seminars

Rehabilitation and the health care field are changing so rapidly with new technology and research that it's sometimes difficult to keep staff and the community up to date.

Rehab facilities can meet this educational challenge in a variety of ways, including holding community fairs, seminars, and even telephone or Internet conferences.

"I think educational events are absolutely crucial because the field itself is changing so quickly," says **Stephanie McAdams**, MA, CCC-SLP, education coordinator for the University of North Carolina Health Care Rehabilitation Centers in Chapel Hill. "It's absolutely important that we stay up to date as rehab professionals," McAdams adds.

Since the hospital-based rehab facility has made educational events a top priority, the number of events geared toward staff have increased from nine to 43 in a three-month period, McAdams says.

"These were attended by the multidisciplinary staff for the most part, although a few were specific to nurses," she adds.

The facility also emphasizes community education and outreach as part of its new focus. Here are some examples of recent educational events sponsored by the rehab center:

• **Local conferences:** Located in an area known for its medical research and new technology, the rehab center makes good use of local medical professionals, inviting them to conduct on-site seminars.

Conferences can be held via Internet

"We can do Internet conferencing, teleconferences, and video conferences," McAdams says. "We are a university hospital, so we have access to that type of network."

Rehab employees have access to educational information on the hospital's web site and may use computers located in all therapy and nursing areas.

The rehab center also has plans to hold a neurological nursing conference, open to all nurses in North Carolina. The conference will provide information about an interdisciplinary team approach to rehabilitation of a stroke patient, and it will give nurse attendees the opportunity to earn continuing education units.

• **National Rehabilitation Awareness Celebration:** Each year the center expands upon its rehab celebration, and in the past two years has included a focus on education. During its rehabilitation reunion for patients, family members, and staff, guest speakers addressed disability issues, McAdams says.

The most recent reunion event, held in September, was attended by several hundred people.

As part of the rehabilitation celebration, the facility also hosted a "grand rounds" speaker at the hospital. The talk was open to the public, although it was mainly attended by students in the allied health profession and hospital staff.

The speaker was David Kiley, who had a spinal cord injury at age 19. Kiley, who spoke on "celebrating the successes of people with disabilities," was a gold medal winner as part of the U.S. paralympic basketball team in 1992 in Barcelona and has competed internationally in skiing and tennis.

Kiley presented an educational forum on general disability and wheelchair sports, including the Adaptive Sports and Adventures Program of Charlotte at the Institute of Rehabilitation in

Executive Summary

Subject:
Rehab facilities can be creative in devising ways to educate staff, area health care professionals, and the public about rehabilitation services.

Essential points:
- ❑ Community educational efforts could include inspirational speakers, rehab fairs, and other types of programs.
- ❑ Local conferences can save money and provide educational outlet for area health care professionals.
- ❑ Tie educational events to a national rehabilitation awareness celebration.

Charlotte, NC, which he directs.

• **Rehab vendor fair:** The rehab facility hosted a large community educational event at a mall in Chapel Hill. The fair included nearly 50 vendors and more than 90 participants who provided educational materials, including community resources for the disabled, assisted living products, and other services.

Displays and booths included: adaptive travel, diabetes screenings, mobility equipment displays, products that assist with daily life, adaptive gardening, disability advocacy, adaptive feeding equipment, general fitness assessments, referral services, alternative medicine exhibits, on-site rehabilitation specialists, workplace ergonomics displays, and assisted living alternatives.

• **Support group:** "Another new educational event is that we've initiated a support group that meets once a month at a local senior center chapter," McAdams says. "The support group has a strong community education focus because we bring in a speaker on a monthly basis to address a variety of topics, including universal design, modifications, estate planning, current stroke research, and pool therapy." ■

CQI project focuses on patient education

Rehab facility offers more resource info

A patient satisfaction survey conducted at the University of North Carolina Health Care Rehabilitation Center in Chapel Hill, indicated that the facility needed to get the word out about community resources.

Only 59% of survey respondents said they had received information about community resources that would be available to them post-discharge, says **Becky Binney**, MEd, TRS/CTRS, senior recreational therapist for the hospital-based facility.

A rehab team decided this warranted a continuous quality improvement (CQI) project that would make improvements and track patient satisfaction outcomes.

Since the facility already was developing new patient education binders, one easy approach would be to place additional information about community resources into the binders.

Although the CQI project still is under way, Binney says she is confident it will be successful. Here's how it works:

1. Form committee to write goals.

The CQI committee consists of a nurse and senior therapists, including a physical therapist, an occupational therapist, and a speech therapist.

Committee members brainstormed to identify goals and possible solutions. The goals were:

• to assist in the development of comprehensive interdisciplinary educational pathways and mechanism for disseminating information to rehabilitation patients prior to their discharge;

• to ensure patients are receiving all necessary educational information prior to discharge;

• to improve staff knowledge and ability to teach and disseminate information to patients;

• to ensure patients are receiving necessary information relevant to their specific diagnosis;

• to improve the rehabilitation patient satisfaction survey scores related to "receipt of community resources" from 59% to at least 80%.

2. Assist in development of patient binders.

The rehab facility already was working on creating patient education binders that would provide patients and their families with detailed descriptions of the rehab experience, information about the patient's specific injury, medication information, and sections on functional needs, exercise, and other important material.

It was not difficult to add a section to the three-ring binder on community resources.

The binder gives recreational therapists a more effective method for providing patients with educational information about community services that patients can access after discharge.

In addition to the patient education notebook, the staff will use a patient education checklist, which is included in the notebook, to make sure patients have received everything they need to know about community resources. Once a patient is given instruction and provided with the information, the recreational therapist checks off that category. Therapists also will file related handouts in the designated sections of the patient's educational binder so that the patient can refer to these after being discharged.

