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INSIDE

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Balance program holds key to fewer falls, healthier patients

Rehab center demonstrates positive outcomes

Fall risk among the elderly is a growing problem, and providers traditionally don't address it until patients already have suffered injuries from falling.

However, a Maine rehab facility has formed a program designed to reduce fall risk among patients who have health problems that place them at high risk for injury, such as patients who have Parkinson's disease.

The program, called Balance and Safety Enhancement (BASE), is designed to evaluate patients for balance and fall risk and then create a training program for those who have balance problems, says **Kim Collett**, MSc, PT, a physical therapist with MaineGeneral Medical Center in Waterville.

Before starting the program, the hospital sometimes received referrals of patients who had frequent falls, yet the facility already had a $25,000 computerized balance testing machine. So it was a logical step to develop a special fall prevention program, Collett adds.

"We saw the need, we had the equipment, and we had the knowledge base, so we developed the program," Collett says.

Executive Summary

Subject:

Rehab center creates balance program to help elderly and disabled patients prevent falls and injuries.

Essential points:

- ❏ Outcomes show objective improvements in flexibility, strength, and walking on a case-by-case basis.
- ❏ Education about fall risks is a big part of the six-week program.
- ❏ Patients who benefit from the program include those with neurological conditions, people who've had neck or spinal cord surgery, people with vertigo or vestibular problems, and the frail elderly.

The multidisciplinary program typically provides six weeks of balance training with two one-hour sessions per week. Patients are evaluated by both a physical therapist and an occupational therapist.

So far, the program has proven a success. Objective tests that compare baseline and discharge assessments of patients' balance show remarkable improvements, at least on an individual patient level. (Composite outcome scores are not yet available.) Also, balance program participants rate their satisfaction in the good or excellent range.

Here are the steps the program takes:

1. Assess patients' balance at initial evaluation.

The program evaluates patients in two sessions, each lasting an hour to 1.5 hours. The first day involves testing of balance and strength coordination, as well as obtaining a medical history. Both physical and occupational therapists conduct the evaluation, Collett says.

The PT goes over the patient's fall history and checks blood pressure, range of motion, strength, reflexes, coordination, balance, and ability to walk. The OT conducts a mini-mental exam and evaluates the patient's vestibular system, although the PT might also do this. The OT also uses the functional assessment tool to review the patient's limitations with mobility skills, household tasks, activities of daily living, and work duties.

Machine provides objective measure

On the second day of evaluation, therapists assess the patient's balance and walking ability on the computerized balance-testing machine.

"The machine is a beautiful objective measure, a wonderful adjunct to our evaluation and treatment program," Collett says. "With this program, everybody has the opportunity to have their balance evaluated at the beginning and at the end of the program."

Patients are shown a red-colored block drawing that indicates when they score below normal for their age group. Green blocks indicate that the patient has scored within the normal range.

"First, the patient will stand still with eyes open, and then the patient will stand still with eyes closed," Collett explains. "Third, the patient stands on a piece of foam with eyes open and then again with eyes closed."

The machine measures patients' sway during these four tasks, and this is what is tested again in six weeks after the program has been completed. The machine provides a good visual feedback tool that helps patients learn where their balance should be, Collett adds.

2. Provide individualized balance program.

Although the program is designed to address each patient's particular strengths and weaknesses, there is a general outline of what will be covered during each session. Here's the outline:

- Week 1, session 1: Description of program and introduction to balance.
- Week 1, session 2: Fall facts and statistics; hearing and vision.
- Week 2, session 1: Home safety.
- Week 2, session 2: Community safety.
- Week 3, session 1: Re-assessment and review.
- Week 3, session 2: Re-assessments.
- Week 4, session 1: Proper footwear and foot care.
- Week 4, session 2: Adaptive equipment.
- Week 5, session 1: Medications and their effect on balance.
- Week 5, session 2: Eye-head exercises.
- Week 6, session 1: Stairs, transfers, and outdoor safety.
- Week 6, session 2: Course evaluation, review, and questions.

Combining lectures with exercises

Patients enrolled in the six-week program receive progressively challenging balance and walking activities led by physical and occupational therapists and PT and OT assistants. Sessions combine a lecture format with exercises in the gymnasium, corridors, and outdoors.

