

Rehab Continuum Report

The essential monthly management advisor for rehabilitation professionals

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Missouri rehab center opens door for holistic women's health center

Women with disabilities receive primary care

This idea may seem so basic that a rehab director may wonder why it hasn't been implemented by dozens of larger rehab facilities across the country: Offer rehab patients a disability-friendly place to receive primary care and health screenings.

SSM Rehab of St. Louis came up with the idea after surveying 1,100 women in August 2000 who were former rehab patients. The survey unleashed a flood of support for the birth of a clinic that would be specialized to meet the needs of women in wheelchairs.

The women were asked how regularly they have Pap smears and mammogram health screenings.

"Most had had one, but what we saw on most of the surveys were comments of, 'I had one before, but haven't had one since my injury,'" says **Angela Allen**, PT, manager of women's services.

"Most said they couldn't get in to be seen by their doctors, and OB/GYNs didn't know how to handle them," recalls **Melinda Clark**, president of SSM Rehab.

Survey responders also added comments, writing brief accounts of some of their own stories about discouraging attempts to seek health care from providers who were not prepared to handle disabled patients.

"The story that upset me the most when I heard it was about a woman who had some sort of lump in her breast," Allen recalls. "She scheduled a mammogram and was unable to stand for the mammogram machine, and it didn't lower enough, so the hospital brought in two male security guards to lift and hold her in a standing position for her mammogram."

The poor woman was nude from the waist up, and the experience was so humiliating and degrading that she never went back, although the mammogram revealed a lump that could have been cancerous, Allen says. "We hope to get her in our clinic."

In other stories, women told about how their gynecologists were unwilling to do cervical exams because it would be too difficult to

transfer the wheelchair-bound women to the high examination table.

Disabled women need preventive medicine that too often is unavailable to them because of access problems, says **Thy Huskey, MD**, a physiatrist and medical director of general rehabilitation for SSM Rehab. Huskey is the director of the new women's clinic.

The chief priority in the clinic's first year is to make mammograms and Pap smears available to disabled women so they may have the life-saving benefits of early detection, Huskey says. **(See story on how clinic and program were launched, p. 99.)**

"I think women with disabilities just want to find a place where they can come and find health care services without seeing the shocked look on people's faces of 'Oh, you're in a wheelchair,'" Huskey says. "And that's what we're hoping to create in this environment."

Huskey adds that she has a special interest in a rehab facility providing this type of service because she experiences life from the perspective of a wheelchair. "I know the feeling of going in for a Pap smear and informing the clinic ahead of time that you're in a wheelchair," Huskey says.

While some training hospitals and rehab facilities may provide some of these services for disabled women, the program created at SSM Rehab is probably one of the first to be designed solely for the purpose of providing women's preventive health care to disabled patients, Huskey adds.

The patients, who include women with spinal cord injuries (SCIs), multiple sclerosis, and other disabilities, have access to examination rooms and radiography equipment that are specially designed to accommodate women in wheelchairs. They also have access to a whole network of rehab and other health services provided at the same location, says Allen.

So an SCI patient can visit the new women's clinic for her Pap smear and mammogram, and then if she is discovered to have breast cancer, she can receive surgery and radiation through the health care system, Allen explains.

"If she has lymphedema, we can send her to

a lymphedema specialist to treat her," Allen adds. "We have a web around patients to give them support."

Just the beginning

Along with a nurse practitioner and obstetrician/gynecologist, Huskey will round out the basic medical team.

Huskey's role will be to provide a rehab perspective on women's health issues, such as helping patients deal with pelvic pain associated with bladder hygiene and helping patients avoid and treat yeast infections, which are common among women confined to a wheelchair.

"The rehab role is to address what kinds of things can go wrong that other women don't have to worry about," Huskey says.

Also, Huskey expects that she will be able to answer questions for patients about sexual pain and other sexual issues that they may be too uncomfortable to ask their OB/GYN.

"We need to address that, because the spinal cord injury didn't affect the patient's mind; the patient may still want to one day have a family and be a part of a meaningful relationship," Huskey says. "As word of this clinic gets out, we hope people realize that we're not doing things superficially here."

Although the clinic still is in its infancy, Huskey already can envision future expansions that could include offering obstetrics services.

"I'd like to do a couple of little items first and do those really well before we get ahead of ourselves and do it very poorly," Huskey says. "But we are anxious to expand to obstetrics."