The CQI team and recreational therapists identified these key components of the community resource information to be provided to each patient:

• transportation systems, car/van modification, and disability permits;

• community resources, including senior centers, adult day care centers, adaptive programs,

YMCAs, wellness facilities, learning opportunities in the community, advocacy groups, and support groups;

• recreational opportunities, including special equipment orders, sign-up for catalogs, adaptive equipment, wheelchair sports programs, adaptive recreational opportunities, and mainstreaming into other community recreational programs.

3. Research community resources.

Committee members already had some information about community resources, and these were updated and added to the community resources section of the binders. The resource material included listings of local facilities and organizations, as well as general support and resource information.

Call local service groups to update list

To make sure they were not missing new resources, CQI team members called various local organizations.

"Some of the problem might be that patients don't understand what you mean by resources," Binney says.

"So we developed handout sheets," she explains. "For stroke patients, we made handouts with phone numbers for the American Heart Association; for spinal cord injury patients, we provided information about support groups."

Each patient is given a flier with this type of information upon discharge.

The team also found some very useful material at an Independent Living Fair the rehab facility sponsored in a local mall. The 50 vendors included assistive technology companies and service organizations catering to disabled individuals.

"This was an opportunity to go around and see what other organizations offered," Binney says.

For example, the rehab fair had booths about transportation systems in different counties, and since that's a big issue for many people, Binney included that information in the community resource section.

Other local resources are senior centers, adult day care, and independent living programs. The binder includes lists of these types of services and their locations, divided by county, so patients can easily see which are closest to their homes.

"We provide catalogs about adaptive equipment, crafts, and sports programs that patients can access after they're discharged," Binney says.

4. Periodically update and track success.

The community resource information is updated frequently. Each time a patient is admitted, a recreational therapist will make more phone calls to find resources in that patient's home town or county.

Once the patient education notebooks are completed and distributed to patients, the CQI team will track patient satisfaction outcomes to see whether the changes have resulted in a measurable improvement.

"We give each patient a satisfaction survey before the patient leaves the rehab center," Binney explains. ■

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Keep staff focused on infection control

Rehab facility's program is comprehensive

As the 21st century ushers in a time of unprecedented antibiotic drug resistance in pneumococcal and other common bacterial infections, rehab facilities need to renew efforts to improve infection control. This could mean further training and competency testing for staff.

Gundersen Lutheran Medical Center in La Crosse, WI, has about 150 employees, including therapists and other rehab staff, who are associate infection control practitioners (AICP), specially trained in standard precautions and other infection control measures. **(See role specification for AICP, p. 148.)**

"We have to attend a four-day orientation program that covers everything about infectious diseases," says **Marguerite Costigan**, PT, AICP, staff physical therapist for the 20-bed rehab unit within the 282-bed hospital.

AICP staff meet monthly

Staff certified as AICPs meet every other month to discuss infectious disease problems that have arisen and how to solve them. They also report how their individual departments are following standard precautions and other procedures. For example, they address questions such as, "Is the temperature in the refrigerator being checked every day and logged?"

The AICP staff also hold one-hour, public educational sessions open to the entire hospital staff. Once a year, there is a community and hospital-wide educational seminar, held over a two day period. It covers different topics through poster-board and other types of presentations.

Previous topics have included rabies, tick bites, how to keep food safe at picnics, and other information about preventing infections. The staff must attend and are required to sign in with employee numbers and complete a one-page evaluation form.

Infection control staff also collect data on nosocomial infections. They assess whether antibiotics are being administered correctly and keep track of each department's infectious disease rate.

The goal is to ensure that the entire staff follows standard precaution measures at all times. The assessment includes a written test and observation of the employee at work. **(See standard precaution assessment test, right.)**

For example, the rehab staff are assessed

Executive Summary

Subject:
A rehab facility has made infection control a major focus by creating an associate infection control practitioner (AICP) position for staff who are specially trained in standard precautions and other infection control measures.

Essential points:
- ❑ Infection control staff collect data on nosocomial infections.
- ❑ AICP staff meet monthly to discuss infection control problems and issues.
- ❑ AICP staff monitor and assess staff's infection control measures.

Assessment Test

Here's a sample standard precaution assessment test given to rehab staff.

Gundersen Lutheran Medical Center in La Crosse, WI, promotes strict attention to infection control among its entire staff, including rehab employees. The hospital's efforts include a written assessment of infection control techniques.

Employee Name _____
Unit _____
Employee Number _____

(True or False)

1. Standard precautions are designed for the care of all individuals regardless of their diagnosis or presumed infectious status and apply to: blood, all body fluids, secretions and excretions regardless of whether they contain visible blood, nonintact skin and mucous membranes.
   A. True
   B. False

(Select the best response)

2. Personal protective equipment (PPE) used in practicing standard precautions includes:
   A. Gowns
   B. Gloves
   C. Masks
   D. Goggles
   E. CPR Mask
   F. All of the above
3. Personal protective equipment should be found:
   A. In the locker room.
   B. In the patient care areas (i.e., nurse's station, standard precautions basket, personal protective equipment cabinets).
   C. In the employee health & safety office.
4. Personal protective equipment should be used when there is contact with:
   A. Urine
   B. Blood
   C. Any body fluid
5. Match the color of the isolation signs with the precaution/isolation categories. (All four need to be correct to receive credit.)

Color	**Category**
A. Green	___ Contact
B. Yellow	___ Droplet
C. Orange	___ Airborne
D. Pink	___ AFB

Answers: 1. a, 2. f, 3. b, 4. c, 5. c,b,a,d

annually on how they wash their hands.

"Every employee goes through a test, and I watch people wash their hands to see if they're doing it appropriately," Costigan says. "Do they do at least 10 seconds of scrubbing of the hands themselves?"

Other competency points are:

• Do employees use a paper towel to turn off the faucet instead of touching the faucet with the hands they just washed?

Role Specification for Associate Infection Control Practitioner

Gundersen Lutheran Medical Center in La Crosse, WI, designates certain staff as associate infection control practitioners. Employees desiring to receive this designation must attend a four-day education program, offered one day a month for four months.