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The program's goals include the following:

• to improve people's balance and walking ability;

• to teach fall prevention strategies to patients;

• to increase their general fitness level;

• to decrease their dizziness or vertigo;

• to teach patients about their condition and how they can become independent in symptom management.

3. Educate patients about fall prevention.

PTs and OTs teach patients how to prevent falls in their homes, and they review fall safety within the community.

"We teach people how to get off the floor if they do have a fall, and we review medications and their effects on balance," Collett says. "We also talk about proper footwear and foot care as reviewed by an orthotist."

The OT or an audiologist will talk with patients about hearing and vision problems that can affect balance.

"The staff who develop and carry out the program have specialty training in balance education, vestibular rehabilitation, and neurological and geriatric medicine," Collett says.

4. Establish referral base and reimbursement sources.

Program participants are referred by physicians and may include anyone who has a neurological condition, such as multiple sclerosis, cerebrovascular accident, and Parkinson's disease.

Others who can be referred to the program include patients who've had surgery on their neck or spinal cord, people with vertigo or vestibular problems, and the generally frail elderly who have a history of falling, Collett says.

Osteoporosis patients are referred to the rehab facility's special osteoporosis program, although once they complete that program, they may be referred to the balance program for further fall safety education and training, she says.

Medicare and most private insurers have readily paid for the balance program, and a program case manager will assist patients in investigating their insurance coverage when necessary, Collett adds.

The only drawback is that none of the payers can be billed for the educational components of the program.

So far, the program has had little difficulty in obtaining referrals. The only marketing has been distribution of a pamphlet to doctor's offices and participation in a senior health day.

From September 1999 through June 2001, the program held nine classes for an average of four classes per year. There typically are six to eight participants per class, Collett says.

"It's a great service," she adds. "And we offer a six-month retest free of charge to all participants."

5. Track outcomes.

The overall outcomes have not yet been determined, but individual outcomes look very promising, Collett says.

Here's what the program has found on the four major outcome measures:

• **Berg Balance Scale:** This test was scored as a zero if a patient showed a decrease in the scale score, one point if the patient had no change or a change that was less than 1.0, and two points if there is an increase of 1.0 or greater. Based on this type of scoring, there were a total of 56 points to be obtained. One patient's score before the program was 31, and at the end of the program the same patient scored 56. In another case, a patient's score increased from 47 to 56, and yet another patient's score increased from 34 to 52.

• **Timed "up and go" test:** This test times how long it takes a patient to stand, walk three meters, turn around, and walk back to sit down. A patient who scores under 15 seconds typically is more independent in activities of daily living. One patient in the balance program scored 22 seconds at the initial evaluation and nine seconds at discharge; a second patient scored 19 seconds initially and 11 seconds at discharge; a third patient improved the score from 12 seconds to eight seconds; and a fourth patient had an improvement from 13 seconds to eight seconds.

• **Functional reach test:** This test measures in inches the patient's ability to lean or reach forward without losing balance. Any score over 10 inches is considered evidence that the patient is more independent. Patients enrolled in the balance program showed improvements in this area, as well. For instance, one patient scored four inches at initial evaluation and 12.5 inches at discharge, and another patient scored six inches at initial evaluation and 11 inches at discharge.

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• **Patient satisfaction survey:** The rehab facility's goal was to have a 75% satisfaction outcome among 95% or greater of patients. The survey was scored from one to four, with one being poor and four being excellent. Scores of three and four were considered acceptable. Although the total has not yet been calculated, the most recent balance class gave the program scores of all threes and fours (good and excellent) on the satisfaction survey. ■

Rehab hospital features specialized pain programs

Facility ranks No. 1 in national survey

The Rehabilitation Institute of Chicago (RIC), which was ranked the No. 1 rehabilitation hospital in the United States by *U.S. News & World Report* in July, probably has a specially designed program that can treat any kind of pain patients experience.

