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INSIDE

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Special Report: Here's the Skinny on Inpatient Rehab PPS

Medicare's final rule has many improvements, but questions remain

Rehab facilities pleased with assessment tool

It appears that the rehab industry has benefited from mistakes made with prospective payment systems (PPS) in the home care and skilled nursing facility industries, because the final rule reflects a more responsive federal government, rehab experts say.

"I think the final rule really does demonstrate a response to the public and to the professionals working in this field," says **Bonnie Breit**, MHSA, OTR, administrative director of rehabilitation services at Crozer-Keystone Health System in Upland, PA.

"Overall, we were extremely pleased with the components of the final regulations, especially with the patient assessment instrument," says **Tom Davis**, president of inpatient services for RehabCare Group of St. Louis.

The rehab industry benefited from being the third in a series of PPS implementations, says **Barbara Marone**, senior associate director of policy at the American Hospital Association in Washington, DC.

Executive Summary

Subject:
Medicare final rules for inpatient rehab prospective payment system (PPS) show that the government can be responsive to industry's concerns.

Essential points:

- ❏ MDS-PAC has been dumped in favor of an assessment tool that resembles the more widely used functional independence measure (FIM).
- ❏ The FIM tool is much shorter and more efficient, and there are more data suggesting its validity and reliability as an assessment instrument.
- ❏ Despite improvements to PPS assessment, some Medicare patients will be left out. For instance, Prader-Willi patients have no FIM mechanism for their diagnosis, which could result in a greatly reduced reimbursement for the rehab services they require.

"We benefited from the learning curves of the home health and skilled nursing facility systems," Marone adds.

The Centers for Medicare and Medicaid Services (CMS) of Baltimore (formerly the Health Care Financing Administration) published the final rule for inpatient rehabilitation PPS on Aug. 7, 2001. The 500-plus-page document confirms earlier reports that CMS reversed its initial proposal that inpatient rehab facilities use the minimum data set for postacute care (MDS-PAC) for an assessment tool. The universally condemned MDS-PAC would have required facilities to invest in extensive staff training and likely would have added hours to the time therapists and clinicians needed to assess patients.

Instead, CMS will require facilities to use a tool called the Inpatient Rehabilitation Facilities Patient Assessment Instrument (IRF-PAI), which incorporates the functional independence measure (FIM). For most inpatient rehab providers, this means the new tool will be very similar to the tool they already have been using for quality and accreditation purposes.

"There will be changes from the way the FIM works, and those changes will make a difference, so I think training is going to be extremely important," says **Carolyn Zollar**, JD, vice president for government relations at the American Medical Rehabilitation Providers Association (AMRPA) in Washington, DC.

"But the implementation won't be as time-consuming," Zollar adds.

CMS received volumes of comments that criticized the MDS-PAC proposal, with AMRPA and others questioning the tool's reliability and validity with regard to assessing quality of care. Criticism also centered around the sheer size of the tool, which had more than 350 items and would have taken more than an hour to complete. Also, it would have required up to five assessments.

The IRF-PAI is much shorter, with only 54 numbered items, and only needs to be completed at admission and at discharge.

"So now there's a lot less extra work for rehab units, and CMS has taken advantage of the systems that most rehab units have had in place," Davis says. "From that aspect, this is very good."

The FIM scale also is a more efficient tool with a much greater base of research supporting its validity, notes **Laura Landmeier**, OTR, MSOT, MBA, assistant vice president of quality and outcomes management with Schwab Rehabilitation Hospital & Care Network in Chicago.

However, not everyone will benefit from use of the FIM. The Children's Institute of Pittsburgh might lose up to half of the Medicare reimbursement it currently receives for treatment of children who have the rare Prader-Willi Syndrome, says **Charles Schuessler**, vice president of finance and treasurer for the institute.

Prader-Willi Syndrome is a chromosomal disorder that results in children experiencing extreme hunger all the time. These patients will eat anything and typically are very obese, with low muscle tone, mild developmental delays, and behavioral problems. When Prader-Willi patients reach adulthood, many receive Medicare coverage because of their disability, Schuessler says.

"We have a fairly major problem because the patients in our Prader-Willi population do not fit the FIM scoring mechanism and never have been included in FIM data," Schuessler says. "So I don't know if we could code our patients satisfactorily to get a claim processed."

