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INSIDE

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Rehab's deluge of PPS comments appears to dampen MDS-PAC prospects

HCFA's putting implementation on hold for now

If the letters received by the American Medical Rehabilitation Providers Association (AMRPA) in Washington, DC, are any indication, then the Health Care Financing Administration (HCFA) is about knee-deep in suggestions, criticism, and comments about the inpatient rehabilitation prospective payment system (PPS).

"I'm looking at over two feet high of letters that our members have sent to HCFA and to their members of Congress and other people who remain in the government," says **Carolyn Zollar**, JD, vice president for government relations for AMRPA.

It will take a while for HCFA administrators to read through the letters and packages sent by rehab facilities across the nation, and this is one reason why the agency decided to postpone PPS implementation indefinitely, according to HCFA's recently released question-and-answer statement. **(See story on HCFA's Q&A, p. 49.)**

Use of functional independence measures recommended

In other recent good news, the independent Medicare Payment Advisory Commission (MedPAC) recommended that HCFA use the functional independence measures (FIM) instead of the minimum data set

Executive Summary

Subject:
Rehab industry asks HCFA for major changes

Essential points:
- ❑ Rehab facilities universally dislike the proposal to have all sites use the minimum data set for post acute care for data collection.
- ❑ The Health Care Financing Administration's list and reimbursement for comorbidities should be reviewed and improved, the industry says.
- ❑ Facilities also take issue with the proposed transfer and outlier policies.

for post acute care (MDS-PAC). This gives weight to the criticism coming from the rehab industry over the proposed use of MDS-PAC. It also unravels one of HCFA's justifications for proposing the use of MDS-PAC. In proposing the industry use MDS-PAC, HCFA cited MedPAC's desire to "seek sufficient data to devise a patient classification system that effectively predicts resource use."

"The MDS-PAC clearly remains our primary concern, both for its content and for its ability to reflect the structure of the classification system and the burden it will place on facilities," Zollar says.

Individual rehab providers also continue to express concern over MDS-PAC.

Schwab Rehabilitation Hospital & Care Network in Chicago will have to use both the FIM and the MDS-PAC instruments — at least for a while — if the MDS-PAC is selected, says **Judy Waterston**, chief executive officer and president of the 125-bed rehab hospital, which is affiliated with Sinai Health System in Chicago.

MDS-PAC takes a while to complete

"They're saying the MDS-PAC would take 85 minutes to complete," Waterston says. "We're talking with colleagues in the field, and we hear that it is taking more than twice that length of time."

Particularly in these days of health care personnel shortages and other staffing issues, this is a major concern, Waterston adds.

Waterston's letter to HCFA reflects this concern. The letter, sent this past January, reads, in part: "Schwab currently has over 20 full time openings in our clinical departments despite an active recruitment and retention program."

There are many good reasons why HCFA should scrap the MDS-PAC proposal and instead recommend making the FIM the Medicare instrument, Waterston adds.

"When you change instruments, it's hard on clinical staff, and the MDS-PAC and FIM scorings are reversed, so that's problematic for clinicians," Waterston says. "It's not that we don't think we can learn the MDS-PAC, but there will be inadvertent mistakes made during a transition period."

PPS may be delayed until fall

On a positive note, many experts predict HCFA will delay implementing PPS until October 2001.

"Given this longer window, I think it gives HCFA some time to fix some of the things the rehab field has commented on, and it gives HCFA time to think long and hard about what they're going to do with MDS-PAC," says **Barbara Marone**, MBA, senior associate director of policy for the American Hospital Association's (AHA) Washington, DC, office.

AHA's letter to HCFA, dated Jan. 26, 2001, states that the "AHA is extremely troubled that the benefits of HCFA's regulatory requirements for data collection under PPS are greatly outweighed by immense regulatory costs imposed by use of the Minimum Data Set-Post-Acute Care (MDS-PAC), both the number of data elements it contains and the frequency with which it is used to assess patients."

The AHA letter further states that the organization, which represents 5,000 hospitals and health systems, supports MedPAC's recommendation to use the FIM for rehabilitation PPS. **(See summary of recommendations by the AHA and AMRPA, p. 48.)**

The rehab industry expressed other major concerns about the proposed PPS rule. Among these are issues concerning HCFA's proposed transfer policy, the list of comorbidities, and the outlier policy.

