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Rehab Continuum Report

Outcomes
Reimbursement
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The essential monthly management advisor for rehabilitation professionals

INSIDE

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The worst isn't over: PPS could devastate specialty rehab programs

Providers ask HCFA to take second look

Discontent over the Health Care Financing Administration's (HCFA's) proposed prospective payment system (PPS) for Medicare is widespread.

But there's one segment of the inpatient rehab industry particularly alarmed over what these changes might entail: rehab facilities with specialty services. At stake are treatment programs for burns, spinal cord injuries (SCI), traumatic brain injuries (TBI), and rare diseases, which may face deep reimbursement cuts under PPS.

The $30,000 proposed PPS reimbursement for burn victims could result in as much as a $60,000 cut on some severe cases, says **Bonnie Breit**, BS, MHSA, administrative director of rehabilitation services for Crozer Keystone Health System in Upland, PA. **(See story on how PPS could impact Crozer's burn rehab program, p. 32.)**

"We have tried to demonstrate a standard of care to maximize our obligation to patients and also to the community and industry as a whole," Breit says. "We believe we're doing the right thing, but with the new structure we may not be able to deliver care in the same manner because of the lower reimbursement."

Similar concerns are echoed by rehab providers who work with other high-cost patients.

After studying HCFA's proposed rule, many say that the cost factors

Executive Summary

Subject:
Rehab centers with specialty programs may suffer most under proposed PPS.

Essential points:
- ❑ Burn center might see $60,000 cut per case.
- ❑ Comorbidities of brain injury cases are not addressed.
- ❑ Adults with rare genetic disease that results in overeating may lose most reimbursement.

and comorbidities do not add up to adequate reimbursement.

"The comorbidities they have identified do not represent our population in either SCI or TBI," says **Loretta McLaughlin**, CPA, MBA, chief operating officer for Magee Rehabilitation Hospital in Philadelphia. The 96-bed hospital is a founding member of the Jefferson Health System.

Not all comorbidities are addressed

Some essential comorbidities are not addressed in the proposed rule, McLaughlin says. For example, if a patient who has had a stroke is admitted with a high blood glucose levels that previously were controlled by diet alone, that would not be recognized as a comorbidity because the patient was not insulin-dependent pre-trauma. However, it's often more difficult to control glucose levels with stroke patients because of their limitations in swallowing and diet.

"My costs of trying to get the patient's blood sugar under control increase significantly, and that is not recognized as a complication of the stroke," McLaughlin explains.

Not all rehab facilities have completed financial projections of what PPS would mean to their reimbursement, but some of those who have are not pleased with their findings.

The Charleston (WV) Area Medical Center completed a financial analysis on its patients between Oct. 1, 1999, and Sept. 30, 2000, and found that it will fare worse under PPS, says **Peter Americo**, MS, CCC, SP, director of rehab.

"It's not going to be revenue-neutral for us," Americo says. "The impression we were given was that it would be revenue-neutral, and those that treated people with severe impairments would be treated relatively well," Americo adds. "Well we do that; we have excellent outcomes, and all the benchmarking we do shows we're doing an excellent job, but the data I'm seeing doesn't reimburse us well."

Even when comorbidities are factored into the analysis, the center doesn't receive adequate reimbursement, Americo says. "We looked at every one of our Medicare patients we saw in that period and applied the formula in the *Federal Register*, dated Nov. 4, and based on that analysis, which is a fairly intense analysis, we do not see that as a revenue-neutral program."

The center has a high number of stroke, TBI, SCI, and multi-system trauma patients. Despite the high percentage of high-intensity patients, the center has a length of stay that is about four days better than benchmark averages, Americo adds.

"We're sending in excess of 90% of patients home even in severely impaired categories," he says. "So we are convinced our quality is high, and we have a low return to acute care."

Although the Roger C. Peace Rehabilitation Hospital in Greenville, SC, has not yet conducted a financial analysis of the proposed rule, a first look at the PPS report suggests the hospital's traumatic brain injury program could suffer from reduced reimbursement, says **Sheldon Herring**, PhD, clinical director of traumatic brain injury program. The hospital is part of the Greenville Hospital System.

"With brain injury, if you have comorbidity, it does not result in increased payment, whereas for many case mix groups, an identified comorbidity results in about a 10% increase in reimbursement," Herring says.

"HCFA's assumption is that the severity of brain injury will account for more variability in outcomes and costs than will any comorbidities, and that's something we'll have to see whether it's true in the field," he adds. "I think we're going to find that comorbidities are more of an issue for select sub-populations of TBI patients, but we don't have the data to predict who those will be right now."

Rural TBI patients could be affected

Another concern is how rehab facilities will discharge TBI or SCI patients who live in rural areas that do not have adequate alternatives to inpatient rehab care, Herring says.

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"It's not uncommon for a patient's length of stay to be extended many weeks or months based on difficulties, and outlier reimbursements are not sufficient to pick up that cost," Herring says. "In the more rural areas, the discharge alternatives for these folks are reduced, and anytime that's reduced the length of stay will go up, and we don't feel like the outlier process is going to help cover that cost real well."

If HCFA goes ahead with the rule as proposed, it's possible rehab hospitals like Roger C. Peace will have to more closely monitor its admissions, giving first priority to patients who come from within the immediate Greenville area, Herring says.