Also, the clinic could be a focal point for women in wheelchairs to receive much-needed support and information about adjusting to daily living challenges, she notes.

"I hope women coming to the clinic can form support groups for things like mothering and how to do chores in a wheelchair or walker," Huskey says. "I hope they will get together and share these things, and in the long run we can form a network of women in wheelchairs." ■

COMING IN FUTURE MONTHS

■ How a facility's lymphedema program expands cancer rehab services

■ Psychosocial issues need to be addressed with TBI patients

■ How HIPAA privacy provisions will impact rehab facilities

■ Will cap repeal fly on Capitol Hill?

Women's health clinic: Here's how it was done

First step: Ask women what they want

After the decision was made to provide preventive care for women with spinal cord injuries, multiple sclerosis, and other disabilities, the real work began. Here's what went into establishing SSM Rehab of St. Louis women's health center:

- **A survey was an essential first step.**

Through a survey that went out to more than 1,000 wheelchair-bound women, SSM Rehab learned what women needed and where they needed it to be located.

"We asked women what they wanted to see in this clinic, and we found that transportation and parking were issues," says **Angela Allen, PT**, manager of women's services.

Women also said they needed educational programs about menopause and information about family planning, psychological counseling, and social services available in their areas. SSM Rehab provides foreign language and sign language interpreters for any patient who needs assistance, so this need, which also was mentioned, could easily be met.

Based on the ZIP codes of the survey responders, SSM Rehab marketing professionals selected two locations for the women's clinics, with the pilot clinic located in St. Mary's Health Center on the sixth floor as part of the rehab program. The pilot clinic opened in July 2002. Even before it opened, the St. Mary's site had patient appointments scheduled for well into November 2002, says **Melinda Clark**, president of SSM Rehab. Though no date for opening the second clinic has been set, it will be located in another SSM Healthcare hospital, called St. Joseph's Medical Center in St. Charles, MO, Allen says.

Right equipment critical

- **The hospital provides specialized equipment to meet the needs of disabled women.**

Allen did research on the Internet to learn about primary care services offered to disabled people, and she contacted people who had worked in this specialized field, including a disabled women's health physician, Sandra Welner, MD. Welner, who died last October, had been the clinical director of primary care for Programs for

Women with Special Needs in Washington, DC.

"Dr. Welner helped Hausmann Industries Inc. of Northvale, NJ, create a universally accessible exam table that would make the pelvic exam easier for women in wheelchairs," Allen says. "Women can be transferred from their wheelchair to the table, which lowers to 19 inches from the floor."

The chair also has special stirrups that give the women whole leg support from the mid-thigh down, and they can strap their legs into them so the physician can move their legs around as needed.

"If a woman has spasticity in her legs or if her legs are too weak to be held up, she no longer has to rely on the physician to hold up her legs," Allen notes. The women's clinic has two of these exam tables, she says.

Allen also discovered that mammography chairs are available for disabled women, so she consulted with the radiology department in St. Mary's and figured out which chair on the market would be appropriate for their use.

"We chose the video imaging chair from STERIS Corp. of Mentor, OH," Allen says. "The patient transfers into the chair and it lowers and rotates, so the patient doesn't have to be disturbed at all."

With two of these chairs, the clinic will be able to provide mammograms to women who might otherwise never be screened. "We're trying to devise ways for this experience to provide total support and comfort for patients, and the mother-in-law doesn't have to be standing there holding the woman's breast in place," Allen remarks.

Adequate staff, sensitive marketing

- **Staff included a wide range of health care providers.**

At present the women's clinic will use two SSM Rehab medical offices one day a week, but this time allotment will be changed as the demand grows. The staff providing care include a physiatrist; a women's health nurse practitioner, who will conduct most of the well-woman exams; and an obstetrician/gynecologist, who will see any patient who needs advanced care.

As a physical therapist, Allen will both manage the clinic and provide treatment as needed.

- **A brochure was created.**

At least during the start-up phase, SSM Rehab did next to no marketing of the new clinic because the patient appointments came easily from women

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who had heard about it after responding to the survey and from referrals from ParaQuad Inc. of St. Louis, which is a nonprofit advocacy group for disabled people.

