

# Rehab Continuum Report

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*The essential monthly management advisor for rehabilitation professionals*

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## Could the future of rehab include walking paraplegics, quadriplegics?

*Researchers in Arkansas may have answer*

Clinicians and researchers recently showed how a quadriplegic, wheelchair-dependent man could walk 400 to 1,000 feet with only a walker for assistance.

Their recently published study sets the stage for a new area of rehabilitation that may one day enable many spinal cord injury (SCI) patients to achieve more independence and mobility in their daily lives.

The treatment that enabled one SCI patient to walk will not necessarily eliminate wheelchair dependence, but it will allow patients to do more for themselves in their homes and possibly enable them to visit restaurants or other places without their wheelchairs, says **Richard Herman**, MD, a research professor of bioengineering and a research professor of exercise science at Arizona State University in Phoenix. Herman also is the director of the Clinical Neurobiology and Bioengineering Research Laboratory at Good Samaritan Rehabilitation Institute in Phoenix.

Herman is a lead author of a study on an ASIA C spinal-cord-injured patient's progress under a treatment plan that included partial weight-bearing therapy (PWBT) followed by epidural spinal cord stimulation.<sup>1</sup>

The rehab process has the potential to work for some patients who have incomplete SCIs and who are highly motivated, because it requires a great deal of physical effort and discipline, Herman says.

Of an estimated quarter-million SCI patients in this country, about half have an incomplete spinal cord injury. Of these patients, the ones who are classified as ASIA Cs or ASIA Bs, who have some movement and sensation in the lower extremities, are the most likely candidates for the program, Herman says.

This might amount to 10,000 to 12,000 SCI people, Herman says, adding that there also is a potential for the program to help patients with multiple sclerosis, cerebral palsy, and strokes.

"We're gearing ourselves on the next experimental round to include a wider variety of patients, including spinal cord B patients and multiple

sclerosis patients, and we may enter into this with cerebral palsy, but we haven't made up our minds yet," Herman says.

It has taken four decades of SCI research to reach this breakthrough point, says **Edgar Garcia-Rill**, PhD, professor of anatomy and neural biology, professor of psychiatry, and director of research for the Arkansas Center for Neuroscience in the department of anatomy and neurobiology at the University of Arkansas for Medical Sciences in Little Rock.

Under a National Institutes of Health grant, Garcia-Rill helped to develop the device that stimulates the spinal cord to induce locomotion.

"Back in the 1960s, studies found that in the spinal cord there is a pre-programmed sequence of contractions needed for walking," Garcia-Rill says. "They're spinal pattern generators, and they generate automatically the flexion-extension sequences for each limb."

By the mid-1980s, researchers began to theorize that when a person's spinal cord is injured, it regresses to a neonatal pattern, very much like a baby or a Parkinson's disease patient who walks on his or her toes, Garcia-Rill says.

"What we thought might happen is that in an adult spinal cord injury patient, you have a spinal cord that turns into a neonatal spinal cord," Garcia-Rill explains. "And we used a fairly complicated preparation to find out that the neonatal spinal cord requires that you stimulate it using very low-frequency, long-duration pulses."

This led to the idea of stimulating the spinal cord on the surface or back of the spinal cord at a low frequency.

The device was patented by the University of Arkansas for Medical Sciences in the early 1990s. Garcia-Rill and colleagues were ready to test it on a spinal cord injury patient in the mid-1990s, which is when they met Herman, who spent the next few years helping to bring the process to a clinical application.

"What Herman did was choose his subject very wisely," Garcia-Rill notes. "This is an individual

who is highly motivated because this program is a lot of hard work and requires a lot of dedication."

Although the patient selected for the study is classified as a quadriplegic, he is capable of standing with a walker. However, the man, who is in his 40s, was unable to walk before the program, Garcia-Rill says.

Herman is working on developing a protocol for the program so it can be duplicated by others, including neurosurgeons and rehab clinicians. He offers this basic look at how the process works:

- A patient is selected based on the type and extent of injury, motivation, and other factors. Two important criteria are that the patient is capable of pushing his/her body weight up from the wheelchair, which is an indication of the patient's upper-body strength, and the patient must be stable in the trunk so that there is a modicum of balance when the patient is upright.
- An oversight committee approves the selected patient, and the patient is told that the project may involve one to two years of commitment.