Here is an outline of what the role requires:

1. Position Title: Associate Infection Control Practitioner
2. Responsible to: Unit Manager
3. Hours and Schedule: To be determined
4. Role Summary: A health care professional, specifically designated and educated to serve as a resource person and work cooperatively with all involved members of the health care team, including the patient and family to prevent nosocomial infections.
5. Background Experience: Staff person with at least one year clinical experience. A minimum of six months experience on the nursing unit/department for which person will be acting as associate infection control practitioner.
6. Duties and Responsibilities:
   - A. Responsibilities — general
     1. Act as liaison between the unit/department and infection control.
     2. Serve as a resource person for all infection control-related practices on the unit/department, such as standard precautions, patient placement, and prevention of nosocomial infections.
     3. Participate on the infection control committee when appropriate.
     4. Attend infection control inservices and conferences.
     5. Participate in development, review, and revision of unit policies.
     6. Facilitate communication to other nursing units or departments.
     7. Participate in surveillance activities as needed.
   - B. Responsibilities — patient-related
     1. Implement infection control precautions and work practice controls to prevent the spread of infectious disease.
     2. Promote practice of standard precautions for all patient care activities.
     3. Assist with problem solving and follow-up for specific unit infection problems.
     4. Guide staff to instruct patients and families regarding infection control and prevention.
     5. Assist in planning care regarding infection problems or isolation.
     6. Promote community health through monitoring immunization records; control of communicable diseases; and teaching related to waste management, sanitation issues, and hygiene.
   - C. Responsibilities to unit staff
     1. Orient new staff in relation to infection hazards and prevention.
     2. Educate staff as needed.
     3. Promote aseptic technique for all patient care.
     4. Assist personnel with the surveillance interpretation of microbiology lab results.
     5. Monitor compliance to standard precautions.
     6. Report findings from epidemiologic investigations.
   - D. Responsibilities for equipment
     1. Be knowledgeable about the equipment used in the unit as it relates to infection hazards, cleaning, and storage or disposal.
     2. Advise staff regarding the proper handling and care of equipment.
     3. Monitor cleanliness of patient rooms, utility and med rooms, bathrooms, kitchens, etc.

• Do employees use soap each time they wash their hands?

• Are employees washing hands between each patient contact?

• Are they using personal protective equipment for whatever procedure they're doing?"

• Are the employees working on wound or debridement wearing a mask and gloves and protective jackets or gowns?

• Are employees recapping needles properly and disposing of them safely in sharps containers? **(See sample policy statement for sharps disposal, above.)**

Assistants observe staff's handwashing

"It's my job to get the assessment done," Costigan says. "We designate two rehab assistants to observe people handwashing throughout the day to make sure they washed them for 10 seconds and that they did all the steps they were supposed to do."

Sharps Disposal Checklist

Gundersen Lutheran Medical Center in La Crosse, WI, created this simple checklist to make sure staff dispose of sharps correctly.

Completed by: _____

Unit: _____

Policy Statement for Sharps Disposal

A. Syringes, needles, and other sharp objects are placed in a rigid, plastic, leakproof, closable sharps container.
B. Used needles should not be broken off, purposely bent, or recapped before disposal. Exception: If procedure requires the contaminated needle to be recapped and no alternative is feasible, the only acceptable method is a one-handed scoop technique.
C. Needles must not be removed from syringes by hand.
D. Sharps containers should be sealed when two-thirds full.
E. Broken glass should not be picked up with bare hands but swept up with a broom. If a small amount, place in sharps container. If a large amount, page janitor.

Were sharps disposed of according to policy statement?
Yes ___ No ___

The hands-on competency test is scored objectively. It applies to every employee who comes into the rehab department, and the hospital's goal is to have the staff score 100%, Costigan says.

Recent infection control results in the rehab department were a 100% on handwashing, 100% on proper use of masks and eyewear, 92.3% on proper use of gowns, and 87.8% on proper use of gloves. ■

Handwashing Checklist

Gundersen Lutheran Medical Center of La Crosse, WI, made this checklist to assess whether staff are correctly following infection control measures with regard to handwashing:

Job Category:
MD ___
Res/Intern ___
Nurse ___
Resp Care ___
Lab ___
Other ___

1. Hands cleansed after patient contact, using gloves, contact with contaminated items, and before caring for immunodeficient patients.
   Y / N
2. Technique with soap and water:
   A. Used soap from dispenser.
      Y / N
   B. Greater than or equal to 10 seconds of friction.
      Y / N
   C. Patted hands dry with paper towel.
      Y / N
   D. Toweling used to turn off water (not applicable if sink with foot controls is used).
      Y / N
3. Alcohol gel used as a handwash substitute.
   Y / N
4. Greater than or equal to 15 second period of friction (hands must be thoroughly wet).
   Y / N

Need More Information?

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Scoliosis screening is good public service

Oklahoma rehab facility reaches students

Oklahoma is among the 30 or so states with no mandates regarding scoliosis screening among school-age children. As a result, many middle-aged adults suffer from its severe ramifications, which include pain and surgery.

"We've all known scoliosis is a severe problem," says **Ashima Bajaj**, MD, grants and research and development associate for Jim Thorpe Rehabilitation Center in Oklahoma City.

Jim Thorpe began a comprehensive scoliosis screening program for middle school students after receiving a grant from a woman who was interested in promoting such screening on behalf of a family member who had scoliosis.

The rehab facility's challenge was to educate physicians and the public about the condition, because it was not well-known.

"We have spoken with orthopedic surgeons and pediatricians in Oklahoma City [about creating] a big education awareness campaign for parents, as well as for physicians," Bajaj says. "Scoliosis was not emphasized in medical training in Oklahoma City."