When patients suffering catastrophic injuries live in rural areas that lack adequate rehab options they often are discharged home without receiving any rehabilitation. "This new emphasis on a funding model is going to cast a brighter light on the continuum-of-care gaps that exist in some of the rural states," Herring adds.

The Children's Institute of Pittsburgh has a small but very important population of adult patients who receive Medicare, and this group could see their reimbursement severely cut under the proposed plan, says **Charles Schuessler**, chief financial officer of the freestanding rehab facility, which specializes in treating children and about 60 to 75 adults a year who have Prader-Willi Syndrome.

"Prader-Willi Syndrome is a chromosomal disorder that manifests itself with extreme eating aberrations," Schuessler explains. "Patients eat anything and are very obese with low muscle tone and mild developmental delays and behavioral problems."

Those suffering from the disorder have relentless hunger, incomplete sexual development, short stature, and often do not live long into adulthood. About half of the adults treated by the institute receive Medicare coverage because of their disability.

The problem is that these adults do not fit into any Medicare category that is proposed under PPS, Schuessler says. "In the past, we had cost reimbursement."

As one of the only providers treating this condition, The Children's Institute receives many of the most severe cases. "By the time they arrive here they are in a very extreme, life-threatening state in many cases," Schuessler says.

The institute's program typically results in a 60-day length of stay in which the adult patients are treated with a program that focuses on weight loss, managing behavior problems, controlling eating, and improving motor skills and muscle tone.

Center could lose $25,000 per case

The cost averages $45,000 per case, Schuessler says. "If we get paid fairly well [by Medicare PPS], we'll still lose $25,000 per case, over half of our costs."

Treatment entails a regimented diet combined with therapy and round-the-clock supervision. A core team includes a psychiatrist, physician, psychologist, occupational therapist, physical therapist, speech therapist, and dietitians who specialize in this syndrome. The patients' hunger is so extreme that they often exhibit behavioral problems, and the rehab facility works with them on controlling these.

The facility also helps the patient manage and control comorbidities associated with obesity, such as diabetes and heart disease. A 60-day stay is necessary for the patient to achieve a maximum weight loss and reconditioning. Without these outcomes, the patient's life-expectancy would be lower. In previous decades, children who had this disease rarely lived until adulthood, Schuessler notes.

"Our board supports our mission even though we'll lose money, but we would have to think about how far we could go," Schuessler says. "I think this at best would be looking at losses of one-half million dollars a year, just from Medicare patients."

The rehab institute has asked HCFA to carve out a niche category, providing adequate reimbursement, that would apply to these types of patients, Schuessler says. "I don't know what the possibility is of that happening."

Rehab facilities should keep in mind that HCFA and the RAND Corp., which helped to develop the proposed PPS, are continuing to look at these areas of concern and may come up with solutions before a final rule is published, suggests **Richard Linn**, PhD, director of the Uniform Data System for Medical Rehabilitation and the Center for Functional Assessment Research in Buffalo, NY.

Researchers with RAND are trying to do a good job to make sure the payment system is fair, Linn says. However, as the rule is now written, rehab providers with very specific programs may not weather the PPS storm very well, Linn adds. "They'll do either very well or very poorly." ■

Burn facility has major problem with PPS

Quality of care could be greatly impacted

Crozer Keystone Health System in Upland, PA, has a unique problem when it comes to the proposed prospective payment system (PPS). The health system's Nathan Speare Burn Treatment Center provides a direct continuum of care to burn patients. The hospital cares for patients in the acute care setting and immediately after the burn, and then continues to provide rehab care as patients recover.

Under the cost-based reimbursement system, the hospital was structured as the setting in which burn patients could receive the initial intensive care with staff that included rehab nurses. "Then the patient can progress closer to home for less burn-related care, or the patient will move literally to our other standard rehab unit," says **Bonnie Breit**, BS, MHSA, administrative director of rehabilitation services at the hospital system, which has 85 rehab beds and four physically distinct rehab units.

However, this type of structure will be a financial detriment under PPS, because the Health Care Financing Administration assumes that burn patients enter rehab care after receiving intensive care from a separate acute care hospital, Breit says. "With PPS, the cost associated with the combined intensive care and rehab time with those patients is not going to be there because they have not considered the uniqueness of burns."

The advantage of the burn hospital's structure is its superior quality, Breit says.

"We have a very good recover rate and a very low morbidity rate from the burn center," she adds. "We've had patients with burns over 90% of their body leave our center, although they might have been here for one year with costs exceeding well over $500,000."

Center's structure achieves best outcomes

Moreover, the burn center focuses on rehabilitation from the start and this improves the patient's long-term quality of life and outcomes, Breit states. "The burn will change the person's life but we have a structure set up to make the person the most independent."

The way the burn center's structure works is as follows:

• **Upon admission:** A patient goes into the intensive care unit of the burn center and has one-on-one or one-to-two nursing, along with treatment by a team of physicians and therapists. Surgery and other options are explored and employed when necessary. The patient's wounds are treated daily and therapy is administered each day. There is round-the-clock staffing.

Therapists work with other team members to make sure the patient is being groomed for independence. For example, the therapist might make sure the patient's hands are positioned correctly, and this could help speed future rehabilitation outcomes. Also, the team of a dietitian, nurse, therapist, and physician meet daily to talk about the patient's medical and social status. They may consult with a social worker, case manager, or psychiatric liaison, and this is a feature that may not be present in the typical intensive care unit setting.