Here are some of the rehab industry experts' concerns:

• **List of comorbidities:** Rehab providers say the comorbidities listed as part of the proposed rule's case mix groups do not adequately reflect what they are seeing with their patients.

For example, Schwab Rehabilitation Hospital provides care to patients who have suffered

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spinal cord injury, traumatic brain injury, stroke, and amputation, all of whom often have a variety of comorbidities that are complications of their disabilities, says **Suzan L. Rayner**, MD, MPH, an executive vice president for medical affairs and medical director at Schwab.

Rayner explained the problems the listed comorbidities pose in a Jan. 19, 2001, letter to HCFA.

"The original list of comorbidities has all kinds of things like TB, which is not relevant to our patient population, " Rayner says. "Our typical patient is a 68-year-old man who is a diabetic who had an amputation and who has hypertension, end-stage renal disease, and is on dialysis three days a week, and he may have a pressure sore from an acute hospital stay."

So the rehab staff has to help the patient manage his insulin levels and his hypertension, assist bringing the patient to dialysis, and still meet all rules and requirements as far as rehabilitation care is concerned. This means the patient's care will be costly and the length of stay may be adversely affected by all the comorbidities, she adds.

Comorbidity list is unrealistic

"HCFA's list of comorbidities doesn't capture the type of patient we're seeing in rehab facilities," Rayner maintains. "They have to look at the whole picture of the patient and not just label someone as an amputee, because that does not capture what's going on with the patient medically."

Rayner lists the following comorbidities that occur often in severely disabled patients: dysesthetic pain, spasticity, electrolyte imbalance, depression, neurogenic bladder, urinary tract infections, pressure sores, autonomic dysfunction, seizures, deep vein thrombosis / pulmonary embolus, heterotopic ossification, incontinence, and fractures.

Any one of these comorbidities could add considerable time to the patient's length of stay, Rayner explains. For example, stroke patients, spinal cord injury patients, amputees, and other rehab patients often suffer from depression. A patient's depression may cause him or her to progress more slowly in rehab treatment and in self-management of health issues. Even if these patients are treated with antidepressants, it may take a couple of weeks for the medication to take effect, and two weeks often is the total length of time allowed for particular rehab patients.

Pressure sores and other wounds also take longer to heal than the proposed rule appears to allow. Rayner cites an example of how HCFA's proposal allows only 1.1 extra days for some patients who have a comorbidity of a grade three pressure sore, although it's obvious to those who work in the field that a grade three pressure sore takes longer than that to heal.

The AHA has a major concern that the inpatient rehab PPS will not deal adequately with medical complexity and the cost of treating medically complex patients, Marone says.

The AMRPA recommends to HCFA that additional comorbidities be added to the PPS rule and that HCFA examine the impact of multiple comorbidities on the cost of a case, relationship to transfer, and special cases. Further, AMRPA writes in the Jan. 29, 2001 comment letter, "Consider including complications that develop over the course of treatment and in the final weights, while balancing the need to assure high quality care with the possibility facilities will only seek higher payments."

• **Transfer policy:** HCFA needs to clarify how facilities will count the patient's length of stay, writes **Louise M. Gutierrez**, Schwab controller, in a Jan. 19, 2001, letter to HCFA. "In many instances the average length of stay is a fraction (i.e., CMG 0101) is 10.4 days," Gutierrez writes. "If the patient is discharged on day 10, do we need to count the hours from admission to discharge for length of stay computation?"

Nursing home transfers need to be addressed

Schwab also is concerned that HCFA does not address the fact that some patients are admitted from a nursing home and therefore would have entirely different length-of-stay expectations, according to Gutierrez' letter. "If a nursing home is the patient's domicile, we recommend that these patients be excluded from this section of the regulations," she writes.

Likewise, Schwab recommends that HCFA not apply the transfer policy to discharges to the community, which require home health or outpatient services, and the hospital asks that HCFA consider an increase in payment for long-stay transfers, which are not outliers.

• **Outlier policy:** Rehab is different from acute care, and the proposed rule's outlier policy should reflect that difference, Zollar says.

Need More Information?

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"The issue I have is the whole system is based on averages, and outliers are a way to address someone who falls outside the average," Zollar explains. "A system of averages works really well with a large system that has a lot of cases, but rehab is very small, with only 360,000 cases total."

Moreover, the number of cases per rehab facility is quite small, with an average of 600 in free-standing rehab facilities and 250 in hospital rehab units, she adds.