Even physicians who received their medical training in Texas or other neighboring states that mandate scoliosis screening might not be providing routine screening to their patients because they expect the schools to take care of the matter, she adds.

The new scoliosis educational campaign includes providing continuing education credit for family practitioners and pediatricians who receive scoliosis training. The free session provides lunch and features national scoliosis experts as speakers.

The rehab facility also will encourage rural physicians to attend.

Plans are to hold the physician training in the morning of the same day that the rehab facility will sponsor a large community education program. The public will have the opportunity to listen to professional speakers talk about scoliosis and why it's important to screen for the problem.

"We would like to hold this program every year for the next three years, and we'd like to set up an endowment for people who can't afford the brace or office visit," Bajaj says.

School nurses also will be trained to screen for scoliosis among the target population of students, ages 12 to 14.

"If schools don't have the money, we'll fund the program or hire school nurses to come up for two to three days to do the screening," Bajaj says.

The community education is expected to result in more parents asking their children's physicians to check the child for scoliosis.

The screening is fairly simple, Bajaj explains.

"A pediatrician can run fingers around the spine and put on a scoliometer to look for lateral deviation," she says. "If there is anything out of the norm the pediatrician can refer the student to a specialist."

Typically, a spine deviation of 10 to 20 degrees is considered a mild curve and could potentially result in a patient being placed in a brace. Any deviation above 20 degrees is considered moderate to severe scoliosis.

Unchecked, scoliosis can grow worse as people age and eventually result in debilitating pain, Bajaj says.

"Middle-aged people with scoliosis may have internal organs that are not placed properly; they're almost dislocated," Bajaj says. "Their lungs and stomach are not in proportion to everything else."

People who have scoliosis that was never detected while they were young often will undergo surgery that may require their bodies being put in a cast for 10 months. But this extreme form of correction typically occurs after they have already suffered from physical and emotional problems resulting from the disorder.

"They live with a lot of pain and have psychological problems because they can't wear certain things without it looking obvious that they don't have a waist on the right and left sides," she explains. "Their bodies have been torqued a lot."

Rehab facilities will see these patients before surgery to assess whether rehab will be enough to help with their pain and show them how to walk properly. If the problem is severe enough, the patient will undergo surgery. ■

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Cross-train rehab and acute care therapists

Program makes for better communication

Cross-training provides a hospital and rehab facility with flexibility when confronted with particularly high or low census periods. It's also a way to bring inexperienced staff up to speed with veteran staff.

Ingham Regional Medical Center in Lansing, MI, moved to cross-training inpatient rehab therapists and acute care therapists after managers realized there was a big gap in experience between the acute care and rehab occupational therapists (OTs).

"For our two OTs on the acute care campus this was their first job out of college," says **Teresa Vinson**, MPA, PT, rehab supervisor for Ingham Regional Medical Center. The hospital has 230 acute care beds and 20 rehab beds.

The hospital's rehab therapists, by contrast, were experienced and trained in many different aspects of therapy.

Cross-training gives staff 'big picture'

Rehab therapists didn't have a good overall picture of what happened to patients, however, because they began to see them only in rehab. The acute care therapists, on the other hand, had the opportunity to observe what happened to their patients when they left the acute care setting.

"So our rehab OTs needed process training on how the system works here," Vinson says. "They needed to grasp an understanding of how acute care is very different and you can't do everything in acute care because the pace is so much faster."

A cross-training program proved to be the ideal learning process for therapists in both acute care and rehab.

Anecdotal evidence suggests it also has saved the hospital money and improved patient care, Vinson says. So far the facility hasn't studied its benefits and outcomes formally, but may look into tracking data related to the change.

Here's how the program worked:

• **Rotation:** The facility required the two acute care OTs to rotate to the medical rehab unit for two months each, and the four medical rehab OTs rotated to acute care for one month each. The rotations were concurrent and lasted for four months. Each OT was assigned a mentor during the rotation. **(See chart on OT mentoring and cross-training, p. 152.)**

"We brought in extra staff to help them have time to do mentoring," Vinson says.

• **Feedback:** The OTs reported that they found the rotation very helpful. The acute care OTs learned from their rehab counterparts how to do a kitchen skill assessment and treatment. "The kitchen had been available, but they didn't use that resource," Vinson says. "And now they try to put it into the treatment plan of patients when appropriate."

Acute care OTs also have changed their perception about how to prioritize patients, she adds.

"In acute care the patient's length of stay is so short that they'll evaluate a patient and don't have

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the opportunity to treat that patient," she explains. "Now they think that maybe it's more important to treat the patient they've already assessed and hold off on starting with a new patient."

The rehab OTs said the rotation helped them learn and understand the difficulties the acute care OTs have because of the faster pace of their work.

"Rehab care OTs might have five patients on caseload in a day, while acute care OTs might have 14 or more," Vinson says. "That's definitely been consistent feedback from rehab OTs." Now when acute care OTs call for help, saying they're busy, the rehab OTs know they really mean it, she adds.

• **Efficiency:** Although the rehab and acute care units are on different campuses, the OTs have been able to fill in for one another since the cross-training was complete.

"They've been able to go from one campus to another on a moment's notice and pick right up with the work, helping out," Vinson says. "Before, we would have to call a PRN person who would have to receive some orientation." ■

OT Mentoring and Cross-Training

Ingham Regional Medical Center of Lansing, MI, had its rehab department occupational therapists cross-train with the acute care OTs. This chart explains how the program works:

Purpose: To increase the knowledge and skills of the OT staff providing services in acute care by exposing them to inpatient medical rehabilitation. It is anticipated that mentoring with the medical rehab OT will broaden evaluation and treatment methods to be utilized in the acute care setting. Developing an understanding and appreciation for the continuum of care will provide a focus for the intent and value of acute care OT.