Special Report: Closer Look at TBI Treatment

TBI program focuses on cognition, other issues

Program treats many accident, gunshot victims

[Editor's note: This is the first in a two-part series about traumatic brain injury (TBI) treatment and advances in knowledge and treatment among rehab facilities and providers. In next month's issue, look for a story highlighting a large rehab center's state-of-the-art TBI program.]

The 15-year-old traumatic brain injury (TBI) unit at Bacharach Institute for Rehabilitation in Pomona, NJ, has a program that treats patients holistically, training staff to handle the cognitive, emotional, and physical needs of patients.

Many of the unit's patients were injured by motor vehicle accidents, gunshot wounds, strokes, or aneurysms, among other problems.

"We treat the physical, cognitive, and behavioral aspects of brain injury," says **Lisa Rocco**, MPT, CBIS, CCCE, clinical education supervisor and physical therapist.

"You can't treat the body without treating the mind," Rocco says.

With a neuropsychologist serving as director of the program, the holistic approach is a natural for Bacharach, and the rehab institute has added some unique services in an effort to fulfill its mission of

"I went ahead and wrote up a brochure and we printed it and faxed it over to ParaQuad, where a dozen women looked at it and wrote down suggestions," Allen says.

Their comments came back with notes of "This sounds patronizing" and "We don't know what you're trying to say here."

Taking their advice, Allen rewrote the brochure until it met the volunteer consultants' approval.

"They were very helpful, because they have a totally different perspective than I do," Allen says. "It took us from being very centered on the barriers that these women face, and once it was reworded, it comes across as we're totally accessible with a well-trained staff."

In essence, the brochure's focus was changed from being written about the disabled population the clinic hopes to recruit to being focused on the services the clinic provides, Allen adds. ■

treating all of a TBI patient's rehab needs.

For example, besides having on staff two physicians, therapists, nurses, and a case manager, the brain injury team also includes a nutritionist, a family therapist who is available when needed, and a vocational rehab counselor. Most unusual is the addition of a neuro-optometrist, whose role is to assess how the patient's brain is interpreting visual information, Rocco says.

"Sometimes after brain injury the person's visual information is distorted, and this affects function," Rocco explains. "The neuro-optometrist comes in every other week. He's a great asset to the team."

Typically, the team begins an evaluation of a brain injury patient within 24 hours of admission. The physical therapist is responsible for seeing the patient on the same day of admission. The speech therapist also might see the patient on that first day.

"We meet the family on the first day and try to alleviate some of their fears," Rocco says. "We have such a comprehensive team that everyone is team-oriented with multidisciplinary goals, and they work together."

The team begins to plan the patient's discharge from Day One of admission, and all disciplines will become involved in meetings with the patient and family. The team's evaluation might include a visit to the family home to determine whether there are structural barriers to the patient's recovery of independence, Rocco says.

One strategy that has helped the brain injury team develop such a holistic approach to care is that the staff are taught about cognition problems that may affect patients and their recovery.

“We go over the different cognitive skills, describing how it’s like a foundation for a house,” Rocco explains. “First, the patient has to be aroused and have some level of being awake and alert before you can ask the patient to do anything.”

Staff are then given tips on helping patients maintain alertness, including choosing the right environment for the therapy or treatment to take place.

Some patients need more stimulation

“If someone is agitated, then we’re not worried about alertness because the patient is in a hyperaroused state,” Rocco says. “But if someone is waking up out of a coma and just beginning to respond, then the person needs more stimulation.”

In other words, such a patient should not be kept in a dark room that is conducive to sleep. Rather, therapists should transfer the patient to a wheelchair and bring the patient to an area that has more activity, such as a gym with lights and people moving about.

“First, you have to keep them awake, and next have them sustain and pay attention,” Rocco says.

If the gym or other public area seems too distracting, then move the patient to a quieter area until the patient is acclimated to the busier setting.

The next step is for therapists to learn functional cognitive activities. For example, a therapist might ask the patient to describe how he or she would visit a family member in the facility. Then the therapist can assist the patient in navigating that route.

Or another cognitive activity might be to take the patient to a staff office where the patient can take drink orders from several employees and then fill those orders.

These types of exercises are important because brain injury patients will recover physical function more quickly than cognitive function, Rocco says.

“Brain injury patients love physical therapy because they can see gains day to day and week to week,” Rocco says. “But cognitively, they are not aware of the problems.”

This difference is also noticeable in how family

and friends react to the person with a brain injury, Rocco notes.