The MDS-PAC tool also had no mechanism for a Prader-Willi diagnosis, so the institute had asked CMS to correct this omission. Unless CMS in some way exempts or recognizes Prader-Willi Syndrome as a separate diagnosis, the institute is facing a $500,000 annual loss in Medicare reimbursement.

The institute's unique program treats Prader-Willi patients with a weight loss and behavioral modification program that focuses on improving motor skills and muscle tone. Prader-Willi patients typically have a 60-day length of stay at the institute.

"This truly is a quandary for us, and we'll

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struggle to find a way to work through this," Schuessler says. "We don't want to turn our backs on a need we've been serving for so long, but there obviously are limits to how much loss we can sustain."

Even those in the rehab industry who are mostly pleased with the inpatient rehab final rule acknowledge that there still are some problems to be resolved. These include the transfer rule, outliers, cost adjustments, the comorbidity list, and patient classifications. **(See story about rehab industry's concerns over the final rule, below.)**

Also, rehab facilities will need to know when all of the necessary software and tools will be available for training and use.

"The critical question is, when will software for data tools be available so facilities can start downloading it and begin training on that," Zollar says.

"One thing all facilities need to be well aware of is if they want to be paid based on 100% of PPS at the very beginning, then they have to get their notification in to the fiscal intermediary 30 days in advance of the start of their cost-reporting period," Zollar adds. "For example, if a facility's cost-reporting period is Jan. 1, 2002, then they need to get the request in and received by the fiscal intermediary no later than Dec. 1, 2001, and preferably before that."

Those who choose not to meet this deadline or who are unable to meet it will be subject to the two-year transition period, in which they'll be paid two-thirds of their reimbursement based on PPS and one-third based on the current TEFRA system. ■

Special Report: Inpatient Rehab PPS

Rehab experts air concerns about inpatient rehab PPS

Transfer policy, comorbidities top list

Although the Centers for Medicare and Medicaid Services (CMS) in Baltimore listened to the rehab industry's concerns about its inpatient rehab prospective payment system (PPS) and made many changes to the proposed rule, industry representatives and providers say they still have significant concerns about the final rule.

"Some of the concerns are tracking the transfers and short stays, and for us there may be some significant concerns for outlier patients, particularly burn and spinal cord injury patient care," says Bonnie Breit, MHSA, OTR, administrative director of rehabilitation services for Crozer-Keystone Health System in Upland, PA.

Here are some of the potential problems and changes seen in the final rule:

• **Comorbidity list:** Rehab facilities will need to educate staff about what is on the comorbidity list, what isn't, and how to document every relevant comorbidity.

"One thing that's more important than everyone had realized before is that coding comorbidities has to be absolutely critical to payment," says **Carolyn Zollar**, JD, vice president for government relations for the American Medical Rehabilitation Providers Association in Washington, DC.

"It will have a significant impact on cost, up to 27% to 28%," Zollar adds.

The final rule provides four weights for each group. Three of those weights relate to the severity of the comorbidities, which in turn relates to the cost of the comorbidities, Zollar explains. "Rehab providers will need to know the [ICD-9-CM] coding very, very well, and anyone involved in the clinical process probably needs to be familiar with the coding."

The list of comorbidities is very long and specific, and rehab providers will need to make certain that physicians are fully aware of which comorbidities have an impact on reimbursement and which do not, says **Laura Landmeier**, OTR, MSOT, MBA, assistant vice president of quality and outcomes management for Schwab Rehabilitation Hospital & Care Network in Chicago.

"That comorbidity list is going to be a bear to work with in an efficient manner, and it will take a smooth system to deal with it," Landmeier says.

Another problem is that the list still doesn't include all of the comorbidities that a rehab facility might encounter and that might affect the cost of care, says **Joe Golob**, PT, director of the inpatient rehab center at Bon Secours St. Francis Health System in Greenville, SC.

"The comorbidity list provides some more opportunities, but it still is not as inclusive as a lot of us would like to see," Golob says.

For example, deep vein thrombosis is not included on the comorbidity list, although rehab patients sometimes will have that comorbid diagnosis, which may result in more costly care.

However, it's not too late for the rehab industry to influence changes to the comorbidity list. CMS has indicated a willingness to make modifications according to inpatient rehab data collected over the first years of PPS.