#### *Patient builds strength before surgery*

• Prior to surgery, a physical therapist works with the patient, guiding the patient during exercises involving partial-weight-bearing therapy (PWBT) and progressive training with increasing treadmill rates.

The patient is placed in a parachute-style harness that supports the patient's weight, Garcia-Rill says. "As the patient gains strength and supports his own weight, he takes over the weight-bearing, and this is a way of building up strength," he adds.

• Once the preparation is complete, a surgeon inserts a pair of Pisces-Quadplus electrodes into the dorsal epidural space over the upper lumbar enlargement of the spinal cord, placing each electrode one to two millimeters off the mid-line.

The devices have a battery with a receiver placed under the skin, and the controller has a transmitter in which frequency and duration can be set.

#### *COMING IN FUTURE MONTHS*

■ Training brain injury staff can be one of the biggest challenges

■ Hospital's TRAIL program gives patients an outside view from the inside

■ Here's how CMS answers the request to change the 75 percent rule

■ Is direct access in the cards for Medicare patients?

■ Obese patients require new strategies for lifting, handling

"The remote device is small like a cell phone, and the whole thing can be carried in a little pouch that a person wears and puts in the pocket," Herman says.

- Once surgical healing is complete, the patient is retrained to pre-surgery PWBT levels. The patient's gait performance is assessed by measuring average speed, stepping symmetry, sense of effort according to the Borg Scale, and physical work capacity.

- With the combination of PWBT and epidural spinal cord stimulation (ESCS) through the implanted device, the patient has smoother stepping patterns at higher treadmill rates, as well as improved endurance and speed during over-ground walking.

ESCS provides very low-level electrical stimulation that the patient experiences as a vibration. There is no pain, Garcia-Rill says.

"What is so impressive about this treatment is that they can not only walk, but have been trained to walk with PWBT and can walk with a low sense of effort," Herman says. "It's near effortless for a period of time."

The patient's self-reported perception that the walking is easily done is supported by data that shows the patient is metabolizing fat while exercising in the program, Herman explains.

"As you metabolize carbohydrates, your sense of effort goes up, and as the sense of effort goes up, it switches off and burns carbs," Herman says.

Investigators also observed what happened when the ESCS was turned off. They found that the patient had learned walking patterns that are active without stimulation, Herman notes.

"He can walk pretty good distances, but not as far as with the current," Herman says. "It takes him a little more effort, but it's pretty functional."

For instance, the first patient has learned to walk within his apartment without the electrical current. It helps that his carpet is more resistant than it would be if he walked on a hard surface, Herman says.

The idea is that one day, patients with SCIs and other injuries could use this sort of device on their own, so when they need greater mobility they can have it, Herman says.

"What it does is help them do more things for themselves independently," Herman says. "He can walk around the house and have access to parts of the house that he didn't have before, like getting into the bathroom by walking in there."

Herman's investigations of the procedure continue with a second patient, who is a wheelchair

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marathon athlete and has more severe weakness due to his spinal cord injury.

"He has a neck injury, and this was a low thoracic T-8 injury," Herman says. "He doesn't walk as beautifully as the first man does, but he does walk with a low sense of effort."

This patient's goal is to walk part of the wheelchair marathon. "So I think we'll allow him to do that somehow," Herman says.

## Reference

1. Herman R, He J, D'Luzansky S, et al. Spinal cord stimulation facilitates functional walking in a chronic, incomplete spinal cord injured. *Spinal Cord* 2002; 40:65-68. ■

## Joint camp improves quality, patient satisfaction

*Everyone follows best practices protocol*

Several years ago, rehab and hospital administrators at Genesys Regional Medical Center in Grand Blanc, MI, decided to revamp their hip and knee replacement programs from start to finish.

"We got physicians together and looked at best practices across the country for everything they did, the operating room [OR], post-op, you name it," says **Sonia Nesbitt**, RN, MS, an orthopedic clinical nurse specialist and orthopedic program manager for the Hip and Knee Replacement Program at Genesys Regional.

The hospital, including rehab staff and physicians, implemented a new program that patients call the joint camp, and the outcomes have been very positive, Nesbitt says.