“If you have a catheter in your leg, it’s more concrete and easier to understand than if you have a brain injury,” Rocco says. “If there are no scars on your head, people will have a hard time thinking through things, and this can be very dangerous if you don’t have the awareness.”

Once a brain injury patient recovers some physical skills, he or she may forget about the brain injury, Rocco says.

“To prevent that, we have central alarms on the beds and wrist band systems where if a patient leaves the unit, there’s an alarm to go off,” Rocco says. “If someone is a threat to himself, there are safety measures in place because we have to be one step ahead of patients at all times.”

Staff also are taught to integrate functional cognitive activities within traditional physical therapy treatment plans of increasing flexibility, range of motion, strength, and balance.

“The goal is to first work on the patient’s function and then put the patient in a realistic environment,” Rocco says. “We create obstacles for distractions, and then move the patient into the hallway where people are going about their business and may not even be aware that a therapist is working with a patient.”

Brain injuries aren’t always obvious

People with brain injuries may not walk around in society and interact with people in the most appropriate way, but people outside their family may not realize they have social and cognitive deficits, Rocco explains.

“If you’re a patient and you have a cane, people will move out of your way and give you more space,” Rocco says. “But if you’re walking around with a brain injury, people may not know it.”

For example, a therapist might take a brain injury patient to a street where the patient will have to visually scan the street from left to right, judge distance, sequence the event, and time the crossing so that he or she will not be hit by a car, Rocco explains. “The patient needs to learn to problem-solve when someone in a car puts a blinker on, or if the patient drops something while crossing and decides whether to stop or continue to the other side.”

Showing staff how to teach social skills to brain injury patients is another area that is very

different from general rehab.

Therapists may be encouraged to take brain injury patients into public settings, such as a gift shop, and then instruct patients to not touch everything in there, Rocco says.

Finally, brain injury staff are taught how disruptive a patient's behavior might be to the therapy session. Brain-injured patients sometimes can be physically combative and violent or verbally agitated, and occasionally they can pose a threat to themselves and others, Rocco notes. **(See story on teaching rehab staff behavioral management skills, below.)**

"We try not to use chemical restraints, but sometimes we need to. We don't use physical restraints," Rocco says.

To prevent violence, a therapist will help an agitated patient avoid obstacles within reach and will not give the person a cane or other assistive device that can be used as a weapon, Rocco adds.

Brain-injury staff are taught how to recognize agitation and potential combativeness in a patient and then how to avoid triggering a violent episode.

"Therapists need to be aware of the environment in which they're working, so they don't close themselves off in a corner of a room or nurses station with a patient," Rocco says. "They should approach the patient at a 45-degree angle and keep stimulation low, with one visitor at a time." ■

Special Report: Closer Look at TBI Treatment

TBI's biggest challenge? Managing patients' anger

Rehab facility trains staff in behavior management

People who have had a traumatic brain injury (TBI) often become impulsive, angry, and easily irritated by others, and this change in their behavior and personality can be one of the most challenging aspects of working with the TBI population.

For example, a recent study published in *Neurology* found that 32% of stroke patients had an inability to control their anger or aggression, which suggests that this symptom is one of the main post-stroke behavioral manifestations.¹

Researchers also found that stroke patients tended to exhibit spontaneous anger and aggression that sometimes was provoked by other people's behavior and that was also closely related to motor dysfunction and dysarthria. The study was of 145 patients at three to 12 months post-injury at the outpatient clinic of Asan Medical Center in Seoul, Korea, between July 2000 and December 2000.

Rehab professionals long have recognized this trait among their TBI population. In some TBI programs, staff training includes some behavioral management skills.

"It's so much a part of brain injury that we're teaching behavioral management," says **Claire McLaughlin**, OTR, staff occupational therapist at Bacharach Institute for Rehabilitation in Pomona, NJ.

Behavioral issues among TBI patients can be particularly challenging as therapists are attempting to reach clinical goals during a therapy session, McLaughlin says.

Therapists benefit from TBI training

"It's challenging especially when you have someone who gets agitated quickly or has internal distractions," McLaughlin adds. "So you try to get the patient to focus and work on attending to a conversation or simple task."

It's been the TBI staff's experience that rehab therapists who have not been trained specifically to deal with a TBI population will have difficulty working with these patients, McLaughlin notes.

"When you have someone with poor attention or impulsiveness, it can cause a therapist to become frustrated," she adds.