"So if you get a few of those outlier cases, you can see it will have a dire effect on your costs," Zollar says.

Policy would have resulted in $450,000 loss

The AMRPA recommends that HCFA examine its outlier policy proposal to ensure that measures are implemented to prevent facilities with higher routine costs and a higher number of cases from being penalized. These measures could include lowering the threshold amount, paying more than 80% of the costs, and increasing the percentage of payments provided for outlier payments.

Schwab estimates indicate that the rehab hospital would have lost more than $450,000 in Medicare reimbursement under HCFA's proposed rule regarding having an 80% cost reimbursement of costs exceeding the case mix group payment, plus the outlier threshold, Gutierrez comments in her letter to HCFA.

"The outlier policy appears to be penalizing facilities that treat patients with severe disabilities and comorbidities," Gutierrez adds. ■

Comments on rule give HCFA plenty to review

AMPRA's 90-page comment covers all bases

The American Medical Rehabilitation Providers Association (AMRPA) and the American Hospital Association's (AHA) legislative office, both in Washington, DC, acknowledge the need for a Medicare prospective payment system (PPS) for inpatient rehabilitation facilities. But the two organizations, which represent the gamut of rehab organizations and facilities, express concern over how PPS would work under the proposed rule published in the *Federal Register* in November 2000 by the Baltimore-based Health Care Financing Administration (HCFA).

After spending nearly three months reviewing the more than 700-page proposed rule, the organizations have made a variety of suggestions about how HCFA may improve the PPS rule. Here is a very brief summary of their comments:

1. Data collection.

The AHA supports the recommendation of the independent Medicare Payment Advisory Commission (MedPAC) to use the functional improvement measure (FIM) for rehabilitation PPS. The AHA suggests the FIM be expanded to include items necessary for complete and accurate patient classification and necessary patient demographic information. The AHA also recommends that HCFA use terminology that is familiar to the rehab industry, including the terms "functional related groups (FRGs)" and "functional independence measure," according to a letter written by **Rick Pollack**, AHA executive vice president.

The AMRPA also recommends replacing the MDS-PAC with the FIM instrument, adding information on patient identification, age, length of stay, comorbidity, and discharge destination. "We believe the use of such in the modified FIM instrument would generate the necessary data pertinent to the payment system during the initial years of the IRF-PPS, while allowing HCFA to obtain the information it will need for future quality monitoring activities," writes **Kenneth Aitchison**, chair of the AMRPA PPS task force. Aitchison is president and chief executive officer of Kessler-Rehab Corp. in West Orange, NJ.

2. Payment for medically complex cases.

"We are very concerned about the compression

of the case weights recognized in the RAND Interim Report of July 2000," Aitchison writes on behalf of the AMRPA. "The net result of case weight and case mix compression is chronic underpayment for more costly, more medically complex cases."

Aitchison's letter suggests the causes for this dilemma may be the incomplete and inaccurate coding of all comorbidities, the use of averaged routine costs that include nursing cost, and other factors.

"If the weights are corrected, ideally fewer cases will become outliers, and a transfer policy will more accurately reflect actual costs," Aitchison adds.

The AHA makes the point that the proposed payment methodology will fail to recognize the higher costs of facilities that care for disproportionate numbers of medically complex cases.

"The systematic under-reimbursement of medically complex cases, a persistent problem in many case-mix systems, results from the interplay of the 'compressed' case-mix group weights, shortfalls as a result of HCFA's proposed transfer policy, and the inadequacy of the proposed outlier payments to rectify the shortfalls," Pollack writes.

He also notes that many of these same concerns about case-mix weight compression are shared by the RAND Corp., which is HCFA's contractor for the proposed rule.

Further, Pollack writes, "The AHA believes that the fundamental cause for underpayments to facilities with medically complex patients is the failure of the prospective payment system to adequately ascertain variation in routine costs for patients with multiple, clinically relevant comorbidities."

The two reasons this occurs, Pollack adds, are that the cost measure used to set the payment weights inadequately measures variation in routine costs at the patient level, and the proposed comorbidity measure has no distinction between one comorbidity and multiple comorbidities for any particular patient.

"Our greatest concern is that, if the PPS is implemented as proposed, access to inpatient rehabilitation for medically complex cases will be jeopardized and facilities with disproportionate numbers of high-cost cases will be unfairly penalized," Pollack writes.