"This is another reason why we really want to make sure the medical conditions that are present as comorbidities, even if they are not necessarily listed on comorbidity sheets, are reported to the government," Landmeier says. "So then they can track that information and see if these comorbidities are in fact adding to costs and need to be adjusted in the future."

• **Transfer policy:** Although CMS has improved the transfer policy by putting into the PPS regulations a provision to pay facilities 150% of the per diem on the first day of admission, it still will result in lower payments whenever a patient has less than the average length of stay (LOS) and then moves to another institutional setting, says **Barbara Marone**, senior associate director of policy for the American Hospital Association in Washington, DC.

"We had argued for the feds to eliminate that policy totally or to narrow it if they didn't eliminate it," Marone says.

The transfer policy — which results in a per diem payment when the patient has not met the average LOS and is moved to a skilled nursing facility, a long-term care hospital, acute care, or another rehab unit — is contrary to the concept of PPS, Marone adds.

Under the short-stay transfer policy, the rehab provider will be paid a per diem rate that is determined by dividing the payment for a particular case mix group (CMG) by the average LOS for that CMG. The first day receives 150% of that per diem rate.

"We feel that in any kind of prospective payment system, it is a system of averages, where you pay an average payment, and as providers you will lose money on higher-resource intensive cases with higher LOS," Marone explains. "But you can't balance out higher-cost cases with lower LOS cases when a transfer policy is imposed at all."

For example, suppose a diagnosis has an average LOS of 15 days. Rehab facilities will not receive full payment for any cases that do not go up to day 14, Marone says. "If they had a transfer policy apply to those days between three and eight, then you could say, 'We don't like it, but we understand.'"

But with the transfer policy, rehab providers will not be able to recoup losses incurred by outlier cases because they will be penalized for having lower-than-average LOS on other cases, Marone adds.

• **Low Income Patient Adjustment (LIPA):** Previously called the disproportionate share adjustment, this has been changed significantly. Rehab providers objected to the proposed rule's adjustment because it would have given an enormous increase in payment to those facilities that served a few low-income people. The new adjustment provides some incentive to treat low-income people, but has raised the base rate so the adjustment is less dramatic.

"They almost doubled the base rate, so you would have to look at both the effect of the LIPA decrease and the base rate increase to determine what the true financial impact of this will be," says **Tom Davis**, president of inpatient services for RehabCare Group in St. Louis.

"Our cursory review would appear to show it's pretty neutral over a large number of units," Davis says. "There are winners and losers within a group, but when looking at the whole universe of rehab hospitals, it's a pretty minor change." ■

Special Report: Inpatient Rehab PPS

Staff, MD education will be crucial to PPS success

There's no time like the present to begin

Now that the final rule has been published for the inpatient rehab prospective payment system (PPS), rehab providers will need to develop education and training programs that will show staff how to assess, document, and maintain or improve quality under PPS.

Everyone from hospital coding staff to therapists to physicians will need to know how PPS reimbursement works and how a facility can be certain to receive the proper reimbursement.

Hospital-based rehab facilities should consider identifying one coding expert to work with rehab charts rather than continuing to rely upon the general medical record staff to do the coding work for rehab PPS, suggests **Carolyn Zollar**, JD, vice president for government relations at the American Medical Rehabilitation Providers Association in Washington, DC.

"I'm hearing from clinicians and coding experts that it's sometimes like blind people describing an elephant because they all see something different," Zollar adds. "So you need one consistent person for the rehab perspective."

Here are some other staff education and training tips:

• **Teach staff impact of PPS on reimbursement and length of stay (LOS).**

Management at Crozer-Keystone Health System in Upland, PA, held meetings with staff about how inpatient rehab PPS would impact the facility's LOS. Staff training covers the appropriate documentation of patient function, verifying and validating consistency in what is reported about the patient's function during the first two or three days, determining appropriate codes, and taking data from the correct sources, says **Bonnie Breit**, MHSA, OTR, administrative director of rehabilitation services.

"There will be training and assurances that all of our existing systems can work with whatever CMS puts out," Breit says.

Staff training at Schwab Rehabilitation Hospital & Care Network in Chicago has been under way since the spring, says **Laura Landmeier**, OTR, MSOT, MBA, assistant vice president of quality and outcomes management.

"We've brought things in the staff's attention in a slower manner," Landmeier says. "We bring it up and then reinforce it, moving on to the next step as we're ready."