This is why behavioral management training and cross-training for rehab staff are so important. Here's how Bacharach Institute's TBI training incorporates behavioral management training:

- **Deal with big misconceptions.**

Therapists may become frustrated with a patient who has a poor attention span or who is impulsive because it's difficult to complete the task at hand. However, it's a misconception for the therapist to think the patient is choosing to behave this way, because it's likely the brain-injured patient just doesn't have the attention span to sustain concentration on the activity, McLaughlin says.

"The therapist just needs to be more on his

guard and be more prepared to react to the person doing something unsafe, such as getting out of the wheelchair quickly," she explains.

If a patient is paying more attention to something else going on in a room than to therapy, the therapist should not think the patient is purposely being disruptive. Rather, the patient has become distracted and needs to be redirected in a simplified manner to the therapy task, McLaughlin says.

"When someone is becoming agitated, you need to use your intuition and assess whether there's an escalation in the patient's voice," McLaughlin says. "If there is, you need to back off with demands on the person and calm down the person's environmental distractions so the person can get back into control."

- **Offer strategies for improving the TBI patient's behavior.**

Although the rehab facility's brain injury and general rehab rooms are separate, the treatment area is the same, and this means brain injury staff will need to pay special attention to the environmental stimuli in every therapy situation, McLaughlin says.

Brain injury staff also must educate patients' families as much as possible and encourage them to spend more time involved with their loved ones' rehab care, she says.

"We teach the family the strategies, and they can help to make rehab less intimidating and anxiety-provoking for the patient," McLaughlin says.

Start off quietly; then add distractions

The education geared toward both family and patients may also include several homemaking sessions in which each one is geared to increase the challenge. This way, the therapist can help the family assess what the patient is capable of doing and what the patient will need assistance doing once he or she is at home, she adds.

"Start off with a quiet environment to give the best cooking training, and as the patient does more in the kitchen, you can add distractions to see what the patient can do," McLaughlin says.

When a patient becomes frustrated, this can be a sign that the patient does not understand how to do a task. It's also a clue that a therapist can use to find out what the problem is.

For example, a patient might be overreaching for an object and not sustaining a grip on it, or the patient might be turning it the wrong way and then tightening it instead of loosening it,

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McLaughlin explains.

"What you want to do is first call the patient by name to get his attention, and then explain to him by a hands-on approach what they need to do," she adds. "Or you can give the patient verbal cueing on what needs to be done."

Be sensitive to nonverbal cues

- **Prepare staff for the times when a patient's agitation rises.**

"Observe a patient's frustration level," McLaughlin advises. "If a patient's frustration is rising, then that's usually a sign that they're not doing a task correctly, so the therapist will have to step in to analyze what they're doing wrong and then cue them tactically, visually, or verbally on how to perform it correctly."

Most importantly, therapists need to be sensitive to nonverbal cues that a patient is agitated and that something has triggered an angry episode, says **Lisa Rocco**, MPT, CBIS, CCCE, clinical educator supervisor and physical therapist.

Rocco learned the importance of these precautions the hard way. A patient of hers who was 6'5 had cornered his mother against a wall. As Rocco approached the patient from the side, he grabbed her arm and twisted it, causing numbness in her hand.

"So you can be prepared, but sometimes still get into a precarious situation, so you need to know your limits," Rocco says. "And you need to know when a patient is going to act out and be aggressive."

Reference

1. Kim JS, Choi S, Kwon SU, Seo YS. Inability to control anger or aggression after stroke. *Neurology* 2002; 58:1106-1108. ■

Insurers say e-mail use increases liability risk

Think about HIPAA before you hit 'send'

As medical communications move on-line, so does medical liability risk, according to the eRisk Working Group for Healthcare, a consortium of national medical societies and liability carriers.

The eRisk Working Group for Healthcare has published an updated list of guidelines for on-line communications with patients, other health care providers, and industry. Driving the creation of these guidelines is the continued growth of e-mail, which is being driven by strong patient demand, according to recent studies published by Boston Consulting Group, Jupiter Media Metrix, and Medem Inc. The new guidelines were developed by the carriers and medical societies at the second annual eRisk Working Group for Healthcare conference held recently in San Francisco.

Authentication, encryption recommended

The new guidelines address both routine on-line interaction as well as on-line consultations, in which providers are reimbursed for providing care on-line, says **Mark Gorney**, MD, medical director for the Doctors Company, one of the largest national malpractice carriers.