The AHA recommends these changes:

- **Eliminate compression of the case-mix weights.**
- **Eliminate or significantly narrow the scope of the short-stay transfer policy.**
- **Pay at least 150% of the per diem rate for the first day's care under any transfer policy.**
- **Modify the outlier policy to ensure that facilities with justifiably higher routine costs are not unduly penalized.**

3. Facility-level adjustments.

Aitchison at the AMRPA recommends that HCFA establish a wage index specific to rehabilitation and correct calculations based on multiple labor shares.

Another AMRPA suggestion is that HCFA make changes to the disproportionate share hospital (DSH) adjustment, which currently accounts for about 40% of total payments. "This formula could result in wide payment variations that could change from year to year," writes Aitchison.

A better strategy, he writes, would be for HCFA to do the following:

- **Work with the rehab field on alternative approaches.**
- **Make certain that unit costs for DSH are utilized.**
- **Clarify the sources of the data used and the process for calculation of the ratios.**
- **Don't use the thresholds established for acute care of 100 hospital beds or 15%.**
- **Include in the respective calculations for both Medicare and Medicaid managed care patients and days.**
- **State how new providers will be treated.**

The AHA also has voiced significant concerns with the disproportionate share policy. "We agree with the concerns raised by MedPAC that there has not been adequate analysis and discussion of the nature of the relationship between low-income patients and costs per case," Pollack writes. "The AHA urges HCFA to proceed cautiously before establishing a DSH payment that represents such a large proportion of total payments, effects which may be compounded by the disparity in data available from freestanding hospitals and rehabilitation units in acute care hospitals."

4. Interrupted stays.

The AHA comment letter to HCFA presses HCFA to review its proposed policy about interrupted stays and perhaps reduce the time frame for the interrupted stay, because a patient's status may change significantly during the course of a brief re-hospitalization.

The AMRPA comment letter recommends

HCFA clarify the definitions of interrupted stay cases under various scenarios; shrink the window for such stays to 24 hours; clarify which entity is responsible for paying for the acute care stay; and include a payment rule in the regulations.

5. Timing of start-up.

Both organizations express concern about the proposed implementation date of April 1, 2001, for inpatient rehab PPS. Pollack's AHA letter to HCFA says the date is both unrealistic and undesirable and that HCFA should instead delay the start-up of the PPS until Oct. 1, 2001, to allow for all refinements.

Aitchison's AMRPA letter to HCFA also states that the April 1, 2001 implementation date is unrealistic. Aitchison asks HCFA to announce as soon as possible the anticipated dates for: training on the MDS-PAC, availability of the data assessment tool software, testing for transmission of data, the deadline for all facilities to submit data on cases, and implementation for payment, including treatment of the transition period. "We recommend that HCFA clarify the implications for the transition period if the IRF-PPS is not implemented until Oct. 1, 2001," Aitchison writes. ■

HCFA answers inpatient rehab PPS questions

Agency says April 1 deadline isn't feasible

The Health Care Financing Administration (HCFA) in Baltimore has received hundreds of questions and comments since publishing the proposed rule for inpatient rehabilitation prospective payment system (PPS) on Nov. 3, 2000.

The volume of concern and the subsequent decision to give rehab providers an extra month to make comments about the proposed rule led the agency to abandon efforts to have PPS implemented on April 1, 2001, as stated in the proposed rule.

"We are currently examining all aspects of the PPS to determine an appropriate implementation date," HCFA officials write in a recently published report that answers the rehab industry's most frequently asked questions.

HCFA further states that the new implementation date will include enough time for providers to educate and train staff and to institute system modifications between the time the final rule is published and the implementation date. The implementation date will be published in the final rule, and no date has been given for when that will be published.

Here are a few of the questions HCFA has received from rehabilitation facilities, along with the agency's answers:

Q: How will the planned delay in implementing the PPS affect the application of the transition percentages?

HCFA: Under the Balanced Budget Act of 1997, the federal fiscal year in which a facility's cost reporting period begins determines which one of the two possible transition period percentages apply. The first transition period percentages are applicable for cost reporting periods beginning during federal fiscal year 2001. This would include only those cost reporting periods that begin on or after the implementation date in the final rule and before Oct. 1, 2001.

The second transition period percentages are applicable to cost reporting periods beginning during federal fiscal year 2002, that is, periods beginning on or after Oct. 1, 2001, and before Oct. 1, 2002. For cost reporting periods beginning during federal fiscal year 2003 and after, payment is based on 100% of the adjusted federal prospective payment. This conforms to proposed section 412.626 of the regulations.