Continuum of care after admission

• **Comprehensive care:** Once a patient is stable, she is moved to the comprehensive care side where she may stay for a week, a month, or longer. The nursing care is now one-to-four and the patient receives three hours of therapy each day. The wounds are still being managed, and the team has a nutrition consult. The patient is given extensive education on managing the wounds and rehabilitation.

Breit estimates that the burn center may lose up to $60,000 per case because the proposed PPS does not cover outliers during the initial seven days.

"So immediately, we're going to be behind the eight-ball because that's where and when our surgeries occur, and there's no way that we can recoup those costs with the new PPS structure," Breit says. ■

Need More Information?

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Providers give HCFA some feedback on MDS-PAC

Letters to HCFA raise other issues, as well

The rehab industry continues to tell the Health Care Financing Administration (HCFA) what is wrong with the proposed prospective payment system (PPS) and why providers oppose certain changes.

One of the biggest lightning rods has been the MDS-PAC, HCFA's proposed new measurement tool.

"The MDS-PAC is onerous, and they haven't field-tested it or verified that their data is reliable or valid," says **Bonnie Breit**, BS, MHSA, administrative director of rehabilitation services for Crozer Keystone Health System in Upland, PA.

Crozer Keystone sent HCFA its comments about the proposed PPS, including the observation that if the MDS-PAC is used then all of the rehab industry's historical data from the widely used FIM system would be lost. This would mean that HCFA could not measure how rehab facilities are faring with regard to quality of care, length of stay, or even costs, between pre-PPS and post-PPS.

"It's important to measure us with a tool where you can compare apples to apples," Breit says. "They should use a tool where you can check historically to see how you're doing."

Although HCFA's stated goal in proposing the MDS-PAC is that it will be a tool similar to what's used in post-acute settings, the MDS-PAC clearly does not meet that objective because it's different from the RUGS that nursing homes use and the OASIS tool used by home care agencies, Breit says.

The MDS-PAC is burdensome and time-consuming, says **Bill Munley**, MHSA, CRA, administrator of rehabilitation and the Vitality Center at Bon Secours St. Francis Health System in Greenville, SC.

Munley and Joe Golob, director of the St. Francis Inpatient Rehabilitation Center, have written HCFA a letter that outlines their concerns with the proposed rule and with the MDS-PAC.

"The majority (86%) of rehabilitation providers, ourselves included, use a smaller, much less burdensome instrument known as the functional independence measure (FIM)," they write. "It seems to make little sense to impose an essentially untested and untried, extensive, burdensome, and costly system that may cause harm to beneficiaries or providers at the outset of the IRF-PPS."

Another point made by the St. Francis administrators is that the basis for the MDS-PAC is the MDS 2.0 that is used in skilled nursing facilities, which have a much different philosophy than do inpatient rehab units.

The data HCFA are relying upon are flawed because they are old and geared toward a different patient population that likely will never become independent in the community, says **Loretta McLaughlin,** CPA, MBA, chief operating officer of Magee Rehabilitation Hospital in Philadelphia.

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- **Tom Smith**, MBA, Administrator of Drucker Brain Injury Center, MossRehab, 1200 West Tabor Road, Philadelphia, PA 19141. Telephone: (215) 456-9472.

"The resources I need for a 65-year-old, spinal cord injury patient who will go back into the community and live independently will be different from the 65-year-old person with a [spinal cord injury] who will be maintained in a nursing home," McLaughlin says.

The MDS-PAC assessment may take therapists up to 2.5 hours to complete, and facilities will have to make major modifications in medical record documentation in order to implement the new system, Munley and Golob write.

Concern about the time and cost burden of the MDS-PAC appears to be universal among inpatient rehab providers.

"The MDS-PAC is a time-consuming tool that will need additional administrative resources," says **Tom Smith**, MBA, administrator of the Drucker Brain Injury Center at MossRehab in Philadelphia.

The Crozer Keystone comments to HCFA also point out that the MDS-PAC requires more frequent assessments than does the FIM tool. This also adds to the time and cost burden.

Golob and Munley urge HCFA, in their comment on the proposed PPS, to adopt the FIM system in place the MDS-PAC. "We also urge that the requirements for assessments other than admission and discharge be dropped," they write. "In doing so, HCFA can institute a payment system, as well as the desired quality monitoring system, and significantly reduce the burden and cost on IRFs." ■

Scare tactics may keep kids out of wheelchairs

Chicago facility has SCI patients talk to youths

Urban rehab facilities often treat spinal cord injury patients who were injured by gunshot wounds. These patients typically are young and economically disadvantaged, and their disabilities are a direct result of self-destructive behavior.

While rehab facilities and their staff work hard to help these patients find a new purpose and new goals in life, this isn't always satisfying when they continue to see the same sort of young faces year after year.

This is why Schwab Rehabilitation Hospital and Care Network in Chicago began two community programs geared toward preventing youths from becoming victims of violence and helping disabled young people regain a new lifetime focus. The programs are called the Disabling Bullet Project and the In My Shoes Program. **(See story on Disabling Bullet Project, p. 39.)**

"We have a lot of patients who are victims of violence, usually spinal cord injury and brain injury patients," says **Kris Vertiz**, LSW, spinal cord team leader for the 86-bed Schwab rehab hospital. "We felt we needed to give back to the community."