Patients with acute pain are handled by one team of physicians and therapists; patients with chronic pain are handled by another team; patients with arthritis pain may be referred to the hospital's new Arthritis Center **(see story on RIC's Arthritis Center in the July issue of *Rehab Continuum Report*)**; and patients who have pain that is related to a sports or occupational injury could be treated for pain in a pain program and/or the Center for Spine, Sports and Occupational Rehabilitation. **(See story on sports medicine center, p. 97.)**

The hospital's 26-year-old chronic pain program treats patients who suffer from pain related to lower- or upper-back problems, musculoskeletal pain, myofascial pain syndrome, fibromyalgia, spinal cord injury pain, amputee phantom limb pain, and headaches associated with traumatic brain injury and post-stroke pain.

"Everybody on our team is full time, and this is all they do," says neurologist **Norman Harden**, MD, director of the Center for Pain Studies at RIC.

The team includes Harden, a physiatrist, two psychologists, physical therapists, physical therapist aides, occupational therapists, occupational therapist aides, a vocational rehabilitation specialist, a therapeutic recreation specialist, a biofeedback therapist, and nursing educators who handle all patient education.

Patients are either self-referred or referred by physicians. A patient is evaluated initially by a physician, who spends about 1.5 hours with the patient, and by a psychologist who talks with the patient for an hour. Occasionally there will be a vocational rehabilitation specialist who also will talk with the patient for an hour.

Patients must meet specific criteria

Before patients can be placed in a pain program, they need to meet the chronic pain facility's basic criteria, which include having a diagnosis that is compatible with the center's work. Also, patients need to be highly motivated and compliant because the program requires very hard work on the patient's part, Harden says.

"There are other criteria, like making sure there are no complicating factors such as inappropriate drug regimes that need to be modified before the patient comes in," Harden says. "For instance, high-dose opioid therapy is not consistent with the work we do."

The chronic pain team also might meet with patients initially to straighten out drug dependence and psychological issues before treatment begins, or they might refer some patients to a chemical dependency specialist.

"Then we decide which of our three basic programs would be appropriate," Harden says.

The three programs are as follows:

• An every-day program requires the patient to attend the center each day for one to four weeks. The every-day program requires patients to meet with each therapist and discipline for an hour, with a break for lunch and a 15-minute consultation with the physician. This program also includes an hour of patient education. Patients do not see each team member daily, but will eventually see them all at some point within the week. Physicians see these patients at least three times during the week.

"This program has very detailed and complex scheduling that changes based on the patient's individual needs," Harden says. "Some patients will need more psychology services, some will need more physical therapy, so it's tailored and adapted as we go along."

• A half-day program has the patient meet the team once a week for half a day. This program is set up as a round robin; for example, patient A will see the physical therapist first while patient B sees the physician first, patient C sees

the occupational therapist, patient D sees the psychologist, and patient E sees the biofeedback therapist. Then after half an hour or 45 minutes of treatment, they all switch, until each patient completes all five sessions.

Program available for less-serious cases

• A modified program for less serious cases is available in which the patient sees a physician and physical therapist, psychologist, or occupational therapist according to need. The modified program is designed by the evaluation team, but once it's under way, the physician makes changes, taking into consideration the patient's and team's opinions.

For example, the modified program for a patient might include medical care, psychology, and physical therapy. The physician, psychologist, and physical therapist would meet to talk about the patient's progress and problems. The team would make suggestions for modifying the patient's plan and adding other modalities as needed.

In addition to traditional services, the center offers some complementary medicine options, including acupuncture, chiropractic care, Pilates treatment performed by physical therapists, and Feldenkrais therapy, a movement therapy administered by physical therapists.

The pain center tracks outcomes by monitoring 14 different psychometrics, including general categories with subjective measures of pain, assessing the patient's depression and anxiety levels, function tests, medication quantification scale, and other validated instruments, including some the center has designed, Harden says.

"The majority of patients report some decrease in their pain, with about 67% reporting a significant decrease in their pain," Harden adds. "Most of our patients, about 95%, achieve maximum medical improvement, which means we do all of the standard-of-care things that are reasonable for the pain so the patient can decrease health care utilization."

About 35% of the center's patients return to work, a considerable achievement in light of the fact that less than 1% of patients nationally return to work after experiencing two years of chronic pain, Harden says.