Landmeier sometimes provides some of the education at team meetings, giving staff a brief overview of PPS. During the less formal training sessions, staff can bring up questions and issues about how PPS would work in a particular situation, and Landmeier can then answer them either individually or in a group setting.

Training also includes inservices and educational memos, as well as quick e-mail notes in answer to an employee's question.

• **Orient staff to case mix groups.**

It's important to show staff how one omission or mistake in assessing a case mix group category could result in a greatly reduced reimbursement, notes **Joe Golob**, PT, director of the inpatient rehab center at Bon Secours St. Francis Health System in Greenville, SC.

"It is amazing how much difference one point score could make in some of those case mix groups," Golob says. "A score correctly identifying a lower-functioning spinal cord patient could make a difference of $12,000 in reimbursement."

Rehab facilities have always tried to be accurate with assessments, but the scoring has never had the financial impact it will have under PPS, Golob adds. "I think we're conveying that message ongoing to staff."

Schwab Rehab staff need to understand that when a patient is admitted, the staff should begin to think of the patient in terms of case mix group and functional level, Landmeier says.

"We need to bring them along a path that is appropriate, but rehab isn't a cookbook, so it's important that everyone is educated on the system, knows the rules and regulations, and keeps sight of the individual within the system," Landmeier adds.

• **Educate physicians about comorbidities and coding.**

"One of our biggest educational pieces will be educating and reminding physicians of the importance of listing all clinically relevant

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comorbidities that affect the treatment and the care of the patient," Breit says.

"We'll do a combination of education at staff meetings, inservices, and through written documentation, providing memos and copies of the rules," Breit adds.

Landmeier has spent several months attending medical staff meetings and providing education in small doses.

"Also, at team conferences we can do individual education concerning an individual case and team with the doctor present," Landmeier says.

Physicians are key players in documenting comorbidities and making certain the coding is done accurately, she adds.

"We've also been working with the medical records staff to make sure we get the coding done up front and to keep communication between clinical groups and medical records flowing efficiently and smoothly," Landmeier says.

• **Hold a dry run of how cases would look under PPS to assess staff training and coding process.**

It's important to educate staff about how and when the test run will be conducted, and a dry run should involve taking case samples from rehab units or focusing on a specific rehab team, Landmeier says.

Managers at Crozer-Keystone will begin a process of evaluating, looking at cases, redoing documentation, and checking accuracy, Breit explains.

"Obviously, we'll need to carefully assess the situation before we're impacted by actual payment," Breit says. "One of the advantages the industry has right now is that there are several companies out there offering tools to provide this assistance."

For some facilities, such as the rehab unit at Bon Secours St. Francis Health System, there will be an automatic "dry run" period because of their fiscal year cycle.

"The fortunate thing for us is that we have an eight-month window in which we'll have to start submitting data on patients on Jan. 1, but we won't actually be paid based on those instruments until September 2002," Golob says. "So hopefully we'll have the bugs worked out by then." ■

Not speaking the same language could cost you

Rehab facilities required to offer translation services

(Editor's note: The next two stories about translation services and diversity issues facing rehabilitation facilities are a follow-up to a special report in the September issue of Rehab Continuum Report*.)*

Title VI of the federal Civil Rights Act of 1964 requires health care organizations receiving federal funds to ensure that patients with limited English proficiency (LEP) have access to language assistance.

The law states that providers could provide oral language assistance using a variety of methods. **(See story on federal requirements for communications services, p. 123.)**

Studies have also examined patient satisfaction among non-English-speaking patients and have found that language difficulties are a problem.[1,2]

While it's important to have a culturally diverse staff, rehab facilities still should consider using interpretation contracting services so professional interpreters can be available at any time they are needed, says **Bonnie Breit**, OTR, MHSA, administrative director of rehabilitation services for four hospitals in the Crozer-Keystone Health System in Upland, PA.

"We've created a systemwide interpretation process so staff can access an interpreter any time in the day or night," Breit says. "We not only train staff about foreign languages and cultures, but we also provide interpretation for deaf patients, and we avoid stereotyping cultures, while showing how cultural differences may affect how a person perceives things."

Rehab facilities should look at interpretation services as yet another way to build a good reputation and to satisfy customers, suggests **Cindy Roat**, MPH, quality assurance specialist with Pacific Interpreters in Portland, OR.