Schwab began the In My shoes program in 1996 by forming a partnership with the Circuit Court of Illinois probation department. The program involved having rehab patients, who were injured because of violent activity that often related to gang involvement, speak with youths who were on probation. The patients also spoke to school children about the importance of making positive choices in life.

"They tell their story of what they were doing, either being involved with gangs or selling drugs, and how that resulted in their injury and why they are in a wheelchair now," Vertiz says.

Patients in the program also describe what it's like to be in a wheelchair, and don't spare details about their skin problems, breathing difficulties, and elimination. Those who have had brain injuries talk about their loss of memory and how difficult it is to get back into their communities.

Kids learn what wheelchair is like

The program also has groups of at-risk youths visit the rehab hospital to attend workshops that show them what it's like to be in a wheelchair.

"We have dressing stations where they simulate paralysis and simulate what it's like to get dressed while paralyzed," Vertiz says. "We put weights on their legs and arms and show them what to do to get dressed."

Another station deals with swallowing issues. The youths are given pureed food and have to drink water through a spigot. Since head injuries often result in visual impairment, the youths are given distorted glasses to wear. They are also shown a small computer board and told to communicate their needs by using a straw in their mouth to push a computer link that would describe whether they are hungry or wet and

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REHABILITATION
OUTCOMES REVIEW™

Documentation tool gets 100% buy-in, low error rate

Staff also developed best practices care maps

Rehab facilities, like other health care organizations, will be increasingly focused on outcomes and quality in coming years as the prospective payment system and other market forces push the industry to find new ways to do everything better.

While rehab therapists and other staff immediately think of clinical care when they hear the word "quality," there's another aspect of health care quality that cannot be overlooked, and that is quality in documentation.

St. Francis Specialty Hospital in Monroe, LA, formed a quality team in 1996 to look at improving the 30-bed rehab department's medical record charts and documentation, says **Eileen Stephan**, PT, MA, administrative director of rehab services.

"Accreditation agencies wanted more interdisciplinary collaboration, and so they were looking at documentation," Stephan says.

The quality team consisted of administrators, rehab nurses, physical therapists, a recreational therapist, a speech therapist, a dietary specialist, and a social worker. They found that there were 18 steps and nine disciplines involved in a case before patient assessment was considered complete. The team identified 815 items and 101 of them were duplicated on the assessment forms. The combination of duplication and complexity of the assessment process made frequent errors likely, says Stephan.

"We decided we definitely needed an improvement," Stephan says.

Here are the steps the team took to improve assessment documentation:

1. Analyze assessment procedure.

The team wrote a goal that states, in part: "The current process causes customer frustration, lacks efficiency and timeliness, is repetitious, fragmented, and costly (staff time involved), and improvement should result in improvement of quality and efficiency of patient care with improved integration of services for the patients and staff on the rehabilitation unit."

The multidisciplinary quality team developed a flow chart that outlined the current procedure. The flow chart listed each of the 18 steps taken during assessment, along with the therapists and other disciplines conducting each of those steps. For example, one flow chart box reads, "Nurses assess within two hours, complete within 24 hours."

Part of the analysis involved obtaining input from former rehab patients in focus groups.

2. Rewrite the assessment tool.

Convinced by the focus group response, the team decided to eliminate all duplication on the assessment by giving all disciplines the same assessment tool to complete.

The team worked together to create a 12-page assessment tool with 250 items and no duplication.

After the assessment was complete the team presented it to the staff for comments and to involve everyone in the process since some employees were concerned about the idea of using a single assessment tool for all disciplines.

"The change from owning their own assessment to putting it into one was a little bit of a problem," Stephan says.

An interdisciplinary assessment staff survey, conducted in August 1997, showed that all of the staff agreed that the new tool reduced the number of repetitious questions, and most rated it as significantly improved. But some employees were less pleased with the amount of time they would spend on the assessment and how helpful

(Continued on page 38)

ST. FRANCIS SPECIALTY HOSPITAL, INC
TRANSDISCIPLINARY FORM

ADDRESSOGRAPH

Name:_____ SS#_____ Admission Date_____ Time_____

Est. D/C Date:_____

Age:_____ DOB:_____ Referring M.D._____ Family M.D._____

Address_____ Telephone_____

_____ Admitted From_____

Marital status: M S D W Sep # Children:_____

Diagnosis:_____

_____

_____ Date of onset:_____

Contact Person:_____ Relationship_____ Phone#_____

Contact Person:_____ Relationship_____ Phone#_____

INSURANCE:

(Primary)_____

(Secondary)_____

ORIENTATION TO UNIT:

_____Call Light _____Side Rails _____TV _____Bed Control _____Phone _____Clothing needed

_____Family Conference _____Smoking Policy _____Visiting hours _____Family Training _____CRT

_____ADL Apt. _____Daily Schedule _____Team Therapy

Allergies_____

Vital Signs - B/P - Rt._____ Lt._____ T_____ P_____ R_____

Height_____ Weight_____

Disposition of Meds: Identified_____ Sent home_____ Not applicable_____

Ever received blood?_____ if yes, reaction?_____ Blood type_____

Power of Attorney/Living Will: Form completed_____ Form signed_____ Dr. aware_____ Referrals_____

Interest in Organ Donation?_____

Source: Sample page of revised form, St. Francis Specialty Hospital, Monroe, LA. Reprinted with permission.