The center's payers typically fall into three categories. These include Medicare and Medicaid, which reimburse about 45 cents per dollar of pain center services; HMOs and similar plans, which cover most services (with an occasional 50% limitation for psychological services); and workers' compensation, which covers 100% of services, as required by state law.

Some of the complementary medicine services are routinely covered by payers; others, such as biofeedback and acupuncture, are not.

Patients occasionally will pay out of pocket for the services, but most of the time, the center will cover the cost of non-covered services, Harden adds. "We take what we can get and don't bill the patient for the rest." ■

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Sports med center gets holistic makeover

Alternative medicine is part of treatment

More than 60% of the referrals to a Chicago sports medicine center come from former patients, which shows that attending to patient satisfaction can pay off for rehabilitation facilities.

"We started the program in 1988, and from the beginning, we'd see anybody and everybody, and we still do, but we always felt that our patients were our best referral sources," says **Joel Press**, MD, medical director of the Center for Spine, Sports and Occupational Rehabilitation, which is part of the Rehabilitation Institute of Chicago (RIC).

The center, which occupies 10,000 square feet in a freestanding building that also features a separately owned health center, sees about 300 new patients per month, Press says.

The center's staff includes four physicians and seven full-time therapists and athletic trainers, as well as physical therapy and occupational therapy aides. Within the past year, the center has added complementary medical treatments to its service menu. The center now has a chiropractor, an acupuncturist, and an orthotist, who can work

with the team on inserts for shoes. Also, a podiatrist rents space at the center and is available to see patients when necessary.

Having the entire staff within the same center cuts down on the length of time between the physician's initial evaluation and the time when the prescribed treatment begins. Also, there is a collaboration between physicians and therapists, so that if a therapist believes a patient might benefit from some other type of treatment, the therapist can easily consult with the physician to make appropriate referrals and changes to the treatment plan.

'Everyone is on the same page'

"That's the beauty of it: the working relationship between physicians and therapists, whether it's the occupational therapist, physical therapist, orthotics person, pain psychology people, chiropractor, or acupuncturist," Press says. "Everyone is on the same page philosophically, and we're all in the same physical plant."

For example, a back patient will be seen by a physiatrist for a physical exam. The physiatrist will make a diagnosis and devise a treatment plan according to the patient's specific problem. The plan could include shoe inserts or an injection in the spine or joint in addition to an exercise program, Press explains.

The center's main services include the following:

• **Evaluation and treatment to prevent re-injury.** Comprehensive evaluations assess the patient's injured area and entire muscular system to determine whether there are imbalances that might have contributed to the injury. Patients are taught about posture, body mechanics, and injury prevention. The staff may use the Gold Coast Multiplex health club, located within the same building, for its weight training equipment, pool, and other amenities that might assist in treatment.

"We offer rehabilitation beyond the resolution of symptoms," Press explains. "Patients who just get better with the right medications typically will see their problems return unless their whole muscular system is evaluated and treated."

The center focuses on treating the patient holistically and devising exercise programs that are functional. "A straight leg raise is not a functional activity," Press adds. "So the more we make the exercises feel and look like sports and activities and movements, the more exercises patients will do."

• **Sports rehabilitation.** After a consultation and thorough examination, the physician creates an individualized rehabilitation program that is devised to keep the patient in good physical condition while allowing him or her to heal.

Therapists use Cybex equipment, video analysis, radiology services, and electrodiagnostics to customize the patient's treatment plan.

"The important thing is to get the patient active and back into sporting and daily activities and to make the patient smarter so he can do it on his own," Press adds. "We're not here to fix people, but we make them able to do what they want to do, and we make them independent sooner than they would have been."

Often patients will be prescribed one or two treatment modalities and will return for a total of five to 10 sessions. "Very rarely do we see people three times a week for six weeks," Press says. "Most of the problems are acute or subacute, and we get patients going on exercise treatment right away."

Patients are given their exercise homework and told they will be re-evaluated when they return.

Spine rehab focuses on education

• **Spine rehabilitation.** This nonsurgical approach to back and neck problems focuses on alleviating pain and improving overall fitness.