A facility will continue to be paid under the TEFRA (reasonable cost-based) system for its entire cost reporting period beginning prior to the implementation date contained in the final rule. If a facility's first cost reporting period under the PPS begins during federal fiscal year 2002, the second transition period percentages would apply. [Based on the recently enacted Beneficiary Improvement and Protection Act of 2000, a provider may elect to be paid 100% of the adjusted federal prospective payment regardless of whether its first cost reporting period under the PPS begins during the transition periods. Additional information on this provision will be provided in the final rule.]

Q: Why does the budget-neutral conversion factor of $6,024 appear to be lower than expected?

HCFA: As explained in the notice of proposed rulemaking, the conversion factor is the payment amount that has been adjusted for budget neutrality and has been standardized to account for

a number of facility and case level adjustments. The federal prospective payments are the result of applying the budget-neutral conversion factor to the relative weights for each case mix group. In computing a facility's prospective payment for a case mix group, it is very important to adjust the federal prospective payment by the applicable facility level adjustments.

Q: Does the DSH [disproportionate share] adjustment apply to all facilities?

HCFA: Yes. At this time we propose to adjust payment for each facility that has Medicaid days and / or beneficiaries that receive SSI benefits by the results of the DSH adjustment formula to account for the cost of furnishing care to low-income patients.

Q: Is the ratio of Medicaid days to total days in the calculation of the disproportionate share specific to rehabilitation units?

HCFA: The ratio of Medicaid days to total days is specific to rehabilitation units if the facility identified this information on its cost report. When the unit-specific information was unavailable, we used the overall Medicaid Days and Total Days for the entire facility.

Q: Who can bill under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)?

HCFA: To be eligible to bill and be paid under IRF PPS, a facility first must meet the conditions for payment under proposed d 412.604 of the regulations. This includes meeting the requirements under d 412.23 (b), which in part states that a facility must:

"Show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75% required intensive rehabilitation services for the treatment of one or more of the following conditions: stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur (hip fracture), brain injury, polyarthritis (including rheumatoid arthritis), neurological disorders (including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease), and burns."

Q: Will the clinical conditions that are applicable to the 75% rule be modified under the IRF PPS?

HCFA: As stated in the previous answer, in order to be paid under the IRF PPS, we have proposed to use the same requirements (including the clinical conditions referenced in the previous answer) to determine if a facility is exempt from the acute care hospital PPS. We believe that this will preserve the budget neutrality in payments made during the initial years of the proposed IRF PPS. However, we will be analyzing data as it becomes available after implementing the IRF PPS to determine if changes to the requirements to be classified as an inpatient rehabilitation facility are appropriate. ■

CMJ program provides pain relief, serves niche

Center often has 4-month waiting list for patients

Patients suffering from craniomandibular joint (CMJ) disorders often need relief for their pain, and treatment doesn't always have to involve surgery. Rehab facilities could play a large role in treating these patients.

The Affinity Health System in Appleton, WI, has a special program for CMJ patients, called The Center for Craniomandibular Disorders. The program's staff include oral surgeons who specialize in CMJ treatment and rehab staff who also work at the hospital system's outpatient rehabilitation center.

The center, which is within St. Elizabeth Hospital, was launched in 1989 when it became clear to physicians that it was increasingly difficult to manage CMJ patients in the hospital because they had to go to so many different places for treatment, says oral surgeon **Arthur Helgerson**, DDS.

Patients who are treated at the center don't need to go anywhere else. Their therapy and doctor appointments all take place at the center. Helgerson, for example, sees patients at the center 2.5 days a week and spends the rest of his time at his private practice in Appleton.

The program built up slowly but has become very popular, and the center does not have to advertise. It often has a three- or four-month waiting list of potential patients.

"Since we opened the center, physicians and dentists in the area have sent a lot of their patients to us," Helgerson says.

The center is the only one of its type in the region, so it has established a very good reputation in the community, says **Susan Van Handel**, CDA, program coordinator.

Helgerson, Van Handel, and other members of the center's staff relate the steps the center took to build a successful market niche by treating CMJ patients:

• **Overcome reimbursement obstacles.**

Business at the CMJ center increased by 35% to 40% in the two years since the state of Wisconsin passed a law mandating insurance coverage of the disorder, Van Handel says.

Previously, many regular insurance carriers either offered no reimbursement or stringent limits, Van Handel says.