The guidelines emphasize the need for secure on-line messaging, with authentication and encryption, he says, as opposed to the use of standard e-mail. A second set of guidelines for reimbursed on-line consultations was created in response to the growing interest in this service among both patients and physicians and an increase in the number of payers who are reimbursing or considering reimbursement for on-line consultations.

"The new eRisk guidelines make it clear that there are risks in using standard e-mail to communicate with patients or to transmit patient information to third parties," Gorney explains. "Charging patients or payers for an on-line consultation likely increases those risks. Given these risks and the HIPAA [Health Insurance Portability and Accountability Act] guidelines, it makes good sense to use a network that includes both encryption and authentication

for transmitting messages."

The liability carriers and the societies agreed that technology adoption among health care providers is advancing rapidly and is challenging the health care industry to keep up with appropriate guidelines and advice. **Ed Gotlieb**, MD, a pediatrician and representative from the American Academy of Pediatrics, whose board has formally endorsed the eRisk guidelines, says the frequency of on-line communications is increasing rapidly.

Get informed consent before using e-mail

Gotlieb points out that many may assume e-mail communication is acceptable to patients, but the guidelines specifically say that informed consent is necessary before beginning any e-mail communication with a patient. That means the sender must explain to the patient that e-mail communication may not be as private as other methods, and the patient must consent to communicating that way despite the privacy shortcomings.

In particular, risk managers should warn staffers and clinicians against routinely soliciting patients' e-mail addresses as part of data collection and then using that address without informed consent. The new guidelines have this to say about getting informed consent for e-mail communication:

"Prior to the initiation of on-line communication between health care provider and patient, informed consent should be obtained from the patient regarding the appropriate use and limitations of this form of communication. Providers should consider developing and publishing specific guidelines for on-line communications with patients, such as avoiding emergency use, appropriate expectations for response times, etc. These guidelines should become part of the legal documentation and medical record when appropriate. Providers should consider developing patient selection criteria to identify those patients suitable for e-mail correspondence, thus eliminating persons who would not be compliant."

The summary guidelines for on-line communications and reimbursed on-line consultations have been posted on the liability carrier Web Sites and are also available at www.medem.com/erisk. (See p. 105 for excerpts from the guidelines.) ■

Guidelines urge: Guard on-line communications

Keep records of on-line communications

Below are excerpts from the eRisk Working Group for Healthcare's guidelines for on-line communications with patients, other health care providers, and industry:

- **Authentication** — The health care provider has a responsibility to take reasonable steps to authenticate the identity of correspondent(s) in an electronic communication and to ensure that recipients of information are authorized to receive it.

- **Confidentiality** — The health care provider is responsible for taking reasonable steps to protect patient privacy and to guard against unauthorized use of patient information.

- **Unauthorized Access** — The use of on-line communications may increase the risk of unauthorized distribution of patient information and create a clear record of this distribution. Health care providers should establish and follow procedures that help to mitigate this risk.

- **Informed Consent** — Prior to the initiation of on-line communication between health care provider and patient, informed consent should be obtained from the patient regarding the appropriate use and limitations of this form of communication. Providers should consider developing and publishing specific guidelines for on-line communications with patients, such as avoiding emergency use and appropriate expectations for response times. These guidelines should become part of the legal documentation and medical record when appropriate. Providers should consider developing patient selection criteria to identify those patients suitable for e-mail correspondence, thus eliminating persons who would not be compliant.

- **Medical Records** — A record of on-line communications pertinent to the ongoing medical care of the patient must be maintained as part of, and integrated into, the patient's medical record, whether that record is paper or electronic.

- **Authoritative Information** — Health care providers are responsible for the information that they provide or make available to their patients on-line. Information that is provided by e-mail or on a medical practice web site should come either directly from the health care provider or from a

recognized and credible source after review by the provider.

- **Commercial Information** — Web sites and on-line communications of an advertising, promotional, or marketing nature may subject providers to increased liability, including implicit guarantees or implied warranty. Misleading or deceptive claims increase this liability.

- **Fee-Based On-line Consultation** — This is defined as a clinical consultation provided by a medical provider to a patient using the Internet or other similar electronic communications network in which the provider expects payment for the service. An on-line consultation that is given in exchange for payment introduces additional risks. In a fee-based on-line consultation, the health care provider has the same obligations for patient care and follow up as in face-to-face, written, and telephone consultations. For example, an on-line consultation should include an explicit follow-up plan that is clearly communicated to the patient.