Therapists and physicians stress education, with the philosophy that patients who have a better understanding of their condition will benefit from conditioning and exercise treatments and will reduce their risk for re-injury.

Patients who have low back pain, sciatica pain, and sacroiliac joint pain also might receive epidural steroid injections as part of the management of lumbar spine pain.

Situations in which patients might be referred to a complementary modality include the following scenarios:

• **Chiropractic care.** A patient with a spine problem related to a degenerative change causing significant limitations in motion or who has pelvic hip muscles and joints that are stiff in movement could benefit from the more aggressive manual therapy that a chiropractor could provide, Press says.

"Some of these problems can be treated by a physical therapist because most of them have significant training in advance manual skills," Press says. "So I might send the patient to the physical therapist, and the therapist will say, 'I can't get it

here,' so let's have the chiropractor have a look at him."

• **Acupuncture.** Patients who have acute pain problems that need to be brought under control quickly could be referred to the acupuncturist. Also, patients with more localized pain could benefit from this treatment. "We will not attempt acupuncture treatment for long periods of time, because our philosophy here is that we're not here to fix you, but we want to get you over the hump," Press explains. "Some treatments, like acupuncture, can become too passive, and patients believe they can come here to be fixed."

• **Pain psychologist.** Patients who have ongoing pain problems may need biofeedback or stress management counseling, and the pain psychologist can assist with these issues. If the patient's pain is chronic, the physician might refer the patient to the chronic pain program that is part of RIC.

"We use pain psychology people as an adjunct to parts of our program; if a patient has had multiple back surgeries, we'll refer the patient to them," Press says.

• **Work hardening.** An interdisciplinary evaluation measures patients' physical strength, flexibility, and ability to perform job-related tasks. The evaluation, which identifies deficits and assets, is used in creating a program that will help the patient improve his or her essential work-related skills.

This treatment might involve four to eight hours each day of real and simulated job activities, as well as exercise programs and education. Therapists also will evaluate the patient's work site for safety and comfort.

Likewise, the rehab facility's staff can provide injury prevention evaluations to local businesses that want to reduce back injury and repetitive motion disorders. Occupational and physical therapists will visit the work site and analyze injury risk factors. ■

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Reader Questions

On-line support: Should you or shouldn't you?

Some groups are successes, but caution is required

Question: "Has your institution created any on-line support groups? If not, do you refer patients to existing on-line support groups? When referring to these support groups sponsored by hospitals or health care systems, how do you evaluate them? Have you had much interest in on-line support groups by patients? What are the advantages and disadvantages of going on-line for support?"

Answer: "We created an on-line version of each of our support groups," says **Deborah Pfaffenhauser**, RN, MSN, director of consumer health education at Bayhealth Medical Center in Dover, DE. The catalyst behind the on-line support groups was the desire to provide community services over the Internet. The groups are set up in bulletin-board fashion, meaning someone posts a question and others provide responses. However, none of the groups has been used much to date.

Marketing may boost group attendance

To encourage use of the on-line groups, Pfaffenhauser got the facilitator of some of the regular sister support groups to start a line of conversation, thinking that regular users may be reluctant to post the first message, but the tactic did not help. This summer, Pfaffenhauser plans to do a marketing blitz to employees as well as the community to determine whether publicity increases traffic.

The on-line support groups currently have no moderators, but as traffic increases, Pfaffenhauser hopes to have an appropriate educator monitor each group. For example, the cancer educator would monitor the on-line cancer support groups.

The Anderson Network, a group of current and former cancer patients who volunteer to offer support to others living through the diagnosis and treatment of cancer, created an on-line support group at Houston-based MD Anderson Cancer Center as a listserv. The volunteers used

the listserv method because they couldn't create a chat group in real time due to the institution's Internet security. People who come across the listserv on the cancer center's Web site can subscribe via e-mail. **(For information on creating an on-line support group in real time, see story, p. 101.)**

"As moderator, I read all the e-mail messages on the listserv, and if there is a question that is not being answered, then I answer it," says **Linda Jones**, moderator of the Anderson Network listserv. "Our group is fairly knowledgeable about use of the Internet, so I don't say a lot to them. They are fairly self-monitoring."