"That insurance mandate really did make a big difference in the number of patients we treat throughout the year," she adds.

Health professionals worked to pass bill

The law's passage was no accident. The center's patients joined the Wisconsin Dental Association and other health care professionals in writing letters to state legislators requesting that they pass such a measure, Helgerson says.

"The idea for the bill was so patients could go to a family dentist and he could make a splint," he explains. "A lot of patients have early disease and can be treated with a splint, a soft diet, and no gum chewing, and it will get better."

The CMJ center's patients are those people who have endured CMJ pain for a long time and have found no lasting relief from multiple prescriptions of anti-inflammatory drugs.

"They have more complex disorders and pain over a long period of time, and it's more difficult to manage, which is why we have put together this team," Helgerson adds.

Since the Wisconsin legislature passed the bill mandating CMJ coverage, insurance carriers have set up a variety of reimbursement policies. Some will pay for all of the services offered by the center, while others have set financial caps on how much they'll reimburse for nonsurgical treatment.

A very small percentage of patients will pay out of pocket for their treatment, and Medicare typically pays 80% of the usual charge. Medicaid coverage is complicated and is not a significant source of revenue. The payers mainly are private insurers and health maintenance organizations, Van Handel says.

• **Establish treatment protocol.**

"Typically the patients who are referred to us have symptoms of muscle pain surrounding their jaw and they hear clicking and popping in their jaw," Van Handel says. "Sometimes there are patients who will complain of crunching teeth and are having a lot of pain because of that."

So one of the first steps in the program is for one of the oral surgeons to evaluate the patient and make sure the problem is related to CMJ.

The oral surgeon makes a diagnosis, and based on that diagnosis, the team will develop a treatment plan.

For example, if a patient visits the center because of popping sounds in his or her mouth, but there isn't much pain, then the patient might need only two to four visits with a physical therapist. The PT can show the person how to open and close the mouth in a way that will manage the problem, Helgerson says.

On the other hand, if the patient has difficulty with clenching his or her teeth, then the patient may be given a splint and sent to the occupational therapist to receive help with muscle problems, Helgerson adds.

Sometimes surgery is necessary

Yet another case may involve a patient who has significant difficulty opening his or her jaw, and this patient may require basic surgery.

"At this center we really try to do surgery only when there's something we can fix and not just to do surgery for pain," Helgerson says, adding that about 3% of patients require surgery.

Those who need surgery typically are covered by insurance carriers, and this type of treatment was well-reimbursed even before Wisconsin passed its bill, Helgerson says.

The physical therapist's main goal is to help the patient maximize CMJ function through modalities and therapeutic exercise, says **Mary Krueger**, PT, a physical therapist for the center and the hospital's outpatient rehabilitation facility.

Physical therapists develop a treatment plan that addresses muscle and joint dysfunction and includes hands-on treatment, an exercise modality, a home exercise program, and education in the use of self-management techniques.

• **Use technology to assist in treatment and treat pain.**

Van Handel generally begins the patient's pain treatment by meeting with the patient and

discussing various strategies the patient can implement to reduce pain, such as heat and diet recommendations.

When self-management methods are unsuccessful, the team will provide specific pain treatment. For example, there may be times when a patient is unable to exercise because the pain levels are so high, says **Jane Steinbach**, PT, a physical therapist for the center and the outpatient rehabilitation facility.

"So we do modality treatment to reduce that inflammation and the swelling in the joint," Steinbach says. "And this may involve phonophoresis, which means administering an anti-inflammatory medication via ultrasound." Another method is iontophoresis, which is the process of administering an anti-inflammatory medication by electrical stimulation, Steinbach explains.

"These are good alternatives to joint injection, and they are much more comfortable," Steinbach adds.

Some CMJ patients live with constant pain that greets them when they arise in the morning and stays with them as they go to bed at night, Steinbach says.

Each time these patients visit the center, they are asked to rate their pain on a scale of zero to 10, with zero being no pain and 10 being the greatest imaginable pain. They also rate the duration and frequency of their pain.

Any reduction in pain is a positive sign

"We are looking for the numbers to come down and for the pain to be intermittent," Steinbach says. "If a person has part of a day with zero pain, then that's a huge breakthrough."

Patients' pain also is treated through ultrasound without medication and through the use of the transcutaneous electronic nerve stimulator unit without medication. This home unit can be used to treat muscle tension pain and for regular pain management, Steinbach says.