In addition to the guidelines stated above, there are additional considerations for fee-based on-line consultations. For instance, on-line consultations should occur only within the context of a previously established doctor-patient relationship that includes a face-to-face encounter when clinically appropriate. Records pertinent to the on-line consultation must be maintained as part of, and integrated into, the patient's medical record. Also, the patient must be clearly informed about charges that will be incurred, and that the charges may not be reimbursed by the patient's health insurance. If the patient chooses not to participate in the fee-based consultation, the patient should be encouraged to contact the provider's office by phone or other means. ■

Back strengthening can help reduce fractures

Program remains effective years after completion

A recent study conducted by The Mayo Clinic in Rochester, MN, has shown not only that a back-strengthening program can provide long-lasting protection against spinal fractures in women at risk for osteoporosis, but also that women who participated in the program retained

a significant advantage in back strength even eight years after the program ended.¹

Even though the program involved postmenopausal women who were between the ages of 48 and 65 when the study began, the implications of its findings may be much broader.

When asked if back-strengthening for even younger women would help prevent injuries later in life, **Mehrsheed Sinaki**, MD, lead author of the study, replies: "I should say yes. Just from this study we can say that having a stronger back helps it to be less injured at whatever age."

It is very important for working women to have strong backs, Sinaki continues. "Strengthening those back muscles is very important to prevent injuries at the job," she says. "Being deconditioned contributes to work-related injuries, even falls."

Sinaki notes that 50% of white women (the group studied) experience a decrease in bone mass as they age, and one of four can develop fractures. "Non-whites [have fewer fractures] because they have such good bone density, but not as many studies have been done," she adds.

Results are impressive

The study involved 50 postmenopausal women, 27 of whom performed "progressive, resistive back-strengthening exercises" for a period of two years. The other 23 served as the control group. Baseline measurements were taken for bone mineral density, back extensor strength, biochemical marker values, level of physical activity, and spine radiographs.

The difference between the two groups in mean back extensor strength and bone mineral density, which favored the exercise group after completion of the program, were still statistically significant ten years after the program was completed. The relative risk for compression fracture was 2.7 times greater in the control group than in the back exercise group.

Interestingly, the control group actually increased the amount of exercise it had during the study period as well, making the results even more impressive. "The control group didn't want to be left behind, so they did more exercise," Sinaki explains. "However, they didn't necessarily do back exercises."

"To our knowledge," the authors wrote, "this is the first study reported in the literature demonstrating the long-term effects of strong back muscles on the reduction of vertebral fractures in

estrogen-deficient women."

Interestingly, both groups experienced similar bone loss during the follow-up period. So why did the exercise group have a lower risk of fractures? "Because their muscles were stronger," Sinaki explains. "Stronger muscles will protect the bones even with bone loss."

Focus on back extensor muscles

Clearly there is not just a single exercise program that will help build back strength, but there are key elements, says Sinaki.

"You need to strengthen the back extensor muscles," she says, "And of course, the tummy, but those extensor muscles are major. There are some machines in the gym that you can use to push against those muscles, and isometrics are not bad, either."

At what age can women begin to show the effects of osteoporosis, to the point where it might threaten their health and productivity? "It's really hard to say, but in general when they experience perimenopause, sometime from 45 on, and usually by 48 to 52," says Sinaki. "That's when you can begin to lose bone mass, and the age at which you need to be watched, especially if you do a lot of heavy lifting."

The biggest challenge in implementing a successful back-strengthening program, says Sinaki, is compliance. "I have tried different things [to increase compliance], but for me what works best is to show the employees how interested you are in their health, and to tell them the reasons that these exercises are so important. You should also tell them how much more likely they are to be injured if they're not in good health."

Reference

1. Sinaki M, Itoi E, Wahner HW, et al. Stronger back muscles reduce the incidence of vertebral fractures: A prospective 10 year follow-up of postmenopausal women. *Bone* 2002; 6: 836-841. ■

Need More Information?

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In-house equipment can boost revenues, quality

Greater control improves care, says occ-med group

Complex medical equipment such as MRI units and extremity scanners don't come cheap, but purchasing such equipment and providing these services in your own facility can help to significantly improve your bottom line in the long run. What's more, the increased control you have over these processes will also improve quality of care.