GOAL	PLAN
Greenlawn OTs will be proficient and skilled in providing services to the inpatient rehab population (Penn Campus).	• Greenlawn OTs will complete a two-month rotation to the inpatient medical rehabilitation unit. • Greenlawn OTs will be assigned a mentor during their rotation. Mentoring will involve but is not limited to observation, feedback, orientation, and instruction.
That each OT will maximize the experience obtained on the medical rehabilitation unit by integrating evaluation and treatment techniques as able in the acute care setting.	Greenlawn OTs and Penn OTs will collaborate on acute care to identify opportunities for integrating skills obtained on med rehab.
Med Rehab OTs will be cross-trained in acute care OT in order to assist in coverage when needed, with minimal orientation necessary.	• Med Rehab OTs will complete a one-month rotation to acute care. • Greenlawn OTs will provide orientation and feedback on procedures and treatment methodology in acute care during the Penn OTs' cross-training experience.

Physical Therapy Treatment for Pelvic Floor Muscular Dysfunctions

PT evaluation for any dysfunction includes an assessment of:

- ❑ Muscle length and strength imbalances
- ❑ Tenderness or trigger points
- ❑ Functional movement patterns
- ❑ Joint dysfunctions
- ❑ Boney alignment
- ❑ Behavioral patterns

Common signs and symptoms of pelvic floor muscular dysfunctions:

- ❑ Poorly localized peri-vaginal or rectal, lower abdominal, suprapublic or coccyx pain
- ❑ Referred pain into the posterior and anterior/medial thigh
- ❑ Sense of heaviness in the vagina, bladder or rectum
- ❑ Dyspareunia — both superficial and deep
- ❑ Urinary dysfunction: urgency, frequency, hesitancy, incontinence (mixed, stress, urge), nocturia or pain with urination
- ❑ Constipation
- ❑ Back pain or other dysfunction that does not get better with conventional treatment - visceral causes ruled out
- ❑ Frequent UTI
- ❑ Suprapubic pressure
- ❑ S/P urogynocologic surgery
- ❑ S/P radical prostatectomy
- ❑ Other symptoms of hypotonus, hypertonus, or incoordination dysfunctions

Treatment can include:

- ❑ Stretching
- ❑ Strengthening - pelvic muscle exercises, vaginal cone retention
- ❑ Relaxation of pelvic floor musculature
- ❑ Modalities - heat, ice, ultrasound, electrical stimulation, biofeedback, massage
- ❑ Education - bladder training, habit training, prompted voiding, functional movement retraining, dietary changes, bowel or bladder habits, posture, body mechanics
- ❑ Home program - may include education and instruction in self massage, assisted massage, stretching, strengthening and/or relaxation of pelvic floor and surrounding muscles, walking
- ❑ Physiological quieting

ICD 9 codes that PT can treat for the above types of pelvic muscular dysfunctions:

- ❑ 728.2 Muscle wasting and tissue atrophy not elsewhere classified
- ❑ 728.85 Spasm of muscle
- ❑ 728.9 Unspecified disorder of muscle, ligament, and fascia

Source: Howard Young Medical Center, Woodruff, WI.

AMERICAN HEALTH CONSULTANTS

2000 SALARY SURVEY RESULTS

Rehab Continuum Report™

Outcomes
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The essential monthly management advisor for rehabilitation professionals

Modest salary increases continue for rehab professionals

Outpatient facilities moving toward flexible schedules

As any physical therapist can tell you, these are not the halcyon days of high salaries, sign-on bonuses, and other perks known in the 1990s.

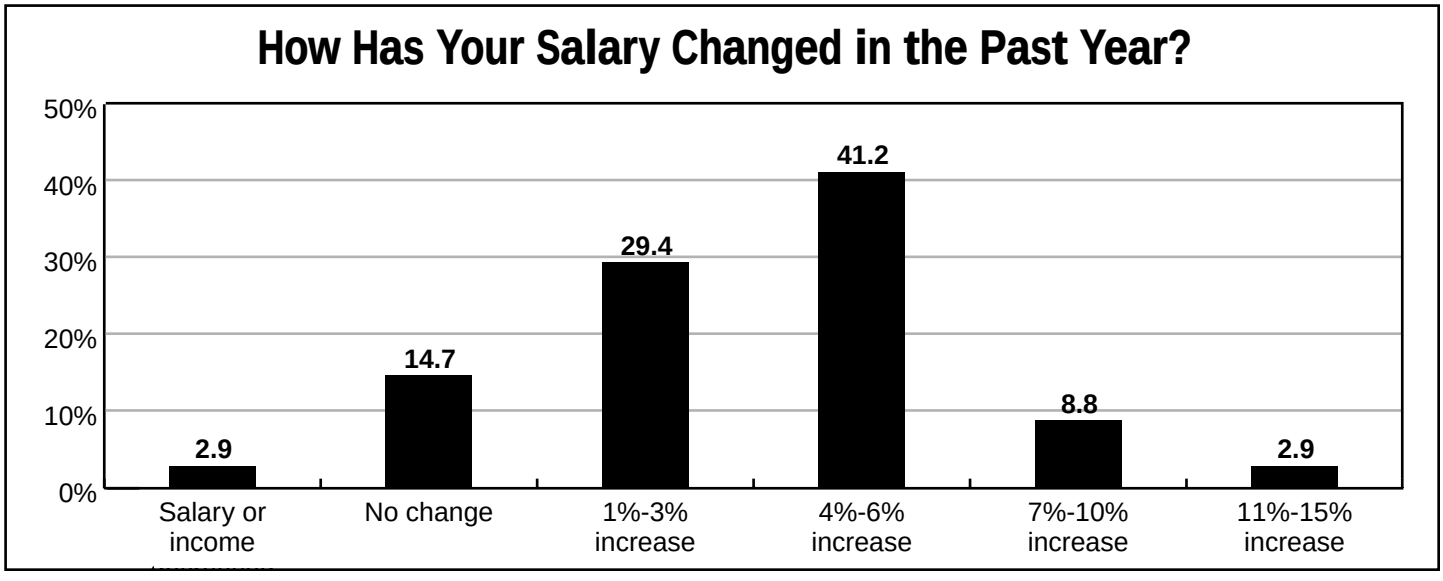
While salaries remain high for rehab administrators and directors, who are the main reader respondents to *Rehab Continuum Report*'s 2000 salary survey, industry experts predict salaries will level out in coming years. **(See annual gross income chart, p. 2.)**

"At the managerial level in the hospital, traditionally they don't cut people's salaries, they freeze them," says **Nancy Beckley**, MS, MBA, president of Bloomingdale Consulting Group, a health consulting firm in Valrico, FL.