Code Status

REASON FOR ADMISSION: (Stated in patient's own words)

DIAGNOSIS

SOURCE OF INFORMATION
__Patient __Referring material __Spouse __Son __Daughter ____Other

ADMITTED FROM
__SFMC __Home __SNF _____Other

ADMIT DATE/TIME
/ / hrs

MODE OF ADMISSION
__Auto __Stretcher __Amb. __W/C __Bed

ALLERGIES
Medications

DESCRIBE REACTION

__No known Allergies

Foods

Latex Sensitive __y __n

Other

Temp: **Oral** **Rect.** **Axill.** **Typ**

Pulse **A** **P**

Resp Rate

B/P / L / R __Supine __Sitting __Stand

Height

Weight _____ Bed scale
_____ W/C scale
_____ Stding scale

BLOOD
__Ever received blood
if yes, reaction?
Blood Type

Organ Donor
__Yes __No

GENERAL INFORMATION
Age _____ Marital: ___S ___W ___D ___M
Primary Language
Culture/Religion practices significant to Health Care

DENTURES Fit __Yes __No __Full __Partial
With patient: __Y __N __N/A

HEARING AID __N/A
Hearing Aid __N/A With patient __Y __N __L __R

GLASSES __N/A With patient __Y __N
Contact Lenses __N/A With patient __Y __N

__Valuables sent to Security
__ Brought X-rays __Y __N
Communication __Normal _Slurred _Nonverbal
Hand Dominanace __R __L

ORIENTATION TO UNIT

__Call light	__Side rails	__Family Conference	__Bed Control	
__Daily Schedule	__Team Therapy	__Family Training	__TV	__ADL apt.
__Smoking Policy	__Visiting hours	__Phone	__CRT	__Clothing Needed

MEDICAL PROBLEMS **A=Active** **H=History of** **P=Potential**

__Anemia	__ERSD	__Kidney disease	__RH Arthritis
__Cancer	__Emphysema	__Liver disease	__Seizure
__COPD	__GI problems	__Lung disease	__TB
__Cognitive/emot.prob.	__GYN problems	__Oteoarthritis	__Ulcer
__CVA	__Heart disease	__MRSA Site _____	__Urinary problems
__Diabetes	__Hypertension	__VRE Site _____	__Ostomy
__Dysreflexia	__Hypotension/Orthost.	__Psyc. trt.	__other

Alcohol consumption: __daily __weekly __monthly Other drug use _____
Tobacco use: __1-2 pk/day __more than 2 pk/day __Prior tobacco use __Other __N/A

Smoking Cessation Program Offered: __N/A __Patient desires program __Patient declines program

__Difficulty sleeping at night __Early or midnight awakening __Staying asleep __Night mares

LEVEL OF CONSCIOUSNESS

Oriented:	__person	__place	__time	__situation
__appropriate	__alert	__agitated	__combative	__confused
__drowsy	__labile	__somulent		

PUPIL SIZE/REACTION

__Equal	__Wide	__Fixed
__Unequal	__Reactive	__Sluggish
__Pinpoint	__Non-Reactive	

GLASCOW COMA SCALE: 3 4 5 6 7 8 9 10 11 12 13 14 15 N/A

Completed by: _____

ST. FRANCIS SPECIALTY HOSPITAL
Monroe, LA
INTERDISCIPLINARY ASSESSMENT
FORM # 6224A REV 8/00 PAGE 1 of 12

Source: Sample page of revised assessment form, St. Francis Specialty Hospital, Monroe, LA. Reprinted with permission.

(Continued from page 35)

its information would be.

3. Rewrite and improve assessment form.

By the end of August 1997 the quality team made three major revisions of the form and many minor revisions, incorporating some of the suggestions from staff.

Then in 1999 the rehab facility switched the assessment tool to a computerized format. "We looked at all of this and decided we needed some revisions," Stephan recalls. "We streamlined it into using check items."

The new form was more concisely organized, with boxes and bold-faced categories in which staff put check marks at appropriate responses. The first revision was called the Transdisciplinary Form and the newer version was named the Interdisciplinary Assessment Form. **(See sample pages of first revised form and latest revision, pp. 36-37.)**

4. Write care maps to accompany assessment documentation.

In addition to improving the rehab facility's assessment documentation, the quality team worked on improving the overall quality of care by making standard guidelines through the creation of care maps.

The quality team researched what other facilities were using for care maps and then created their own care maps to fit the hospital's needs.

The completed care maps include one for general rehab, stroke, amputee, hip replacement, knee replacement, brain injury, burn treatment, and spinal cord injury. Each care map seven or eight pages long.

Since the rehab facility now has documentation on the computer, it is easier for staff to retrieve and print out copies of the care maps. The care maps have five categories, corresponding to five columns on a printed page: stage one, stage two, stage three, stage four, and stage five.

Staff were instructed to follow the care map, recording variables when there is some treatment or circumstance that falls outside of the care map, which are in a checklist format.

Then under each of the four areas the staff can check whether the task was completed, whether a variable was needed, or whether it was not applicable. Beside each of those items, there is a place to date it.

5. Assess outcomes and audit documentation.

Stephan began to assess the number of errors on documentation forms soon after the facility began using the new assessment tool. She found about 50 errors on the assessment tools. However, after staff education and revision of the tool, the error rate began to decline.

By the end of 2000, Stephan could find only three errors, and the therapists and social workers had a 100% rate of completion on the forms. Previously the completion rate had been a bit of a problem, she acknowledges.