That's the dual hypothesis that led officials at Southern California Orthopaedic Institute (SCOI) Medical Group, in Van Nuys, CA, to bring such services in-house, says **Cindy Lesonsky**, CPA, who is CEO and CFO of SCOI. "With 27 physicians, we have lots of referrals [for scans]," she explains. "It's very rare to have so many referrals, but here there's every incentive to make this successful."

"We just signed doctor number 27, so there are 27 physicians who potentially will feed into the MRI referral sources as well as the physical therapy practices," adds **Judy Colby**, RN, COHN, workers' compensation liaison at SCOI, which includes a headquarters and eight satellite facilities, with a complete physical therapy (PT) department and a wholly owned surgicenter in its headquarters. The staff includes four physiatrists as well as orthopedic surgeons.

The new equipment also gives SCOI greater creativity for referrals, says Colby. "L.A. has a very mobile population," she notes. "It's not uncommon for someone to start out as a Bakersfield patient, but because of the types of services they need they could end up down in Van Nuys, which is 90 miles south of Bakersfield, for their surgery. If you have to choose between that and waiting two weeks for an appointment in Bakersfield, you may opt for a different doctor — and for the [trek] — in order to be seen earlier. The bottom line here is that we have more opportunities to enhance revenues."

Two machines to start

The investment has begun with two machines. The first, a 1.5 Tesla MRI unit, was delivered in April 2002. It was installed after completion of new construction on space within SCOI's 92,000 square. ft. headquarters that had already

been earmarked for growth.

An extremity scanner, which Lesonsky hopes will be installed by the end of summer, was purchased for one of the larger satellite offices. Shaped like an oven, it allows for the scanning of body parts such as feet and knees. "It's similar to the MRI, and gives excellent quality," says Lesonsky.

The cost, however, is only 40% to 50% of the MRI, and requirements for the room are not as severe. "It doesn't require RG shielding, and it can go on the second floor, because it's not as heavy as the MRI," Lesonsky explains. She adds that the physicians are very excited about the extremity scanner. Based on its expected success, they hope to use additional scanners in some of the larger satellite offices.

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Editorial Questions

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In evaluating this strategy, quality is at least as important as revenue enhancement, says Lesonsky. "One thing I'm really proud of is that our physicians really put quality of care first," she says. "They told us that if the quality was not acceptable, we shouldn't do it. It leads to problems down the road if the scans are not good and you make a poor diagnosis, or if you take people to surgery who don't need it or you perform the wrong surgery."

Lesonsky says that in ancillary services, greater control leads to greater quality. "You can contract with a radiologist you like and who does good reads, or with someone who is particularly good on spines," she observes. "You also have more control in terms of techs [when you bring services in-house]."

If you send patients out and you believe they are not receiving excellent care, "you can complain, but that's it," Lesonsky notes. "This way, it's your place. You not only have control over the people, but they feel they are more a part of things and they're happier."

In-house PT services also offer another opportunity for improved quality, notes Colby. "Several years ago, there was some state legislation that led all medical providers to believe it was illegal to own and operate your own PT practices because of the self-referral issue," she recalls. "That whole scenario has now relaxed. We had contracted out physical therapy and were increasingly dissatisfied with the quality and elected to bring it back in-house two years ago. The physicians have been much happier since that change, and as a result, we have also begun to offer it in some satellite facilities."

Not for everybody

From a financial standpoint, the new investment seems to be paying off, says Lesonsky. "We've been doing 14-15 scans per day," she notes.

How soon does she expect to recoup her investment? "Usually, you lease this type of equipment [due to cost], although we're buying the extremity scanner," she says. "We would envision being in the black within six months in both cases."

Nevertheless, she notes, bringing such equipment in-house is not necessarily going to be as profitable for all occ-med practices. "It really depends on the practice," she explains. "We have three spine physicians. If we did not have these scanners in our main office, we'd lose all that

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spine business. For us, spine referrals are clearly very important. But if you had a sports medicine practice and you didn't do a lot of spine work, you might not lose very much business [by not having in-house equipment]."

You've really got to study the numbers, she continues. "If you don't have an MRI now, see what you're referring out. If it's 100 patients a month, and you'd get \$1 for each scan you did in-house, if the associated expenses of the equipment are less than \$100 a month, it probably makes sense to do it." ■

Need More Information?

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