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Rehab Continuum Report™

Outcomes
Reimbursement
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The essential monthly management advisor for rehabilitation professionals

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Special Report: Balancing Cost and Quality

Doing more with less: Facilities cope with declining reimbursements

IDS, quality measurement approaches being used

Editor's note: If members of the rehabilitation industry were to adopt a theme song, it would have to be a blues tune addressing the woes of shrinking reimbursements. The one-two punch of declining commercial reimbursement due to cutbacks from managed care organizations and the government's move toward a prospective payment system (PPS) for Medicare services ***(see p. 48 for an update on PPS activities)*** *have left many organizations looking for ways to cope with revenue declines. In this special report,* Rehab Continuum Report *looks at techniques some organizations have used to ensure quality of care and market competitiveness remain strong despite these payment challenges.*

Dorothy in "The Wizard of Oz" may have said it best: "We're not in Kansas anymore." Applying that philosophy to the current winds of change sweeping the rehab industry, managers are rethinking the way they do business, creating strategies to prosper in an environment of declining reimbursements, and educating staff to adapt to these changes. There is one caveat to this strategic planning, however: Changes must be made without sacrificing quality of patient care.

"The way we do business now and the way we deliver care now is not going to be viable under [a system of] prospective pay," summarizes **Frank Wong**, MD, medical director of the rehabilitation unit of Legacy HealthCare in Portland, OR, and a member of the governing body of the American Hospital Association's long-term care section.

Wong and other rehab leaders interviewed by *Rehab Continuum Report* sounded a common theme in how their strategic planning will address the challenges of meeting reimbursement declines from managed care organizations and from the Health Care Financing Administration (HCFA) once the government moves to a prospective payment system in October 2000:

Executive Summary

Subject:
Declining reimbursements for rehab care

Essential points:
- ❑ Many rehab managers are working to ensure quality of care isn t compromised by cost-cutting measures.
- ❑ Managers are trying to avoid staff cutbacks by reassigning clinicians to busier departments.
- ❑ Managed care is not necessarily a bad thing for the rehab business, at least one manager argues.

• Many are pursuing participation in an integrated delivery system by thinking of rehabilitation as part of a continuum of care rather than just care received in a hospital setting.

• Leaders are devising strategies to make therapists and other clinical staff more productive.

• Institutions are determining how to define quality of care and are establishing guidelines for desired outcomes.

• Some organizations are pursuing business with consumers who are paying for rehab services directly out of their own pockets and thus are sidestepping cutbacks among commercial and government payers.

Wong's experience at Legacy HealthCare is a case in point. In 1991, the hospital he worked for merged with a Portland health care system consisting of four hospitals, an organization his hospital had competed with for the past 20 years. As a result of market competition and reimbursement cutbacks, the combined system, which grew to five hospitals with the addition of Wong's, has shrunk from 66 hospital rehab beds to 33. "I'm totally convinced that we would not have survived at all if we hadn't integrated," he says.

The Legacy system includes four hospitals (one has closed since the merger) with inpatient and outpatient care facilities, two skilled nursing facilities, and a home health service.

If the cultural changes involved in merging systems represent round one of Wong's experience in adapting a rehab environment to change, then the impending switch to a prospective payment system represents round two. Legacy's senior management team, which includes Wong, is in the midst of a planning process that is re-evaluating its current way of doing business and providing patient care.

Legacy has stressed staff communications throughout the process, Wong says. One element that received particularly positive feedback from staff was a series of internal newsletters explaining reimbursement changes. The first newsletter explained how the reimbursement system works, including a definition of how rehab hospitals are reimbursed through the Tax Equity and Fiscal Responsibility Act. The second explained reimbursement changes that will be implemented as a result of the Balanced Budget Act of 1997, while the third explained the move to prospective pay.

Legacy has created two committees as part of its strategic planning process, Wong says: a rehab operations council, which deals with administrative issues, and a rehab standards and quality council, which will look at quality care and outcomes.

In a managed care environment that demands clinicians see larger numbers of patients per day, time spent in meetings means time away from patient care. As a result, Legacy asked clinical staff to document every meeting they attended. Managers studied the list to determine if each meeting added value to the quality of patient care delivered and, in some cases, decreased the frequency of the meetings or shortened the list of required attendees.

The standards and quality council will investigate quality of care and the possibility of incorporating clinical pathways into rehab treatments, Wong says.

One organization already making use of clinical pathways is Crozer Keystone Health System

COMING IN FUTURE MONTHS

- ■ Staffing trends in rehab
- ■ Prospective payment planning continues
- ■ Shifting to an electronic medical record
- ■ How telemedicine can work for rehab
- ■ The impact of the $1,500 Medicare limit

in the Delaware County area of Pennsylvania. The organization's outpatient therapy department recommends its therapists use the *Guide to Physical Therapist Practice* published by the Alexandria, VA-based American Physical Therapy Association (APTA). The guide lists preferred practice patterns, desired outcomes, and interventions for specific types of cases, although APTA stresses in the manual they are not to be applied as clinical guidelines.