Since 1994, hospital clinicians have done assessments of each joint patient to see how they've improved after surgery and rehabilitation. They've found some significant improvements in a variety of measurements, including these:

- Prior to the new program, 52% of patients could ambulate 100 feet after hip surgery; since the new program, 99% of patients can do so.
- Before the new program, 57% of knee patients could walk 100 feet; after the program, 94% of knee patients could do so.
- Previously, 84% of joint patients could achieve a 65-degree flexion; after the program, 100% of patients could achieve this.
- Likewise, before the program, only 22% of patients could achieve a 90-degree flexion; afterward, 88% of patients reached that level of flexion.

Another benefit is that the hospital has reduced its length of stay by an entire day for both hip and knee patients, Nesbitt says.

"Patient satisfaction has been amazing," Nesbitt adds. "We haven't done a lot of marketing about the program, but we have patients telling other patients, and that's the greatest marketing tool."

As a result, the hospital's total number of hip and knee replacement surgeries has increased within the past three years from 400 to 700 annually, Nesbitt says.

Here's how the hospital started the program:

## **1. Research best practices.**

A group, consisting of Nesbitt, three orthopedic surgeons who each represented a different orthopedic practice, a nurse administrator, a surgical technician, an operating room nurse manager, and a floor nurse manager, traveled to two hospitals to observe their hip and knee programs.

They visited Anne Arundel Medical Center of Annapolis, MD, and Grant Medical Center of Columbus, OH. Grant Hospital had an efficient OR process, and Anne Arundel Medical Center had a special joint program in place, Nesbitt says.

After seeing the other hospitals' programs, the team continued to research joint replacement best practices before coming up with a suggestion for the new program.

## **2. Write a business proposal for hospital top brass.**

Nesbitt and others wrote and then presented the business proposal for Genesys Regional to

change its joint program to a more efficient and systematic process.

To simplify the process, they decided it would work best if the hospital purchased a prepackaged replacement program called Joint Ventures, marketed by TeleVisual Communications of Clearwater, FL, Nesbitt says.

"They give you a basic framework, and you work with your physicians and say this is how you'll standardize your protocol," Nesbitt says. "It's a template, a how-to manual, and it cuts down on start-up time."

After hearing the business proposal, hospital administrators and the board agreed to the purchase, Nesbitt says.

## **3. Physicians and other staff adjusted the program to fit hospital's needs.**

"We had physicians and each member of the task force take different components of the OR piece, the post-op piece, exercise, and pain protocol and work with these to come up with a best practices idea," Nesbitt says.

## *Physicians eager to implement program*

Because physicians from each orthopedic group were represented, there was better communication and input about what various surgeons did and didn't want to see changed.

"We meet monthly with all orthopedic surgeons and give them an update on where we are," Nesbitt says. "We also have a physician coordinator for the program."

Physicians very quickly became excited about the changes and were eager to see the efficiencies put in place, she says.

## **4. Implement new protocol for joint patients.**

After several months of writing and improving the program, the hospital was ready to begin. The protocol basically works this way:

- It begins in the physician's office when a patient has decided to have surgery. The patient is given a knee or hip replacement booklet that discusses the process from its beginning to what happens two months after surgery, Nesbitt says.

"The doctor reinforces the message that the patient has to go to a pre-op class and tells the patient more about the joint program," Nesbitt explains. Then the patient is told to take pre-op vitamins.

- The physician sends the patient's information to the hospital, where a secretary sends the patient a letter inviting the patient to a pre-op class, which is held once a week. Nesbitt, an

occupational therapist, and a physical therapist lead the classes, teaching patients about what they have to do prior to surgery and what to expect.

"I call it expectation setting: Here's what they have to do to be successful," Nesbitt says.

Patients are encouraged to bring a family member/coach to the pre-op classes and to any hospital therapy sessions.

"It's very important for a family member to be here while we go through all the typical things, including pain management, IVs, catheters, and how long they'll be in the hospital," Nesbitt says.

• On the day of surgery, the patient is encouraged to relax, but physical therapy begins aggressively on the very next day, Nesbitt says.

"We have all the patients bring in their own clothing, and most dress in shorts or T-shirts," Nesbitt says. "They do group therapy twice a day, and then they walk a lot and are encouraged to go to the bathroom on their own."

Therapists also encourage patients to walk to the group room for a lunch buffet.

• Therapy continues on the remaining days the patient is in the hospital. Patients are encouraged to visit the rehab center and practice getting in and out of a car, walking down steps, and getting in and out of a shower.