To improve the completion rate, managers told the staff that the assessment tool was owned by all disciplines and if any member of the staff saw an incomplete area that person was to complete it if he or she had the skills to do so, Stephan says.

Also, each rehab team has a coordinator who is held responsible for making sure the assessments are complete.

"Everyone understands how to do both the assessment and care maps," Stephan says. "And everyone is pretty much happy with it." ■

Need More Information?

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needing to be changed, Vertiz describes.

After a session of this type of hands-on education, the youths typically are scared and they express a desire to get out of their gangs, she says.

Seeing peers who have experienced spinal cord injuries or traumatic brain injuries often has a greater impact on the youths than even going to funerals of dead friends, Vertiz notes.

"They hear about kids who get shot and die, but they don't hear about the people who end up in a wheelchair," she says. "A lot of them have been shot and they feel invincible."

Presenters at the program give the children three scenarios of what will happen to them if they continue with their gang or drug selling activities: "You'll end up in jail; you'll end up dead, or you'll end up in a wheelchair like me because people are only invincible for so long," Vertiz says.

The program now is funded with about $33,000 by the Illinois Violence Prevention Authority, which receives money from license plate sales, she adds. ■

Mentors help gun violence victims find new roles

Program's outcomes being researched

It's difficult for people who've had a spinal cord injury (SCI) to find new roles in their family, workplace, and community. If they also are young, without a high school degree, and have no legitimate work experience, the transition is even more daunting.

Schwab Rehabilitation Hospital and Care Network of Chicago teamed up with the University of Illinois in Chicago to provide a peer mentor program for people with SCIs who were injured by a gunshot wound. The program, called the Disabling Bullet Project, provides three weeks of training to peer mentors, who are then hired as part-time employees by the hospital.

"The purpose is to assign new patients on the unit a peer who is similar to them in their disability and who will provide support by listening and identifying community resources that are available for them," explains **Brigida Hernandez**, PhD, project director of the Disabling Bullet Project. Hernandez is a post-doctorate research associate with the University of Illinois at Chicago through the Department of Disability and Human Development and Psychology.

Investigators spent the first year developing the training curriculum and additional time piloting the project. It was finally launched in September 2000.

Unlike Schwab's In My Shoes program, this project does not address violence prevention, says **Kris Vertiz**, LSW, spinal cord team leader at Schwab. "The main focus is on the patient's need to integrate into the community," she says.

Here's how the program works:

1. Mentors are selected and trained.

The mentors are patients who have spinal cord injuries caused by gunshot wounds and who have been through the entire rehabilitation process. They typically are two to four years post-injury. Mentors are interested in sharing their experiences in seeking community support and coping with the changes in their lives with newly disabled patients.

The mentors receive three weeks of training and then they are supervised by Vertiz on a weekly basis. They work 10 hours a week.

If they have any questions, whether it's about how a patient will receive medication, supplies, etc., the mentors can ask Vertiz for answers.

2. Mentors meet with new patients.

Vertiz identifies which of the new patients is likely to benefit from this program and then she connects them with mentors. Each mentor is responsible for no more than five SCI patients at a time.

Mentors meet with newcomers often

"They meet with the patients several times a week during their inpatient stay," Hernandez says. For paraplegic patients this might be for four to six weeks, and for quadriplegic patients for three months.

"Peer mentors stop by patients' rooms, stop by their therapy sessions, and just talk with the patient about how their adjustment has been going," Hernandez says. "The big issue is talking about how they are adjusting to the disability, and then they discuss how they'll go back to the community, and how to have accessibility in their homes and safety in their neighborhoods."

Safety is an important goal because so many of

the gunshot victims are young men of minority backgrounds who were involved in gangs and illegal activities, Hernandez notes.

"Many have not completed high school, so their needs are great," she notes. "And many do not have stable employment history because they basically have been hustling on the streets, so life can be very overwhelming."

The mentor program aims to help these patients realize that their life isn't over because of the disability, she adds.

"When in the hospital, the mentors and patients have conversations about how the individual was shot and what the experience was like," Hernandez says. "The mentor and mentee share stories, and oftentimes the patient goes through the phases of shock, disbelief, and sadness so the peer mentor is a sounding board for the patient to share these experiences."

Peer mentors have a more emotional relationship with the patients than the therapists who have been working with them. "In occupational therapy and physical therapy, patients learn how to develop with the disability, but the mentor adds the component of how do you emotionally deal with the disability, especially if you go back into the community where being on your own and being independent is so important," Hernandez says.

3. Mentors help SCI patients set new goals.

The mentors themselves demonstrate how SCI patients can develop new lives, with new goals. For example, one of the peer mentors recently decided to attend a technical school to study computer science, and another went back to high school to complete a math course and then obtain a high school diploma, Hernandez says.

"As the peer mentor relationship develops, more concrete things are talked about," Hernandez says. "First, it's the patient's adjustment to the disability and what life's going to be like."

Then the patient and mentor begin to talk about what the patient will need to do to get his or her life back on track. "That's where the peer mentor comes in with goal-setting in mind," Hernandez says.

Patient sets own new goals

"We don't have prescribed goals, and we don't make the patient talk about employment or education," she adds. "It's up to the patient what goals to set."

Peer mentors also might help to expose patients to the various recreational activities available to people with SCIs. For example, Schwab has wheelchair basketball that a patient might be interested in trying after being discharged.