Crozer managers used the guide to help establish procedures for common diagnoses their outpatient therapists handle, and they keep these guidelines in a notebook for outpatient therapists and other team members to use, says **Bonnie Breit**, administrative director of rehab services for Crozer.

Crozer also uses weekly team meetings of therapists, assistants, and other rehab staff to update its operations manager on the clinical outcomes and expected number of visits for each therapy patient, Breit says. "We monitor the number of times the patient has been seen by a physician, how many visits they've had . . . literally a clinical and time review weekly for every patient."

Get payers involved

At the Rehab Institute of Chicago, leaders have published outcomes studies on specific patient populations, such as care for stroke patients. The organization has begun to approach payers about conducting jointly sponsored outcomes studies to demonstrate clinical outcomes and patient and family satisfaction, says **Wayne Lerner**, chief executive officer. "What's missing from our equation now is a conversation between clinical institutions and their medical staffs and payers. What we're trying to do . . . is to get the attention of some of the payers to work with us on looking at the long-term impact of short-term adjustments in payment. In the old days, when acute care was going through changes, people would ring their hands and talk about anecdotes," Lerner says. "The world has hardened, and anecdotes will not come into play. We're trying to collect facts and add anecdotes to these facts." **(For more on how institutions use outcomes data, see story, p. 47.)**

Most facilities interviewed by *Rehab Continuum Report* have not resorted to clinical staff layoffs, but they have had to do some creative juggling. The Rehab Institute of Chicago, for example, has chosen to reduce its management team rather than institute cutbacks in its clinical staff.

Because the patient load was expected to decline for the rehab unit due to time constraints or denials by managed care organizations, Breit shifted her clinical staff to different areas as patient loads shift. "That's part of the luxury of being part of an integrated delivery system," she says. "If I'm light in inpatient [rehab], I can move therapists to outpatient." This option has helped her maintain staff rather than having to lay them off.

She also has invested time in greater staff education to make clinicians aware of the realities of practicing in an environment increasingly governed by the requirements of managed care organizations. "Quality doesn't necessarily mean quantity, and that's an important delineation," she says. "Certain diagnoses require more quantity [than others]; you can't teach a new spinal cord injury patient everything in two weeks, but you may be able to cover those goals in that time period with a total hip replacement patient."

Breit also reminds her therapists that rehab is about teaching patients to do things for themselves. "Therapy is not just the results of the therapist doing something to the patient. . . . It's the patient taking an active role in their recovery. We're making that part of our treatment approaches on a regular basis and earlier."

The Rehab Institute of Chicago also is thinking outside the box by taking its therapists outside the hospital walls. The institution has entered into a series of outside partnerships with other acute care institutions in which staff of the Rehab Institute provide rehab services on the partner hospital's campus. Profits and expenses are split 50/50, Lerner says. ■

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Linking with an IDS? Make it easy for patients

Ensure quality of care across the continuum

A concept that sounds simple on paper can be surprisingly full of twists and turns in real life. The same can be said for life in a rehab unit after becoming part of an integrated delivery system (IDS). The advantages to becoming part of an IDS are numerous, rehabilitation managers say, but one major challenge is to make the continuum of care as smooth as possible for patients as they move through the system.

Staff education and forwarding initial patient evaluation forms are two key strategies the Delaware County, PA-based Crozer Keystone Health System has used to ensure patient care flows smoothly, says **Bonnie Breit**, Crozer Keystone's administrative director of rehab service. The Crozer Keystone system includes five hospitals, three hospital-based nursing homes, five outpatient satellite offices, and several physician practices that are part of the network.

Rotate staff to build knowledge

When a patient is moved from acute care to inpatient rehab, for example, the acute care therapist photocopies the initial patient evaluation form and sends it to the inpatient rehabilitation unit.

The therapist handling the patient in inpatient care simply adds new goals, rather than doing an entire patient evaluation from scratch and filling out the related paperwork that goes with it. Usually, the therapist discharging the patient from one continuum will call the new therapist to discuss the patient's progress.

In addition, Crozer rotates therapists throughout the system so they can gain an appreciation for the type of care patients receive in each part of the continuum. A therapist might spend six months in inpatient rehab and then move on to outpatient care for an additional six months, for example.

Legacy HealthCare in Portland also has educated staff to ensure a smooth transfer of information, says **Frank Wong**, MD, medical director of rehabilitation services at Legacy. Physicians' performance reviews include an evaluation of how quickly they complete discharge reports, he says. ■

Practitioners adapting to realities of managed care

Yes, you can survive and thrive

Surviving in a managed care environment doesn't have to be the end of the world for a rehab department or practice, say two national leaders in the physical therapy industry.

Larry Fronheiser, PT, and **Peter Kovacek**, MSA, PT, board members of the Alexandria, VA-based American Physical Therapy Association, say managed care has simply accelerated the direction in which the rehab industry was headed anyway: namely, becoming more efficient in providing patient care in terms of costs and average number of patient visits for a particular condition.

"Patients by and large are getting better under managed care. If a therapist remains flexible and goes the extra mile needed for additional authorization, patients will get the care they need," says Fronheiser, senior executive officer of Allegheny & Chesapeake Physical Therapists Inc. in Allegheny, PA.