On their last day, patients are given group therapy in the morning, and they have a graduation ceremony at which they are given certificates and pins.

"And we have a putting tournament on a roll-up putting green," Nesbitt says. "If they get a hole-in-one they win, and the nurses give them little model cars of Ferraris and Corvettes."

The ending event is meant to be fun and the patients' families are encouraged to be involved, Nesbitt says.

• Most patients are sent home after four days, and they're expected to continue their exercises for the next few weeks before they are scheduled to return to their physician's office.

"Our hip replacement patients will continue with the exercise protocol using notebooks from the pre-op visit," Nesbitt says.

They are supposed to exercise three times a day, doing typical hip replacement exercises, she says.

While in the hospital, the patient may have started at 10 repetitions of quad sets, straight leg raises, and short arc quad sets, but by the time they return home, they may do 40 repetitions, Nesbitt says.

## Need More Information?

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"We had exercises weekly, and have about 20 different exercises," she says.

"Knee replacement patients do the same thing, but they also go to outpatient therapy three times a week for three to six weeks, because they need to improve flexion and extension," Nesbitt says. "These patients need the expertise of a physical therapist involved in those cases."

Only about 2% of these joint patients are referred to home care services.

Most of the patients are encouraged to return to their normal daily routines and to walk in a mall or wherever they're comfortable.

To treat patients' pain, physicians may ask them to try oral narcotics with Tylenol and cold therapies on the knee or hip, Nesbitt says. ■

## AMRPA, others ask CMS to change 75 percent rule

*They cite potential problems under PPS*

Among the many onerous rules and regulations governing rehab facilities has been the 75 percent rule, which is one of the exclusion criteria used to determine whether a rehab facility qualifies for exclusion from the inpatient acute prospective payment system (PPS).

The nearly 20-year-old rule specifies that free-standing rehabilitation hospitals or rehabilitation units of hospital systems qualify for exclusion from PPS if 75% of their patients have diagnoses that fall within the following 10 categories, which have remained the same since 1984:

- stroke;
- spinal cord injury;
- congenital deformity;
- major multiple trauma;
- fracture of femur;
- amputations;

- brain injury;
- polyarthritis (including rheumatoid arthritis);
- neurological disorders (including multiple sclerosis, motor neuron disease, polyneuropathy, muscular dystrophy, and Parkinson's disease);
- burns.

Now the American Medical Rehabilitation Providers Association (AMRPA) of Washington, DC, the American Hospital Association (AHA) of Chicago, and several other organizations, including the American Academy of Neurology of St. Paul, MN, the American Academy of Physical Medicine and Rehabilitation of Chicago, and the Federation of American Hospitals of Washington, DC, have asked the Centers for Medicare and Medicaid Services (CMS) to change the rule.

"Currently, inpatient rehabilitation facilities provide intensive rehabilitation services to patients with other conditions, including cardiac conditions, pulmonary conditions, and pain," wrote the organizations in a letter addressed to Thomas Scully, CMS administrator, on April 17, 2002.

The letter states that conditions typical of rehabilitation facilities have significantly changed since the mid-1980s, so the time to revise exclusion criteria is at hand.

Because the new inpatient rehabilitation facility PPS, implemented in 2002, replaces the Tax Equity and Fiscal Responsibility Act system, there are now more data available about how patients are classified. For instance, the new assessment tool provides data for classifying each Medicare Part A fee-for-service patient into a rehabilitation impairment category (RIC) and then into a case-mix group, according to the letter.

"In the interest of administrative efficiency and greater clarity to the regulated parties, the undersigned organizations respectfully request that CMS adopt an 'administrative presumption' whereby if 75 percent of a rehabilitation hospital or unit's Medicare patients were in 20 of the 21 RICs, then it would be presumed to be in compliance with the 75 percent rule," the letter states.

"The one RIC not included in the administrative presumption would be RIC 20 (Miscellaneous)," the letter continues.

AMRPA and the other organizations also requested that CMS place a moratorium on qualifying 75 percent audits, including those being conducted in New Jersey and Tennessee.

"If these audits remain in place, facilities risk losing their status as rehabilitation hospitals and units and patients will have less access to the

high quality rehabilitation services they need," the letter concludes.