Although there has not been much of a problem with incorrect information being provided on-line, there is a policy in place to handle the problem. Jones would intercede with a statement about MD Anderson policy on the issue or would refer interested parties to a web site that has correct information.

Anyone signing up for the listserv receives an automated letter explaining the rules of participation. Advertising is not tolerated, and people who don't obey the rules are removed from the listserv.

Set criteria for referral

Although USC/Norris Comprehensive Cancer Center and Hospital in Los Angeles does not sponsor on-line support groups, patients are referred to these groups. "In evaluating which groups we refer to, we look at the organization that the group is sponsored by and who the facilitator is. We only refer to groups that are led by a professional," says **Carol Marcusen**, LCSW, director of social services and patient education.

Patients who have participated in chat rooms or support groups that are not led by professionals have received invalid information and have had problems with people who monopolize the group and have their own agendas, says Marcusen.

Any on-line support group listed as a referral should be sponsored by a reputable organization and led by a well-credentialed health professional, agrees **Mary Szczepanik**, MS, BSN, RN, manager of cancer education, support and outreach for Grant/Riverside Methodist Hospital in Columbus, OH.

For example, a reputable institution for cancer support groups would be one that is a National Cancer Institute (NCI) -designated Comprehensive Cancer Center. The moderator for an on-line cancer support group should be a psychologist, psychiatrist, advanced practice nurse, or licensed social worker; all involved should have strong oncology experience. "Their credentials should be available on-line," she says.

Check into policies and procedures

Before referring a person to an on-line support group, Szczepanik would make sure it had policies and procedures that covered such issues as how a suicidal person is handled on-line, what is done when someone makes statements or asks questions that indicate he or she has a life-threatening medical condition, or how complaints about specific physicians, hospitals, or health care providers are handled.

"We provide one-on-one counseling over the phone, and since we have general and disease-specific live support groups, we funnel people into those. We rarely get questions about on-line support groups," says Szczepanik. Of the 600 to 700 calls received monthly on the information line, only one or two are requests for information about on-line support groups, she says.

"There are numerous on-line support groups on the web currently, but I have been very leery of

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recommending them to patients because I do not have enough time to frequent the groups myself and/or to assess the information that is shared within the group," says **Barbara Petersen**, RN, BSN, patient education coordinator at Great Plains Regional Medical Center in North Platte, NE.

One disadvantage of on-line support groups is that they cannot provide the trust and rapport that occur when people who share a medical problem meet in person. Often, the casual conversation that occurs as members enter the room before a support group meeting or walk to their cars afterward is more productive than the structured conversation, says Petersen.

On-line support groups are difficult to regulate, and it is easy for participants to misrepresent themselves. "Some of the ideas shared can be unproven or debatable issues and advice which can really lead someone astray," says Petersen. Also, people trying to make a fast buck prey on desperate people looking for a cure or alternative treatment. While she acknowledges that many on-line support groups have protection measures, such as passwords or registration methods, not all of them do.

An advantage of on-line support groups is that people do not have to leave home to attend. This can be especially advantageous for caregivers, says Pfaffenhauser. These on-line groups also are beneficial when there is limited space available for meetings. With on-line support groups, there is no limit to the number of participants you can accommodate, she says.

Another advantage on-line groups offer is anonymity, says Petersen. "The major advantage of an on-line support group is that someone can maintain their confidentiality when the patient does not wish to reveal to members of a community their illness or other reason for attending a support group," she says. ■

Education and support on-line is winning combination

Homebound patients not forgotten

The on-line support group for cancer patients organized by James Cancer Hospital and Solove Research Institute in Columbus, OH, is like any other support group that meets in person except that it is two-dimensional, says **Pat Schmitt**, MA, CRC, program director for comprehensive oncology rehabilitation.

The group, which has a facilitator and a guest speaker, meets once a month. A handout with more detailed information often is available for participants to download. To participate, people contact the webmaster via e-mail to obtain a password and instructions before logging on at the designated time.

"One of the reasons we started the on-line group is because we realized that traditional support groups are not for everybody anymore. We were trying to very deliberately expand the menu of options that we were providing to our patients," says Schmitt, who acts as the group's facilitator.