"If a patient needs a little more help at home, then we can send the patient home with a unit," she adds.

The center also uses biofeedback technology to monitor a patient's pain and to help teach the patient how to reduce muscle tension and learn relaxation strategies, says **Linda Nett-Duesterhoeft**, OTR, an occupational therapy / biofeedback therapist at the center and the outpatient rehabilitation facility.

"This helps to reduce episodes, duration, and intensity of pain flare-up," Nett-Duesterhoeft says. "We look at the patient's autonomic nervous system and muscular system, and then look at the patient's stress response, monitoring changes in hand temperature and hand sweating."

The patient's muscle temperature in the jaw also is measured. The therapist gives the patient a print-out of his or her individual stress response. This demonstrates how the patient may clench his or her jaw during stress, an action that patients largely are unaware that they're doing.

"If they can listen to signs of their stress response by knowing what those changes are, then they are empowered to do something about it, and that's where relaxation skills are important," Nett-Duesterhoeft explains.

Patients respond well to receiving both visual and auditory feedback, says **Shelly Vanness**, OTR, an occupational therapist and biofeedback specialist for the center and the outpatient rehabilitation facility.

"Many muscles are hypertrophied from clenching, and these patients clench more significantly than people who don't have the disorder, so when they see what they're doing on the computer screen, it's very helpful," Vanness says.

• **Provide therapy when needed.**

The CMJ center also offers patients therapy sessions when needed.

"I come into play when the majority of the team feels that the patient has some personal problems that are leading to a more abnormal level of stress, and they need to talk to a psychologist to work out some issues," says **Kathleen Clarke**, PhD, rehabilitation psychologist.

Clarke provides individual therapy and cognitive behavioral training in six to eight sessions. "I see maybe 30% of the patients," she adds.

Typical patient is young woman

About 80% of the CMJ patients are female, and the typical age range is from age 13 to 45, with the average patient age being 21, Helgerson says.

"These are people in the early stages of the disorder," he adds.

Many of the patients have difficulty coping with stress related to a combination of work and family, Clarke says.

"Generally a person is overstressed because she's trying to handle too many things," she says. "She has children and is trying to get them to and from school, and she has a job and is overstressed

with personal problems and from trying to handle it all at once."

• **Educate patients.**

Patient education is a crucial component of CMJ management because stress, diet, and other issues can affect the patient's pain from the disorder, and education can make the difference between a short-term and long-term solution to the problem.

"We want the patient to be independent in caring for chronic problems," Krueger says.

Physical and occupational therapists teach patients active relaxation techniques that they can practice throughout the day. These relaxation skills might take them 20 to 30 minutes of practicing in a reclined position in a controlled environment, Nett-Duesterhoeft says.

One small and easy technique is to have the patient repeatedly say the word, "emma," which automatically puts the jaw in a relaxed position.

"I've had people joke about driving through the Rocky Mountains and wanting to clench their teeth, but instead are saying 'emma' to themselves throughout the Continental Divide," Nett-Duesterhoeft says.

Teaching patients these relaxation techniques in a way that will sink in may take an hour a week for six weeks. However, Nett-Duesterhoeft says she often has to accomplish everything in one visit because of reimbursement constraints.

Van Handel educates patients about their own insurance coverage, giving them pointers on how to ask the insurance company questions in order to learn what the coverage is.

She also explains how they will use splint therapy at night, when this is prescribed. The splint is a device worn on the upper teeth to take pressure off of the joint and prevent night-time clenching.

"A lot of patients complain of waking up with stiff and sore muscles in the face," Van Handel notes.

Then Van Handel explains the oral surgeon's orders and gives patients an idea of what they can expect from therapy. She also tells patients what the treatment team's expectations are for the patient.

"There is a time commitment with our program, and there is no quick fix," Van Handel says. "Our goal is to treat for four to six weeks so the patient doesn't have to come back, and if the patient has a flare-up, she can handle it at home." ■

Need More Information?

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Grocery store becomes center with rehab ties

Family practice physicians share space

In what may be one of the more novel expansion moves, Phoebe Putney Memorial Hospital in Albany, GA, turned a 64,000-square-foot former grocery store building into a fitness center with full outpatient therapy services.

A group of family practice physicians shares the building, using the space for both clinical practice and as a teaching facility for residents.