"Before the peer mentor program we'd hear that patients go back to their homes and try to be involved in the lifestyle of gangs, but slowly their gang friends drift away," Hernandez says. "So they sit around in their apartment or home and watch the years go by without doing much."

4. Mentors provide follow-up support.

Within one week after an SCI patient is discharged the peer mentor will visit the patient at home or meet with the patient when the patient returns for an outpatient visit. Peer mentors also may call patients to see how they are doing.

The mentors continue to stay in touch with the patients on a weekly basis, at least by telephone. This way they can continue to provide support and serve as role models as patients adjust to their home environment and attempt to fit into the community.

Since the program is a demonstration project that is being researched, investigators will interview peer mentors, patients, and hospital staff to evaluate its effectiveness, Hernandez says.

The project probably will be expanded and implemented at several other rehabilitation hospitals during the next couple of years, she adds.

"Once we have outcomes, and hopefully they'll be positive, the idea is to disseminate them to other hospitals and independent living centers," she explains. "The idea is to educate independent living centers about this new emerging disability group and show them a way to reach out and better serve them." ■

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Facility assesses patients' opinions of therapists

Computer opinion tool does the job

While patient satisfaction surveys will give rehab facilities a general idea of trends and quality as perceived by patients, they may miss some specific concerns about the way a particular therapist provides care.

Provena St. Joseph Physical Rehab & Sports Injury Center in Joliet, IL, found a way to identify patients' precise issues and concerns through the use of a computer survey.

The tool has a higher response rate than the standard patient satisfaction tool the facility previously used, says **Paul Lagomarcino**, PT, MBA, director of rehab services for the hospital-based rehab unit, which has 28 beds.

Rehab patients and family are reminded by a therapist or front desk staff to take a few seconds to fill out the questionnaire before they leave the outpatient facility, says **Deb Andreason**, marketing coordinator for the facility.

They approach a small machine that looks like a gum dispenser and punch in their responses. Those answers are saved in a computer ,where they can be tabulated and compiled. No one knows which patient made a particular response. The machines, costing $1,500-$2,000, are the chief expense in using the Opinion Meter tool. The hospital selects its own questions to use on the machines.

Although the facility's previous patient satisfaction tool could be anonymous, the patients had to hand-write their responses and hand it to someone face-to-face and that made it less confidential, Andreason says.

Better than mail surveys

Lagomarcino believes the tool works better than mailed surveys, as well.

"It's more confidential than a mailer, where you might get only 20% response rate and that could be only the 20% that likes you or hates you, so you don't get the response of those in the middle," Lagomarcino says.

Also, the nine-question tool gives patients an opportunity to rate and name their particular therapists. For example one question asks, "How satisfied are you with the way your treatment was explained?" The respondent is given four answer options, ranging from very satisfied to very unsatisfied.

Each month the responses are tabulated for each

Opinion Meter Tool

1. **Please indicate how long you have been in therapy.**
   A. 10 days or less
   B. more than 10 days
2. **How satisfied are you with the competence of your therapist?**
   A. Very Satisfied
   B. Satisfied
   C. Unsatisfied
   D. Very unsatisfied
3. **Is your therapist(s) kind, courteous, and supportive?**
   A. YES
   B. NO
4. **How satisfied are you with the way your treatment was explained?**
   A. Very Satisfied
   B. Satisfied
   C. Unsatisfied
   D. Very Unsatisfied
5. **How satisfied are you with the assistance you receive from the front desk staff?**
   A. Very Satisfied
   B. Satisfied
   C. Unsatisfied
   D. Very Unsatisfied
6. **Are the front desk and support staff kind, courteous, and supportive?**
   A. YES
   B. NO
7. **Are you satisfied that therapy has been beneficial in improving your condition?**
   A. Very Satisfied
   B. Satisfied
   C. Unsatisfied
   D. Very Unsatisfied
8. **Would you recommend outpatient therapy at the Physical Rehab and Sports Injury Center to others?**
   A. YES
   B. NO
9. **What is your therapist's name: (please enter 2-digit number, as shown before therapist's name).**

Source: Provena St. Joseph Physical Rehab & Sports Injury Center, Joliet, IL.

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therapist, giving management information about how each therapist is doing with patient satisfaction — information can be used to identify problems that can be addressed quickly through meetings with supervisors and sometimes through additional training and education.

"I've been able to counsel certain therapists," Lagomarcino says. "If someone is having more than their share of issues, then I can look at them individually over a course of time and see how they've improved."

The tool makes it very easy for supervisors to pinpoint problems and create solutions that will fix exactly what's wrong, he adds.

Not used for punishment

For example, one therapist might have a number of patients who rate his ability to explain therapy as unsatisfactory. A supervisor could meet with the therapist and discuss better ways for the therapist to communicate with patients, Andreason says.

"We're not using this information for performance ratings or raises," she adds. "We're just giving feedback to improve customer satisfaction." ■

Newsletter helps patients seize their day

Schedule of tests, procedures prompts education

The idea to improve patient satisfaction came to the nurse manager at 2:00 a.m. one morning when she couldn't sleep. She got out of bed to check her appointment book for the day and thought that patients might like to know what tests or procedures were scheduled on any given day, as well.

Soon patients on the unit that she managed were receiving individualized newsletters with the appointments for the day so they had some control over their time and family members knew when to visit.