"Non-English-speaking people are living here, working here, and now are a paying clientele to be served," Roat says. "So if you're a business, you'd be silly not to try to accommodate Spanish speakers or others because they're consumers."

Besides possibly being in violation of the law, using family members to interpret for an LEP patient could result in malpractice, says **Bill Martin**, executive director of Phoenix Language Services of Huntington Valley, PA.

Martin offers this example: "We had an incident where a woman was scheduled for a D&C [dilation and curettage], and the hospital had

used the patient's husband to interpret," he says. "It turned out that she wasn't experiencing vaginal bleeding; it was rectal bleeding."

Some studies have found that non-English-speaking patients are more likely to be compliant with medical instructions, more likely to seek preventive services, and more likely to have positive outcomes when they are provided interpreters.[3-7]

"There's a growing body of research about the importance of interpreter services," Roat says.

Roat has personally reviewed some informal, unpublished studies comparing a hospital that provided interpreter services to one that did not. "If you looked at the patients from the same language group with the same diagnosis, you would see that those who were provided interpreters had a hospital stay that was an average of one day shorter and a lower readmission rate than the patients at the hospital that did not provide interpreter services," she says.

"Overall, there are direct and indirect costs to not having an interpreter," Roat adds.

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What's required under Title VI of 1964 Civil Rights Act

Demographics no longer the same as 40 years ago

When the 1964 Civil Rights Act was signed into law, there probably were few places in the country where health care providers would be faced with more than the occasional patient with limited English proficiency (LEP).

Shifts in the nation's demographics over the past 40 years and more recent changes in immigration patterns have changed this landscape considerably. Now towns as small as Columbus, NC, which has a population of under 2,000, have found it necessary to place Spanish-language signs in front of businesses and in public buildings.

Likewise, rehabilitation facilities increasingly are seeing the need for interpretation and translation services, which no longer can simply be handled by the nurse who had four years of Spanish or the Asian aunt of a therapist.

Due to the nation's demographic changes, the federal government has spread the word to health care facilities that it's high time they get into compliance with Title VI of the Civil Rights Act, which requires health care organizations receiving federal funds to ensure that patients with limited English proficiency (LEP) have access to language assistance, because enforcement will become more stringent.

Here are some ways a rehab facility can meet the guidelines set by the Office for Civil Rights (OCR) in Washington, DC:

— hiring bilingual staff for patient and client contact positions;

— hiring staff interpreters;

— contracting for interpreter services;

— recruiting community volunteers;

— contracting with a telephone interpreter service.

The law also states that practices that may violate Title VI are as follows:

— providing services to LEP people that are more limited in scope or are lower in quality than those provided to other people;

— subjecting LEP people to unreasonable delays in the delivery of services;

— limiting participation in a program or activity on the basis of English proficiency;

— providing services to LEP people that are not as effective as services provided to those who are proficient in English;

— failing to inform LEP people of the right to receive free interpreter services and/or requiring LEP people to provide their own interpreter.

OCR also suggests that health care providers ensure effective communication by developing and implementing a comprehensive written language assistance program that includes these features:

— policies and procedures for identifying and assessing the language needs of LEP applicants / clients;

— a range of oral language assistance options;

— notice to LEP people of the right to language assistance;

— periodic training of staff;

— monitoring of the program;

— in certain circumstances, the translation of written materials.

The law specifies that the necessity to translate written documents may vary depending on these factors:

— the size of the population being served;

— the size of the agency or provider.

OCR will enforce the regulations through these procedures:

— complaint investigations;

— compliance reviews;

— efforts to secure voluntary compliance and technical assistance.

For more information about the Title VI standards, visit the OCR web site at www.hhs.gov / ocr / lep / or call a regional office of OCR. The regional offices are as follows:

• **Region I - Boston (CT, ME, MA, NH, RI, VT):** Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, Government Center, J.F. Kennedy Federal Building, Room 1875, Boston, MA 02203. Telephone: (617) 565-1340. Fax: (617) 565-3809. TDD: (617) 565-1343.

• **Region II - New York (NJ, NY, Puerto Rico, Virgin Islands):** Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, NY 10278. Telephone: (212) 264-3313. Fax: (212) 264-3039. TDD: (212) 264-2355.