The 75 percent rule has been a concern of AMRPA's since IRF-PPS was implemented Jan. 1. In a letter to CMS dated March 5, 2002, AMRPA provided public input on regulatory reform to Christy Schmidt, executive coordinator of the Regulatory Reform Initiative of the Office of the Assistance Secretary for Planning and Evaluation of the Department of Health and Human Services in Washington, DC.

That letter's second key point was that CMS had not bothered to change the 75 percent rule since changing the way rehab facilities are paid.

"This impairs access to rehabilitation services for Medicare beneficiaries requiring services that are excluded from the list of 10 conditions, but are still necessary medical rehabilitation services," writes **Robert P. Main**, chairman of the board of AMRPA and president and chief executive officer of Siskin Hospital for Physical Rehabilitation in Chattanooga, TN. ■

## Workers ready to leave over stress, high workload

*Loyalty disappears on work survey*

**H**ealth care workers gave their employers a wake-up call in a recent survey of employee attitudes, as they revealed that work stress has diminished their commitment to their employers and their careers.

About one in five respondents said they don't intend to stay at their current jobs for the next several years. One-third said they would leave for a slight increase in pay.

As an industry, health care scored lower than the national average for all employers in every major category of the Healthcare@Work survey, conducted by The Loyalty Institute of Aon Consulting in Miami and sponsored by the American Society for Healthcare Human Resources Administration in Chicago, a membership organization of the American Hospital Association (AHA).<sup>1</sup>

The work force shortage is both a cause and an effect of the discontent shown on the survey, notes **Erin H. Wilkins**, senior consultant and director of the Healthcare@Work study. The

health care work force has endured downsizing and restructuring, as well as the impact of declining enrollment in nursing programs. The average age of nurses is rising nationwide as fewer young recruits enter the field.

"Doing more with less obviously places a greater amount of stress on employees in health care than in other industries," she says.

"The impact to the organization of the extreme stress is a less-committed work force, a less-productive work force," Wilkins says. "If people are so stressed out on a daily basis, they are going to be tired at work, sick, or they're going to leave."

Aon surveyed 3,433 health care employees in 2001 to determine their views on workplace practices and their commitment to their organizations. Concerns were greatest in the area of stress and workload. Some 56% of respondents said their employer didn't meet their expectations for creating a stress-free environment or providing an adequate staff load.

Those results add to the growing evidence of problems in the health care work force. More than one in seven hospitals reported a severe shortage of nurses — RN vacancies of more than 20% — in a study conducted by First Consulting Group of Long Beach, CA, for the AHA and other health care organizations.<sup>2</sup>

"I think it's very important for organizations to take a step back and look at themselves," Wilkins says. "Other than money, what can we do to attract and motivate and retain the work force we need to be successful?"

From its data, Aon creates the Performance Pyramid, with safety and security at the bottom and work-life harmony at the top. The bottom-level needs must be met before highest-level needs can be fully addressed, Wilkins says. Work/life harmony actually scored well, largely because health care workers reported a sense of teamwork. Some 83% of respondents said the willingness of their co-workers to help each other in times of high workload met or exceeded their expectations.

However, 43% of health care workers said their employers failed to meet their expectations for safety and security. Those concerns focus more on psychological issues than physical safety, Wilkins says. For example, 35% of RNs and technical employees said they believed their organization was not doing enough to create an environment "free from fear, intimidation, or harassment."

That includes feelings employees may have about how they are treated by patients, as well

as by management, physicians, and co-workers, Wilkins notes.

What can managers do to help workers feel less stress and improve their work environment?

They can be on the lookout for physical symptoms of stress and can discuss health and productivity issues with human resources managers, says **Deborah V. DiBenedetto**, MBA, RN, COHN-S/CM, ABDA, an occupational health consultant based in Yonkers, NY, and president of the American Association of Occupational Health Nurses (AAOHN) in Atlanta. "People will show up for blood pressure checks, headaches, minor complaints, without ever addressing the real issues. It's a missed opportunity," she says.

Employee Assistance Programs can offer support for stressed-out employees, adds **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, employee health nurse practitioner with Western Pennsylvania Hospital in Pittsburgh. "Employee health can be an advocate for the employee. We can direct them to get some help, whether their stress is work-based or home-based."

### *Stress may contribute to injuries*

Managers also should look for signs that work stress is contributing to injuries, notes Gruden. "Where are their injuries occurring? Are they occurring on a shift where employees have worked 12 hours or have been required to work overtime? Certainly, you want to look at the root cause [of injuries], but you also have to look at other factors." Understanding the link between stress, workload, and injuries may help convince administration to address staffing issues, she notes.