The *Rehab Continuum Report* salary survey indicates that salaries have mostly increased for respondents. Only 2.9% reported a salary decrease, and 14.7% reported no change in salary. The majority, 41.2%, said their salary increased between 4% and 6% in the past 12 months. **(See chart on salary changes, below.)**

Beckley says that even hospitals that gave staff hearty raises in the past year probably were making up for a couple of years in which salaries remained flat.

Also, hospitals have found other ways to cut costs, including tightening or eliminating budgets for business travel and discontinuing education



expenses and seminars. In a recent study Beckley did of attendees at her company's educational seminars, called Rehabilitation Seminars of Tampa, FL, she found that 95% of attendees paid by personal check or credit card, whereas five years ago, 85% were sent by their company.

To save money, some facilities are having staff earn their continuing education units through tele-classes or home study courses.

Even so, hospitals are in a better position to withstand all of the changes the Balanced Budget Act (BBA) of 1997 forced on rehab and other industries.

Outpatient and freestanding rehab facilities have had more difficulty. These businesses have had to cut staff and in some cases salaries, Beckley says. They might make these changes by redefining certain positions and turning full-time therapy jobs into as-needed positions.

"In outpatient rehab there are more people working on a per diem basis or some type of flexible hourly schedule," Beckley says. "So if there are only 25 hours of therapy scheduled that week, they'll provide only 25 hours of therapy."

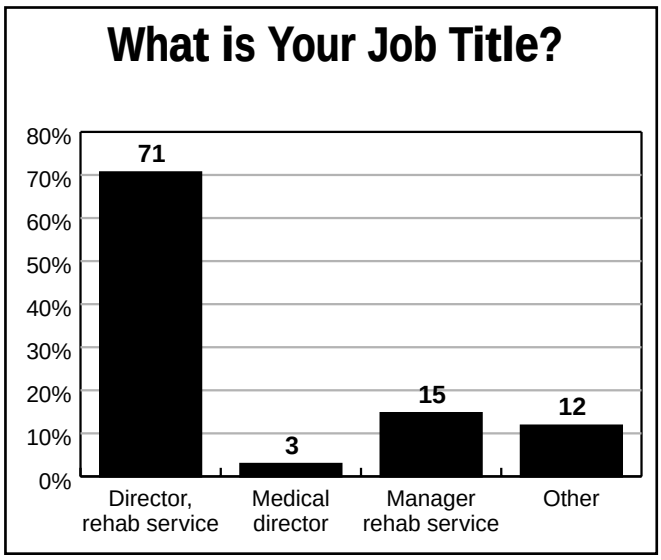
Further, the therapy professions are only now beginning to rebound from the job losses and salary cuts put into motion by the BBA.

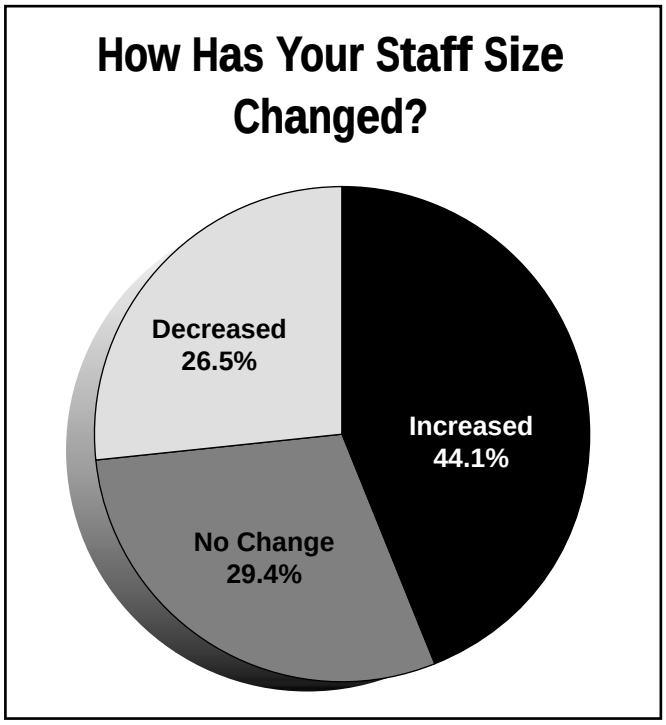
"When the BBA came into effect it sent the rehab world into a tizzy, especially in skilled nursing facilities," recalls **Bill Munley**, MHSA, CRA, administrator of rehab / neuro / ortho services for Bon Secours St. Francis Health System in Greenville, SC.

"Many companies were laying off physical therapists and physical therapy assistants, which before that was unheard of," Munley says. "Then all of a sudden there was a glut of therapists out there, whereas in the past we couldn't even get them without using agencies and sign-on bonuses."

Munley speculates that nursing facility, rehab, and other businesses probably laid off too many PTs, and now the demand has returned as nursing facilities are again hiring PTs.

Bon Secours St. Francis handled the salary issue differently than some rehab facilities, which simply cut PT wages. "Instead of taking a therapist making





$22 per hour and saying, 'You now make $18 an hour,' what we did was lower the range," Munley explains. "A therapist out of school may come in at $17 per hour instead of $18, and the cap might be $25 per hour instead of $26 per hour."