• **Region III - Philadelphia (DE, DC, MD, PA, VA, WV):** Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 150 S. Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111. Telephone: (215) 861-4441. Fax: (215) 861-4431. TDD: (215) 861-4440.

• **Region IV - Atlanta (AL, FL, GA, KY, MS, NC, SC, TN):** Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth St. SW, Atlanta, GA 30303-8909. Telephone: (404) 562-7886. Fax: (404) 562-7881. TDD: (404) 331-2867.

• **Region V - Chicago (IL, IN, MI, MN, OH, WI):** Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. Telephone: (312) 886-2359. Fax: (312) 886-1807. TDD: (312) 353-5693.

• **Region VI - Dallas (AR, LA, NM, OK, TX):** Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 1301 Young St., Suite 1169, Dallas, TX 75202. Telephone: (214) 767-4056. Fax: (214) 767-0432. TDD: (214) 767-8940.

• **Region VII - Kansas City (IA, KS, MO, NE):** Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 601 East 12th St., Room 248, Kansas City, MO 64106. Telephone: (816) 426-7278. Fax: (816) 426-3686. TDD: (816) 426-7065.

• **Region VIII - Denver (CO, MT, ND, SD, UT, WY):** Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 1961 Stout St., Room 1185 FOB, Denver, CO 80294-3538. Telephone: (303) 844-2024. Fax: (303) 844-2025. TDD: (303) 844-3439.

• **Region IX - San Francisco (American Samoa, AZ, CA, Guam, HA, NV):** Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 50 United Nations Plaza, Room 322, San Francisco, CA 94102. Telephone: (415) 437-8310. Fax: (415) 437-8329. TDD: (415) 437-8311.

• **Region X - Seattle (AK, ID, OR, WA):** Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 2201 Sixth Ave., Suite 900, Seattle, WA 98121-1831. Telephone: (206) 615-2290. Fax: (206) 615-2297. TDD: (206) 615-2296. ■

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Take a little Yanni, and call me Bach

Music therapy is in wide use for chronic disease

The rehab room is anything but quiet. In one corner, a Parkinson's patient is engaged in a lively drum duet with a therapist. Across the room, a woman who has had a stroke waves her arms to the rhythm of a Bach concerto her therapist is playing on an electronic keyboard. In an adjoining room, a young man with asthma plays a gentle air on a recorder.

And in a hospital half a dozen states away, a child with sickle cell anemia smiles at the guitarist by her side during a painful procedure. In the intensive care unit, a cancer patient recovering from a painful surgery is lulled into a peaceful, healing slumber by the muted strains of "Amazing Grace," played by her therapist on the keyboard.

Music is a universal language to calm fears and to soothe pains. Increasingly, music therapy has found its way into the clinical setting as a way of addressing a host of illnesses and disease process — directly and through pain relief.

Music therapists — board-certified graduates of one of 70 approved college and university music therapy programs — are found in hospitals, nursing homes, outpatient treatment centers, and a host of other medical and nonmedical settings throughout the country.

When was the last time you wrote "Bach" or "Beatles" on a prescription pad? Probably never. But proponents of music therapy want to remind you that music is powerful medicine.

Neurological disorders

"Music is of essential importance in understanding the brain and behavior," says **Michael Thaut**, PhD, professor of music and neuroscience at Colorado State University in Fort Collins.

Thaut's work with stroke and Alzheimer's patients has produced maps of the cortical and subcortical areas of the brain that perceive rhythm and synchronize movement with rhythm. His findings have informed the design of rhythmic entrainment routines used to improve the gait of patients with stroke, Parkinson's disease, cerebral palsy, and traumatic brain injury.

"We discovered about 10 years ago that the strong synchronization effect of rhythm on gait movements has a profound effect on the ability to walk," says Thaut. "In fact, rhythmic training has produced sustainable improvements for people with all of these types of neurological disorders."

In simple terms, Thaut says, rhythm helps retrain the nervous system. "It may begin with something as simple as moving arms to the music during some simple exercise. Then it can progress to walking, sitting down, and standing up," he says.

Think of a brass band playing marching music or a rock band thundering the bass at a steady pace. "It's almost impossible not to stay in rhythm with the music," Thaut says. "What we're doing is taking a measured beat and using that same principal for neurological therapy."