Workplaces that respond to these common concerns may benefit in recruitment and retention, Wilkins says.

"I'm not surprised either that there's decreased commitment to the employer [among a significant number of health care workers]," Gruden says. "People are looking for someplace where it's better."

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# Try magnetic approach to treating, preventing pain

*Don't let treatment mask underlying condition*

**W**hile most physicians may not be telling patients with minor aches, pains, strains, and sprains to tape a static magnet to the region of pain and call in the morning, many of their patients are doing just that, especially athletic people experiencing sports-related injuries.

For these types of injuries, it is no different from taking a couple of Advil or putting ice on the injury, says **Milt Hammerly**, MD, director of integrated medicine at Catholic Health Initiative in Denver. "It is very benign, noninvasive, safe therapy," he says. Magnetic therapy also is good for treating chronic pain.

It is important that people know what they are treating when using magnets, because the treatment can mask the symptoms of an underlying condition, such as metastatic prostate cancer of the spine. "Anyone with chronic symptoms needs to have an adequate work-up and diagnosis to know what he or she is treating," he says.

It is thought that magnets help with minor aches and strains by enhancing blood flow because the ionic or charged particles of the blood respond to the magnetic field. The reduction of inflammation is a slightly different process, says Hammerly. It appears that part of the inflammatory process consists of white blood cells being attracted to a charge imbalance in the area of the injury. "By overriding that charge imbalance with the presence of the external magnetic field, it actually decreases the migration of the white cells to the area of injury and thereby decreases the whole inflammatory response," he explains.

With chronic pain, the nervous system seems to be working abnormally, and anything can trigger the nerves — even weather changes. Small nerve fibers are continuously firing and depolarizing in a vicious cycle. "With that kind of pain, an external magnetic field has been shown to block the depolarization and the pain impulse," Hammerly explains.

In practice, he finds that some people have great results from magnet therapy and others have no response at all. "I wish we were sophisticated enough to be able to predict in advance who would respond and who wouldn't, but we aren't there yet," says Hammerly. Magnet therapy does

## Need More Information?

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work often enough to make it worth a try for patients with chronic pain and sprains, strains, and aches, he says. Hammerly recommends that people order magnets from a company that offers a 60- to 90-day money-back guarantee in case the therapy does not work for them.

Magnets often are designed into products such as belts, wraps, or mattress pads but can be purchased separately and taped onto the area of discomfort. Magnets to be used as part of therapy are designed with strength measured in gauss. A typical strength for magnets is from 400-4,000 gauss. Weaker magnets are not very effective, and stronger magnets can cause problems, says Hammerly.

People who have pacemakers or any electrically driven medical device should not use magnetic therapy. Pregnant women should not use it on the abdomen, because some research suggests that it could cause developmental changes, says Hammerly. Also, it should not be used as a cancer treatment because the cancer is just as likely to be stimulated as it is to be inhibited, he says.

While there are some practitioners who specialize in magnetic therapy, Hammerly doesn't recommend them. "They don't seem to be giving any better advice to their patients than what they can get on their own. Some of the advice is misguided and inappropriate," says Hammerly. ■

## Transitional work keeps employees on the job

*Temp jobs may be good fit for injured workers*

**T**he longer employees are out of work due to injury, the less likely they are to return. That is a maxim that has led hospitals to embrace transitional work programs, which enable employees to continue working with physical restrictions.

Transitional work means more than sending a worker to a desk job or telling her to limit her

tasks. It's a formalized program that involves senior management support, supervisor involvement, and employee education, says **Livia Pontani Bailey**, RN, MA, COHN-S, risk control supervisor for PMA Insurance, a workers' compensation insurer in Blue Bell, PA.

"The whole purpose of this [program] is to transition employees back to their full capacity," says Bailey.

At El Camino Hospital in Mountainview, CA, the transitional work program has contributed to a steady decline in lost work days, from 36 in the first quarter of 1999 to 17 in the last quarter of 2001, says **John Deex**, RN, MS, OHNP, COHN, the hospital's director of employee health and safety.

"We have opportunities for people to do transitional work as opposed to losing days," says Deex, who notes that the labor shortage in health care makes such programs even more valuable. But it also has a direct benefit to the employees, he says. "By keeping people productive within their professional environment, they get better."