The rehab facility wanted to reward therapists who were loyal and stayed with the hospital when they could have chosen a higher-paying job, he adds.

The salary survey suggests that while the rehab industry has continued to cut jobs fairly significantly, there is an even bigger trend of adding new positions. **(See chart on how the number of employees has changed in the past year, left.)**

Rehab facilities are being affected by the nationwide nursing shortage, which is another indication that times are changing.

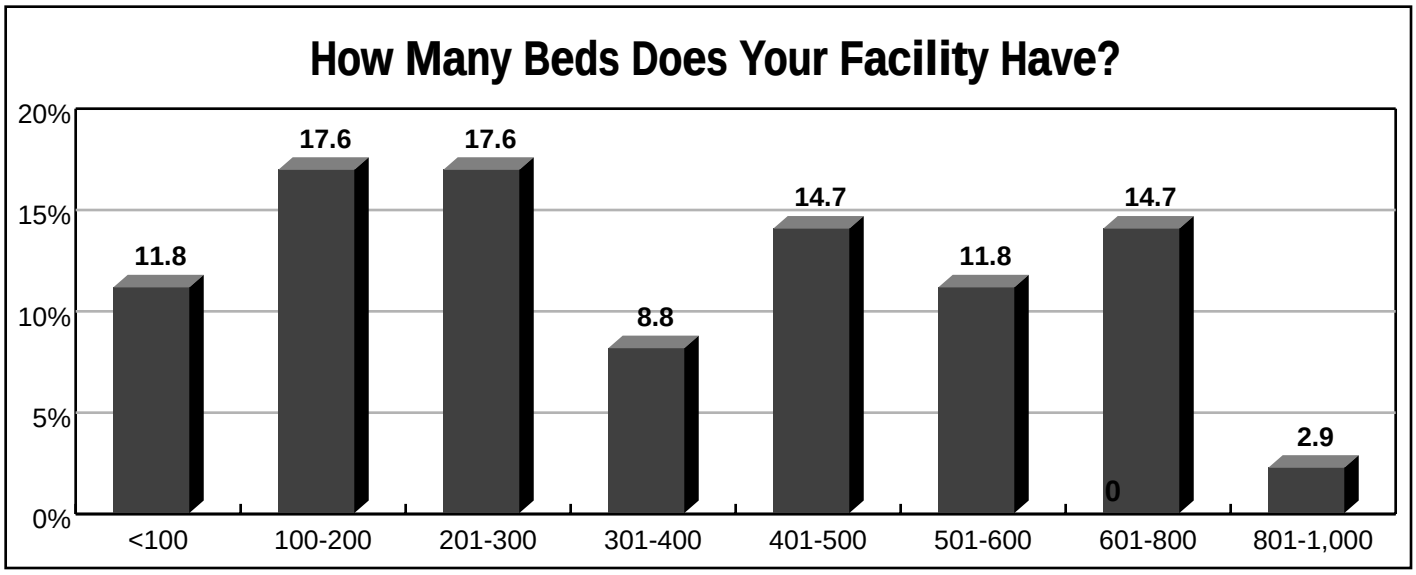
"I think it goes in cycles where every five years we either have a glut of nurses or we can't find a nurse," Munley says. "But this is the worse shortage I've seen since I've been in the health care field."

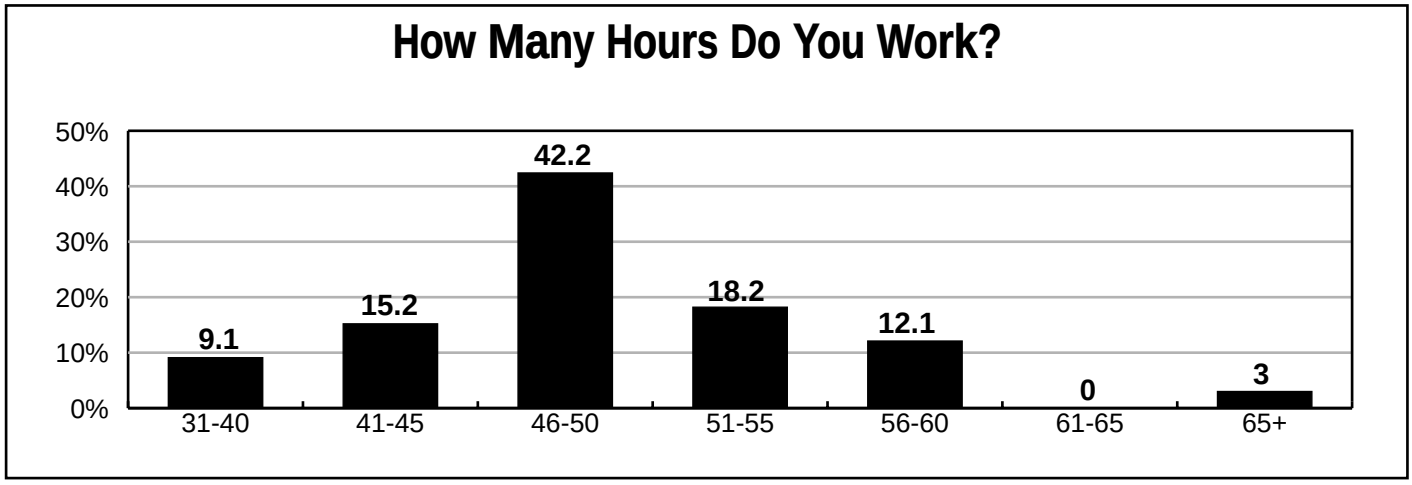
The Greenville area has 1.5% unemployment, which particularly hurts a rehab facility's ability to hire nursing assistants, he adds. "Anybody can stand behind the counter of a department store and say, "Do you like this perfume?' and make 50% more than a nursing assistant."