Thaut has published several studies, including one studying patients with traumatic brain injury.[1] None of the brain injury patients had responded to traditional physical therapy, and all had passed the initial three-month phase for spontaneous neurological recovery, during which the most significant benefits usually occur. A key, says Thaut, is that each patient's walking speed and gait were analyzed at the beginning of the process, and specific metronome beats were inserted into music that was played while they walked every day for five weeks. Patients increased their walking speed by 50%, their cadence by 16%, and their stride length by 29% with the use of daily rhythmic auditory stimulation therapy.

In practice, he says, similar results are obtained for patients with other neurological disorders.

It's important to coordinate the structure of the music and the movement, so Thaut and most of his colleagues favor live music. Some patients will be slower and others faster, or their ability to keep to the rhythm may diminish as they become fatigued.

"We compose most of our own music, because we have found that very specific rhythms works with very specific parts of the brain to help a patient execute movement in a coordinated way," he adds.

Treating chronic pain

Pain is a factor in almost every chronic disease process, and music has a role in relieving that pain, says **Joanne Loewy**, DA, a music therapist at New York's Beth Israel Hospital.

Loewy has seen dramatic pain relief in adults and children with such painful conditions as

sickle cell anemia, cancer, asthma, spinal pain, and pelvic inflammatory disease.

"In some cases, music can be a distractor from the pain, but I think that music, especially live music, acts as an integrator," says Loewy.

She explains that live music helps a patient integrate the breath with the heart rate and the mind in the process of entraining. Music, coupled with an art exercise, also helps young patients tell health care professionals where the pain is and how intense it is.

"Let the music carry you on a journey away to a place where there is no pain," Loewy says to the young patient with sickle cell anemia. "See where the pain is. Then draw where the pain is using these colors," she continues.

"Often we get new clues about the pain from this exercise," says Loewy. "The pain may be directly due to a physiological condition, but they may be holding emotional pain as well — pain of trauma or sexual abuse — and this helps us identify it."

In its simplest form, music may help a patient relax his or her muscles, which often can contribute to pain relief.

Anxiety is always a component in chronic disease, but the benefits of music therapy may go beyond anxiety relief.

Benefits of Music Therapy

Music therapy provides opportunities to:

- Explore personal feelings and therapeutic issues such as self-esteem or personal insight
- Make positive changes in mood and emotional status
- Have a sense of control over life through successful experiences
- Enhance awareness of self and environment
- Express oneself verbally and nonverbally
- Develop coping and relaxing skills
- Support healthy feelings and thoughts
- Improve reality testing and problem-solving skills
- Interact socially with others
- Develop independence and decision-making skills
- Improve concentration and attention span
- Adopt positive forms of behavior
- Resolve conflicts leading to strong family and peer relationships

Source: American Music Therapy Association, Silver Spring, MD.

'Each of us is a musical being'

Loewy, who devotes a large portion of her work to children, says observing the child is an important way of understanding what the child is feeling and thinking. "Observation is central to the act of understanding and feeling another being's music of the body. By music, I am referring to a person's rhythm of breath, patterns of speech, pitch of sentences expressed, as well as the dance of his or her every movement. Each of us is a musical being, even without musical instruments," says Loewy. "If we listen carefully, we can feel the music of a person's being."

For example, Loewy says, music can help a patient's ability to void: "Drumming in particular has enhanced the flow and release of energy, beginning from the outside of the body and affecting movement and eventual release from inside the body. As patients actively structure and control their own body's ability to create rhythms for sustained periods, the body responds and rids itself of waste."

Specific instruments have specific effects on pain. In addition, each person experiences pain differently, so different instruments would be appropriate for different people at different times, says Loewy.

"For a person who wants to be nurtured, violin music is soothing and releasing. For a person who is angry about the pain, drumming might work better," she explains.

Hymns can comfort the dying

"Music is also a wonderful way to help people transition from life to death," says Loewy.

Depending on the age of the patient, a favorite prayer or hymn might be used to calm anxieties and give him or her comfort, creating an atmosphere of safety.

"I can watch the breath and the heart rate and the mood and adjust the music as it is needed," she says.

"We know the last sense to go at death is the sense of hearing, so we can relieve the pain and anxiety with a song of comfort," she adds.

Several studies show music therapy is a tool that can address anxiety and discomfort associated with a variety of chronic diseases and hospitalization due to those illnesses.