To determine what people would want in an on-line support group, the institute conducted a survey in the outpatient ambulatory area, which has a high volume of patients, making it easy to collect data. Patients who were interested in trying an on-line support group said they wanted it to be educational as well as supportive.

The project team decided the group should be professionally facilitated, rather than being set up as a bulletin board or open chat. They also determined that an expert on the featured topic should be invited as a guest speaker. "Because this is offered by our institution, we wanted to bring a level of clinical expertise to it," says Schmitt.

People can choose when they want to participate based on whether or not the topic being covered meets their specific personal issues. Those with a password are sent an e-mail reminder. The information about the support group and the monthly topic also is on the James Cancer Hospital web site.

On-line anonymity can facilitate questions

Some patients log onto the support group on a monthly basis because they like the contact with other people. Others like the anonymity of the Internet environment. Some of the topics covered, such as dealing with changes in sexuality and intimacy, work really well on-line, says Schmitt. "Some of the questions people wouldn't feel comfortable asking in person with a lot of other people around, they have no hesitation asking on-line," she explains.

Older adults are participating in the on-line

support group, which particularly pleases rehab managers because they have had difficulties serving this patient group in the past. That's because older adults don't like to come back to the hospital in the evenings to attend a class, clinic, or traditional support group, says Schmitt.

In addition, the 30% to 40% of patients who live out of the area can take advantage of the on-line support group once they leave the hospital. It's also convenient for chemotherapy patients who need to conserve their energy by running fewer errands.

The general attendance of the on-line group is between eight to 10 people, including a few regulars and several one-time participants, which fits with the support group's design. The cutoff point for the number of participants would be 15 because high numbers reduce the amount of time people actually have to communicate, says Schmitt.

Facilitation a challenge

To facilitate the communication process, Schmitt monitors the discussion. She tries to ensure that people who ask questions receive a response, and she redirects people when necessary by typing something like, "We have had many questions from Ian, let's hear from Sally." Schmitt often takes notes to keep track of who is participating.

Sometimes a participant will type in several questions in rapid succession, so she will select the question she thinks will be of interest to most people and then ask the guest speaker to answer it. If time permits, the other questions are answered later.

Often, the guest speaker needs help getting used to the on-line chat environment. Therefore, Schmitt has the physician, dietitian, or other member of the health care team who is speaking arrive 30 minutes early to practice using the system. She will then spend about 20 minutes chatting via the computer with the guest speaker so that he or she can learn how long it takes to type answers, how long it takes for entered text to show up on the screen, and what it's like to be reading questions and thinking of answers simultaneously.

To make sure the session runs smoothly, Schmitt will send e-mail messages to everyone who has a password, asking them to submit their questions in advance. Then she will conduct an interview with the speaker for the first 20 minutes so that all the common questions are addressed.

The physician or other guest speaker is given the questions in advance so he or she can prepare brief answers. In this way, all the participants aren't entering text at the same time during the session, barraging the speaker with a flood of questions that don't have a proper flow. Also, this cuts the amount of time that the screen is blank as the speaker types in answers to questions.

"It is helpful to have as much structure as you can bring to the format because discussion goes really, really fast," says Schmitt. Once the speaker has had time to present the topic, Schmitt opens the discussion up for questions that pertain to information that has been covered.

Working around the firewall

While practice makes perfect, many challenges have had to be addressed in order for the on-line support group to run smoothly. For example, the firewall that protects the hospital's computer network system from hackers could not be removed to create the support group; therefore, the sessions take place off-campus. The hospital had to contract with a company that provides a site from which group sessions are run.

Another challenge has been finding enough generic topics to present to the general cancer group. Topics covered have included work-related issues, symptom management, and nutrition.

Also, people who participate are asking that the sessions be more frequent. "We are thinking about holding the sessions more than once a month. From the feedback we get from our participants, it is too infrequent. If you are using an on-line modality on a frequent basis, a month seems like a really long time to go before you connect with people again," says Schmitt. ■

Need More Information?