Some of the residents specialize in sports medicine or geriatric medicine and will shadow one of the hospital's physical therapists for a couple of days a month while they are next door to the fitness center, says **Sue Lanier Freeman**, PT, manager of outpatient physical therapy for Phoebe Northwest.

The physical medicine side of the building has 31,000 square feet on two stories. The top floor contains the managers' offices and a walking track that overlooks a solarium and main gym area for physical therapy and cardiac rehab. The lower level contains most of the patient care area.

The sports medicine area, in the back of the building, has the more advanced equipment, including free weights, cardiovascular equipment, leg presses, hand-strength curls, and other weight machines. There also is a small whirlpool for therapy.

The hospital chose the location because it's in the northwest area of Albany, closer to the heart of the hub area and the major mall. Previously, outpatient rehab services were situated on the

sixth floor of the hospital, which proved a major problem for some patients. It was difficult for them to find parking, and they would have to allow 15 minutes from the time they arrived at the hospital to make their way to the sixth floor, Freeman says.

The expansion, which cost more than $1 million during the renovation several years ago, gave the rehab facility a great deal more space with room for top-of-the-line equipment, Freeman adds.

"We have 10 exam rooms now whereas we had three before, and we have a lot more mobility," she says.

In addition to physical therapy, occupational therapy, cardiac rehab, speech therapy, and wellness services, the facility offers the services of two audiologists. There also are two physical therapists and two physical therapy assistants who are trained in neuro rehab, including stroke and traumatic brain injury. Another rehab program offered at the facility is a lymphedema program for women who have swelling caused by mastectomy.

"We do a lot of work with the spine, back, neck, and thoracic dysfunction," Freeman says. "One PT only sees spinal cord injury patients."

The facility's wellness services include a staff member who holds wellness classes addressing such topics as weight loss, strength training, tai chi, and fibromyalgia wellness. At a cost to participants of only $15 for two to three sessions over a six-week period, the services are not profitable, Freeman says.

"These are more of a community service, and the people are getting exposure to our facility and our staff, so if they end up needing therapy in the future, we're the first ones they will think of," she explains.

The facility's other community services include sponsoring an annual physical of all area junior high and high school athletes from both public and private schools. Hospital volunteers assist the rehab staff in assessing the more than 2,500 students' weight, height, blood pressure, and flexibility. Between 15 and 20 orthopedists and general practitioners help provide the physicals. This free service is held on the third weekend of May.

"It indirectly provides more referrals because if a family doesn't already have a doctor, they'll remember how they went to the Phoebe physical medicine facility," Freeman says.

Another annual event is a sports symposium in which area coaches are invited to listen to orthopedists and general practitioners speak about sports nutrition, injury prevention, and treatment after an injury on the field.

"They talk about how to cut a helmet off without fracturing the athlete's neck and how to immobilize a spine on a spine board," Freeman explains. "We also have about 10 PTs, OTs, and athletic trainers talk about rehab and what to do if you've had an ankle sprain."

The therapists give coaches examples of stretching techniques and a basic outline of what kinds of muscles need to be worked through various exercises. The all-day session typically draws more than 100 coaches. The facility provides lunch and usually has a celebrity keynote speaker, including sports figures and university coaches.

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After each annual session, the rehab facility asks the coaches for feedback.

"After the first year or two, they said we were too technical and had too much anatomy," says Freeman. "They wanted more practical advice about how to prevent injuries."

In subsequent years, they made the sessions more practical. Sometimes the sessions also combine fun and games with education. One year, the coaches were invited to a golf tournament in which both doctors and coaches would play golf.

"This is just a marketing tool," Freeman says. "It's the way sports medicine works."

Another marketing tool, this one geared at senior citizens, is a health fair held for people ages 55 or older. The quarterly fairs include free screenings for posture, balance, test grip strength, and fall risk. Senior citizens who are part of the 55+ Golden Key Club also may walk on the facility's indoor track between 7 a.m. and 7 p.m. The walkers are encouraged to ask the staff about any injuries or joint pain they may experience, and this can lead to a therapy referral. Typically, there are between 200 and 250 walkers per day on the track, Freeman says.

Before the hospital expanded into the former grocery store space, the rehab department was entirely dependent on physician referrals. Because of the large facility's prominent public exposure, there are many self-referrals or referrals made by physicians whose patients specifically asked to be sent to the Phoebe Northwest facility.

"We're no longer totally dependent on doctors," Freeman adds. "We still have a long way to go in marketing, but we're trying." ■

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