One Japanese study showed significant changes in natural killer (NK) cell activity in

patients with Alzheimer's disease, Parkinson's disease, and cerebrovessel disease after a single music therapy session.[2]

The researchers wrote: "The results indicate that music therapy can significantly increase NK cell count and activity. The change in NK cell and function were independent of neurodegenerative diseases."

Patients with heart disease and hypertension have benefited from music therapy as well.

Music therapy reduces blood pressure

An Israeli study shows that hypertensive patients given a home treatment that integrates slow, regular breathing with rhythmic music for two months reduced systolic blood pressure by 15.2 mm Hg,diastolic pressure by 10.07 mm Hg, and mean arterial pressure (MAP) by 11.7 mm Hg. A control group that listened to quiet music with no particular beat inserted had smaller reductions: systolic 11.3, diastolic 5.6, and MAP 7.5.[3]

A study at Massachusetts General Hospital showed that cardiac patients on bed rest because of invasive cardiac procedures responded to a single 30-minute music therapy session with reduced blood pressure, respiratory rate, and psychological distress.[4]

"Some people may think we just play music and people relax and that's the end of it," says Thaut. "Our research is not anecdotal. It's conducted in a scientific manner, and the results are verifiable."

[Editor's note: The American Music Therapy Association in Silver Spring, MD, can help you find a certified music therapist in your area. Their web site is www.musictherapy.org, or they can be reached by phone at (301) 589-3300.]

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Structured interviews improve hiring decisions

Key criteria: Clinical experience, global viewpoint

One of the most significant challenges facing case management departments is how to hire a team of effective case managers to meet ever-changing demands. **Vicki Alexander**, RN, CCM, a team leader in the case management department at Community Hospitals in Indianapolis, says two key criteria that she looks for are recent clinical experience and a global viewpoint of the managed care industry. "We have not had good luck hiring people who have been in only one venue their entire career," she reports.

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Alexander, who is responsible for case management operations in the hospital's inpatient services, says it is important to find case managers who can communicate effectively with a variety of audiences. For example, some case managers are reluctant to challenge physicians. Some applicants even indicate that if a physician writes an order, they won't challenge it. "That doesn't work very well in our business," she contends.

On the other hand, some case managers may be able to communicate effectively with physicians as well as the multidisciplinary team but do a poor job at the patient's bedside or with families facing a crisis situation. Alexander also seeks case managers who have appropriate delegation skills. "The workload ebbs and flows," she points out. "You have to be someone who is able to delegate to individuals."

In order to identify the right type of case manager, Community Hospitals has developed a structured interview process. "No matter who performs the first-round interview, they use the same format," says Alexander. The hospital uses a scoring system to help assess résumés of qualified applicants; if two dozen applicants are interviewed, it is very difficult to recall the specifics of each applicant, she notes.

Community then uses a ranking system of 1 to 4. A 4 indicates there is something obviously wrong with that candidate, while a 3 indicates at least a serious flaw. A 2 is used for someone who reveals positive attributes and can be trained, while a 1 is the ideal candidate.

The hospital then uses a team evaluation process after the first round of interviews to develop initial impressions and pinpoint areas to explore on the second round of interviews. Alexander says she tries to perform the first round of interviews herself, along with managers from various hospitals.

The hospital often uses team interviews as well. For example, if a general case management RN is being interviewed, several managers may sit in on the initial interview. If it is a specialty position for an area such as cardiac or rehabilitation, the hospital frequently will add someone on staff from that area. Social workers typically are interviewed by several other social workers.

According to Alexander, it is also important to present an honest portrayal of the position. "Sometimes, you feel like you are selling the job to the employee," she explains. To avoid that problem, Community sometimes uses what it calls "employee shadowing," where selected applicants are asked to spend a full day with the case manager to see first-hand what that case manager does.

"We have found shadowing to be very beneficial for the applicant," she says. "But we only do this when we are down to the final applicants and can't make a decision."

The hospital uses standard interview questions as well as customized questions for each position. It also differentiates the questions it uses based on the facility because some facilities have a more rural flavor and very different culture from the larger urban tertiary facilities that are more specialized and have a different type of patient and physician.

Community also asks applicants about their ideal working environment and asks them how they would handle several hypothetical scenarios. "We find it very important to give them a scenario and have them kind of work the case," she explains. "Not only does it give us an idea of the employee, but it also helps us to understand the baseline that they are coming in at." ■