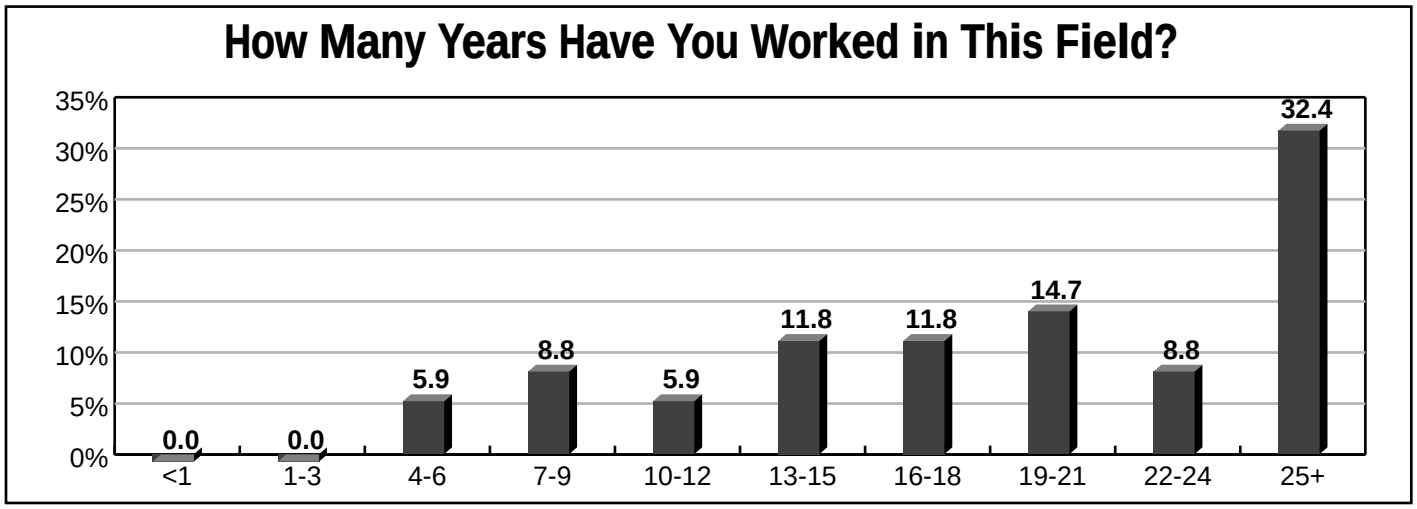
The Greenville facility has begun to hire more LPNs, with wages in the $11-$12 range, since RNs, starting at $15/hour, are so difficult to find.

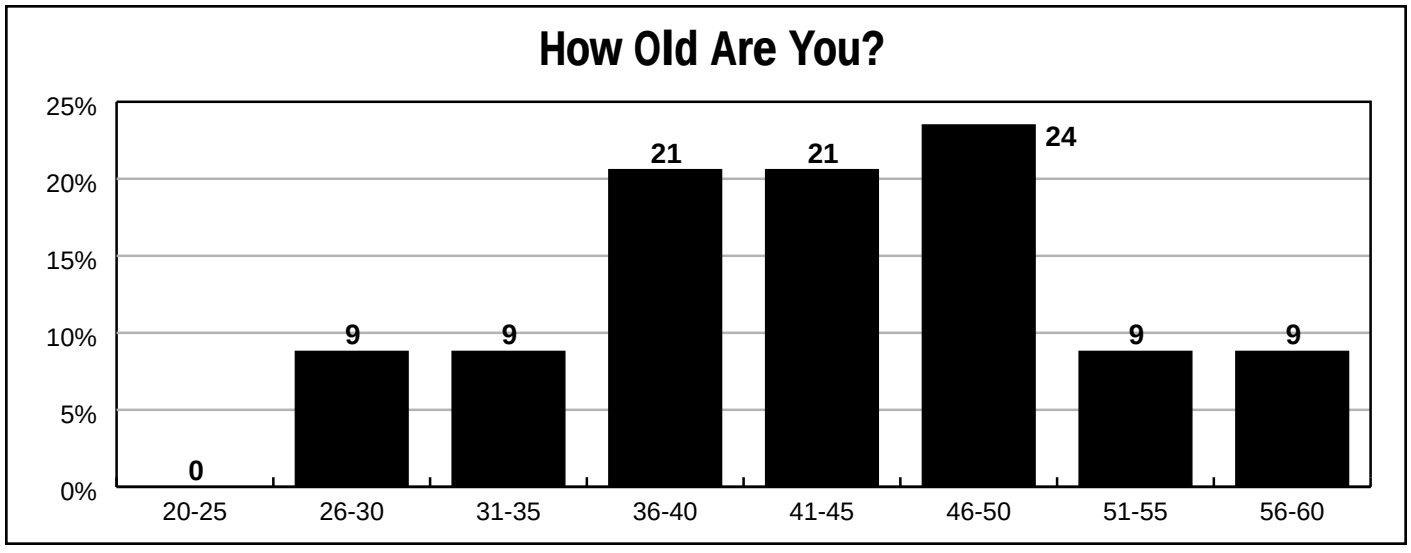
The challenge many rehab facilities are facing is to maintain the same level of quality that skilled RNs bring to patients when reimbursement issues and recruitment problems make it difficult to staff a facility adequately.

"Patients still expect the same level of service as









15 years ago, and it just doesn't happen because the nursing-to-patient ratio has deteriorated," Munley notes. "Nurses are frazzled, and nursing assistants you can't get because you can't pay them enough."

Support staff also have been cut in many rehab facilities and hospitals, although the solution to preventing these cutbacks is simple, Munley says. "My philosophy is that the best way to cut costs is to increase volume, the more volume you do the more you're just using incremental costs and you'll not have to cut support staff."

Another area that hospital-based rehab facilities have been cutting back is in marketing, Beckley says. The hospitals are either cutting the rehab marketing altogether or combining it with the hospital's own marketing department, she adds. ■

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