"The newsletter empowered patients," explains **Lisa Oldham**, BSN, RNC, CAN, nurse manager at Hackensack (NJ) University Medical Center.

It also prompted patient education. The day shift nurse would go over the newsletter with the patient, discussing the tests and procedures scheduled for the day, and answer any questions. Because the nurses on night shift had distributed the newsletters at 7:00 a.m., the patients had had time to formulate questions.

The evening staff would review the newsletter with the patient again at the end of the day to answer any questions about what had happened that day. "Within a 24-hour period the patient would have been educated, or his or her education reviewed, on every single scheduled test and procedure at least twice," says Oldham.

Nurses customize newsletters

Newsletters were preprinted sheets geared toward specific conditions and containing both educational information and important phone numbers the patient might need, such as the consumer affairs department and the physician on the case. Nurses then individualized the newsletters by writing down the scheduled tests and procedures by hand. Routinely scheduled events such as lab rounds and meal breaks were pre-printed on the newsletters. The newsletter was kept by the patient's bedside so nurses could easily make changes during the day.

Need More Information?

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Although the newsletter was pilot-tested on a new unit, patient satisfaction scores kept increasing during the month it was implemented, says Oldham. Its success prompted the medical center to conduct a pilot test on several units.

If the scores for patient satisfaction on those units are up on the third-quarter report from Press Ganey, a health care satisfaction measurement company based in South Bend, IN, the newsletter will go hospitalwide. The pilot newsletter is professionally designed and printed unlike the original, which was printed from a computer. ■

Web site offers tools for compliance improvement

Physician-patient teamwork emphasized

According to the Dallas-based American Heart Association, failure to follow a physician's advice can delay recovery from illness, increase medical costs, and heighten risk for certain conditions such as cardiovascular disease. That's why the AHA has added a new section to its Web site that provides tools for health care professionals and consumers to aid compliance.

"One of the main things professionals have been asking for are tools they can use in clinical practice to help patients self-monitor their compliance and their behaviors. That is why the American Heart Association decided to take on this particular site," says **Nancy Houston-Miller**, BSN, RN, director of the Stanford Cardiac Rehabilitation Program at Stanford Medical Center in Palo Alto, CA, and head of a task force on patient education for the association.

The site is divided into two areas. The consumer area has information, tools, and tips on following appropriate professional advice about medications, diet, and exercise. The professional area provides tools to help patients comply with a physician's treatment recommendations. The consumer and professional sites include the following information:

- **Professional area.**

— Physician's Tool Kit.

Includes *AHA Cardiovascular Disease Guidelines*, a patient tracking form for the chart, a compliance brochure, tip sheet on how to increase patient compliance, and heart healthy diet references. The 9 1/2" X 12" folder of materials can be ordered online.

— Patient information sheets.

These sheets, which are available on the Web site, provide information on a variety of risk factors, including smoking, blood pressure, cholesterol, physical activity, nutrition and weight management, medicines, and diabetes. They include space for individualized patient recommendations and some have charts so patients can track their progress. For example, the physical activity sheet offers suggestions for developing a plan for exercise and tips on how to make the necessary lifestyle changes such as setting specific and realistic goals. It also has a chart to track

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exercise so patients can determine if they are meeting their goals and information on how to determine a target heart rate to get the most from the exercise program.

— Compliance Challenge.

To help develop a team effort, both patients and physicians can take a compliance quiz during an office visit and then sign a compliance pledge.

The physicians' quiz includes such yes/no questions as: "When it comes to developing a health regimen, I involve my patients in the decision, getting their input on prescriptions, diet, and exercise changes," and "Whenever I make diet recommendations I carefully explain why the changes are important. I also suggest what foods and cooking methods to avoid and new things to try."

The patient's compliance quiz includes such questions as: "Have you ever been confused about what [medication] side effects to expect and what to do?" and "Are you confused about what type of exercise you should be doing?"

— Consumer area of site.

Practitioners can refer patients to the consumer site, which helps teach patients how to be more compliant with medications and lifestyle changes.

• **Consumer area.**

— Records to increase compliance.

Patients can print charts to help track medications, blood pressure, cholesterol, physical activity, food intake, and weight management. The charts are designed to help patients develop better daily habits. For example, the cholesterol compliance chart explains what cholesterol levels mean and provides a section for tracking blood cholesterol level, HDL cholesterol level, LDL cholesterol level, and triglyceride level.

— Health risk awareness quiz.

This quiz is designed to help people understand their personal heart health challenges and identify risk factors. Risk factors include less than 30 minutes of physical activity on most days and being 20 pounds or more overweight for a person's height and build.

— Lifestyle information.

These educational sheets provide tips on such lifestyle issues as nutrition, physical activity, and smoking. For example, tips for handling the urge to smoke include: "Change your habits. Instead of having a cigarette after dinner, brush your teeth or walk the dog," and "Write down the reasons why you quit and look at the list often."

— Medication Checkup.

This section gives patients advice on what to do when they are confused about how to take their medications and what they are for.

The Web site benefits the health care professional by providing developed tools that have been tested. Doctors need only tailor them to their needs. It helps patients by providing them the skills and tools to monitor their compliance every day. "We know compliance is not just the patient's problem. It is the problem of the patients, the provider, and the health care system. It is all three having to work together," explains Houston-Miller. ■

Need More Information?

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