How you structure a transitional work program may be critical to its success, say Bailey and Deex. Here are some major components:

- **Gain buy-in from senior management.**

As with many other health and safety initiatives, the full support of senior management can make the difference between success and failure. After all, the supervisors need to identify appropriate placements for injured workers, and the employees need to have a positive feeling about the program.

"You've got to have the commitment from senior management that all the departments are going to cooperate with you to come up with a bank of positions that you can place people in," Bailey says. "This gives you the control you need [to develop transitional work]."

- **Create a formal, written policy.**

Managers may informally arrange for workers to perform lighter tasks when they return after work-related injuries. But a transitional work program involves definitions, protocols, and limitations.

Transitional work programs typically set a time limit of 90 days in which the employee can remain in the transitional job. "The philosophy is progress [toward recovery] within the scope of work," says Deex. "If you're not making progress within 90 days, then [perhaps] something we're doing is putting a barrier in front of you getting better."

By placing a cap on the duration of transitional work, employers avoid creating new, permanent jobs. "Under the Americans with Disabilities Act, you have to be very careful about modifying work," says Deex. "If you let it go on for a period of time, you have established a sense of permanence. That could be perceived as creating an [permanent work] accommodation."

The policy would state who is eligible for transitional work. For example, some hospitals might include non-occupational injuries as part of an integrated disability management program, notes Bailey. The policy defines transitional work as temporarily modifying the current position to meet the restrictions, placing the employee in a transitional duty position in the same department or another department, temporarily altering the number of hours an employee may work, or placing the employee in another division or business unit.

#### *Laws may limit pay for transitional duty*

The policy also outlines what steps employees and managers should take after a work-related injury and specifies each party's accountability and responsibility. Employees generally are paid their regular rate of pay while on transitional duty. In some states, workers' compensation laws may dictate how much they can earn per week. For example, in California, the maximum workers' compensation benefit is \$490 per week, says Deex. "If you made \$20 an hour, you would work 24.5 hours a week to get to that \$490," he says.

- **Find jobs that fit the restrictions.**

Who will decide what transitional work an injured employee should perform? That is the duty of a team made up of the employee, supervisor, and transitional work program coordinator.

The physician who examines an injured employee should have a copy of the employee's job description so they have an idea of what types of restrictions might be necessary. "Sometimes their work restrictions may meet the job description and there's no need to put them in transitional duty," notes Bailey.

You want the treating physician or clinician to be as specific as possible, says Bailey. A physical capabilities form can enable the physician to identify what tasks must be curtailed, such as repetitive motion, and what can still be performed. (**See "Return to Work Physical Capabilities" form, p. 70.**)

(Continued on page 72)

NOTE TO WILCOR: WITHIN THIS FRAME, SHOOT NEGATIVE FROM HEH JUNE 2002, "RETURN TO WORK PHYSICAL CAPABILITIES," TO FIT. NOTE SOURCE LINE AT BOTTOM.

Source: PMA Insurance, Blue Bell, PA.

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When you set up a transitional work program, you may want to designate a "bank" of possible jobs. These will not be charged to a department's budget, but will be part of a separate transitional work program budget, notes Bailey. Otherwise, managers may have a disincentive to create transitional work positions.

"When a physician assigns restrictions, then there is dialogue between the manager, employee, and nurse practitioner who handles the case, to try to determine if there are accommodations that can be made within the usual and customary work," says Deex. "If that is possible, that is the ideal situation. If that is not possible, then we look at other work alternatives, with the home department being the preference."

The jobs should conform to the expertise of the injured employee, says Bailey. "You want to make sure the employee is being utilized to the fullest capacity in that position, and you want to make sure it's meaningful work," she says. "The goal is

to transition them back to their position. You want them to have maximum potential."

### • Monitor the program.

The transitional work program coordinator should follow up with the employee periodically while he or she is in the program. After all, you don't want employees to violate their restrictions and impede their healing process, Bailey notes.

At El Camino, employee health nurse practitioners treat patients in-house and function as case managers. "They understand the work environment and how that relates to the recovery and treating process," says Deex.

Facilities can compare their lost work days before and after the implementation of transitional work to show the cost impact of the program. But there are other, less tangible benefits of employee loyalty and retention, Deex says. ■

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