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Experts: Medicare computers can be hacked

Private contractors should be monitored

The financial data and patient records of 39 million Medicare beneficiaries stored on computers throughout the nation's health care facilities are not secure, according to security experts who testified recently before Congress.

The records are vulnerable both to outside computer hackers and unscrupulous workers with access, the security experts said. They told a House investigative subcommittee that the Centers for Medicare and Medicaid Services (CMS) should exert more control over private contractors who run the agency's computer networks linking providers and insurers with CMS' headquarters in Baltimore.

CMS recently improved some computer security measures, but **Joseph E. Vengrin**, assistant inspector general for audits at CMS, says there still is a lot of room for improvement. In particular, CMS cannot guarantee the security of passwords among employees with access to sensitive medical and payment information, he says. CMS contracts with private companies such as IBM and AT&T to administer its nationwide computer network.

"We remain concerned that inadequate internal controls over Medicare operations leave the program vulnerable to loss of funds, unauthorized access to and disclosure of sensitive medical information, and malicious changes that could interrupt data processing or destroy data files," he says.

Vengrin's office issued a report showing that computer programmers working on the system had access to payment records and medical information — information they did not need and should have been barred from accessing. Another investigation performed by a private security firm showed that hackers could access CMS' network through the agency's web site.

The good news is that the risk seems theoretical, so far. Neither the agency nor its contractors has ever had an outside break-in that threatened the security of sensitive information, says **Jared Adair**, CMS deputy chief information officer.

Adair says CMS recently doubled to 60 the number of people dedicated to computer security, and the agency has asked Congress for $30 million to improve security. ■

NEWS BRIEFS

HealthSouth pays $7.9 million to settle

HealthSouth, the nation's largest outpatient surgery and rehabilitation chain, has agreed to pay $7.9 million to settle allegations that the company overcharged federal health programs.

The Justice Department announced the settlement recently, saying the health care provider

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had agreed to pay the penalty, plus 7% interest from Oct. 1, 2000, without admitting liability. HealthSouth is based in Birmingham, AL.

Acting Assistant Attorney General **Stuart E. Schiffer**, JD, said the government alleged that HealthSouth overcharged Medicare and the Defense Department's TRICARE program for equipment and supplies purchased from G.G. Enterprises, a corporation owned by the parents of HealthSouth chairman and CEO Richard M. Scrushy. The allegations involved costs related to three rehabilitation hospital leases, the purchase of certain computers and related goods and services, and the abandonment of computer assets owned by another company acquired by HealthSouth in 1994.

HealthSouth said the previous company's treatment of these costs in cost reports submitted for reimbursement was inconsistent with Medicare regulations, resulting in overpayments. In a statement released at the time of the settlement, HealthSouth officials said they decided to settle the matter to avoid the time, expense, and distraction of litigation. Scrushy said, "While we devote significant resources to complying with all reimbursement regulations, the volume and complexity of those regulations make it inevitable that differences in interpretation and even errors may occur."

The settlement stems in part from a lawsuit filed by whistle-blower Greg Madrid, a former HealthSouth billing clerk. As part of the settlement, Madrid will receive $1.48 million. ▼

Joint Commission forms task force

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is taking a hard look at the relevance of its hospital standards and compliance requirements. An 18-member task force will pinpoint which accreditation standards are most relevant to the safety and quality of patient care, with the goal of eliminating or modifying those that don't contribute to good patient outcomes. In addition, the task force will identify redundant and overly burdensome documentation requirements for potential streamlining, as well as areas needing additional focus.

Led by Ken Shull of the South Carolina Hospital Association, the task force will include quality directors, medical records directors, nurses, physicians, engineers, risk managers, and other hospital leaders who have first-hand experience with Joint Commission accreditation standards and surveys. Doctor groups also will be enlisted to review medical staff standards.

Shull and his colleagues will consider the following when reviewing standards and regulations:

- continuing relevance in promoting patient safety or high-quality care;
- redundancy with other external quality requirements;
- applicability of standards to hospital care;
- likelihood that compliance will be consistently evaluated;
- extent to which compliance can actually be measured;
- linkage to patient outcomes.

The Joint Commission also will ask the task force to identify common misconceptions and misinformation regarding requirements for demonstrating standards compliance. ■