Fronheiser's practice has decided to apply managed care standards to its entire patient population rather than establishing one set of rules for those covered under managed care plans and another set for everyone else, he says. "We started out that way, but we found that managed care rules were the best ones to apply universally to get efficiency out of our staff."

Executive Summary

Subject:
Practicing in a managed care setting

Essential points:
- ❏ An Allegheny, PA, physical therapy group applies managed care standards to its patient population.
- ❏ Managers must show employees how to be more productive.

Allegheny & Chesapeake PT has adapted to the needs of a managed care environment by:

• **Implementing clinical pathways and outcomes measurement for the major procedures done in the practice.** The practice has tracked visit data for its top 50 ICD-9 codes for the past four years. Recently, practice leaders developed clinical pathways for the top 10 codes in this group to encourage good quality of care with fewer visits when possible. They incorporated these guidelines using their own best practices, networking with other practice leaders, and utilizing standards outlined in *The Guide to Physical Therapy* published by the Alexandria, VA-based American Physical Therapy Association.

A good first step Fronheiser, says, is for administrators to pick out the most common procedures they see during a year, using data from the practice's billing system.

• **Benchmarking results against national standards**. The practice participates in a national database called FOTO (Focus on Therapeutic Outcomes Inc.) as well as the Physical Therapy Provider Network to compare its results with practitioners in other parts of the country.

• **Educating staff about the need to adapt their skills to a managed care environment**. "We're still educating staff to come around," Fronheiser admits. "It's an education process on the part of us in administration. The most significant roadblock to implementation has been among the general willingness of therapists to change their clinical practice [in implementing clinical pathways]. It's become a part and parcel of every internal education [program] we've had."

• **Adding a director of utilization management**. This individual deals with the paperwork and billing components associated with managed care, such as the need to document medical necessity for specific treatments. Even in challenging financial times, Fronheiser considered hiring someone for this job to be worth the investment because of the paperwork and other "hassle factors" in dealing with managed care organizations.

Fronheiser's practice also is going after an increasingly lucrative patient base that is attracting many firms: consumers who are willing to pay for services out of their own pockets. This patient population already has flocked to alternative care practitioners and is interested in many of the services physical therapy practices can provide, Fronheiser says. Allegheny & Chesapeake has started a program called ACE (Athletic Accredited Edge) that uses the expertise of physical therapists to address sports-specific remedies. For example, therapists work with patients to treat or avoid injuries that result from a bad posture or stance. In addition to treatment from therapists, the program also includes tips from golf pros on how patients can improve their form to become better golfers. The practice has advertised the service through direct mail, billboards, and newspaper ads.

The No. 1 area rehab practitioners should study is productivity, says Kovacek, a physical therapy consultant and president of KovacekManagementServices in Harper Woods, MI.

When a market is in the early stages of managed care, revenue potential drops, he explains. This means managers have to better control their overhead. The largest part of overhead for most rehab facilities is in staff salaries and benefits.

Define productivity goals

While productivity long has been measured by patient visits, that isn't always the solution in an era when many managed care organizations are reducing visits allowed for many patients, he says. "For some patients, being productive might be having more visits; for others, it might be having the patient become more independent earlier on. It's very difficult to talk about productivity until you define what needs to get done."

He recommends two strategies to help rehab managers and their staff increase productivity. He developed a quiz he uses with clients to help staff improve in this area **(see insert)**. The quiz helps identify ways for therapists to become more efficient. "It's one thing to tell employees they need to be more productive. It's another thing to tell them *how* to be more productive," he says.

The second strategy is for managers to become involved in industry organizations and talk with peers in more mature managed care markets as a way to learn from others. If managers try to work with managed care organizations rather than against them, the end result, both Kovacek and Fronheiser say, is that the challenges of managed care actually can benefit the rehab industry.

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"I think physical therapy was coming to a crossroads in trying to decide how it was going to prove the efficacy of what we did, in terms of the types of procedures we were using and the amount of time it was taking to get an appropriate outcome," Fronheiser says. "Managed care, I think, served as a catalyst for getting that process accelerated."

Editor's note: KovacekManagementServices operates a listserv for rehab managers to offer news affecting the rehab industry and offer a forum for exchange of ideas. Participation in the listserv is free. Details on signing up for the listserv can be found on the Internet at www.ptmanager.com. ■

Industry group calls for better outcomes measures

Goal: Standardization of reporting

Open any corporation's annual report and you'll notice one thing: The key message isn't about financial results. It's about the atmosphere in which those results were achieved, as well as how the results compare with previous years' performance.

Sales figures and revenue figures are more meaningful, for example, when they are compared with similar data from competitors, against previous years, and even in the context of the economy and other marketplace factors.

The same could be said for outcomes reporting in the rehab industry. Measuring outcomes is a good start, but actually presenting the data in a meaningful way for managed care organizations and consumers to make health care purchasing decisions can be a major challenge.

One national industry group, the American Congress of Rehabilitation Medicine (ACRM) in Glenview, IL, is reaching out to other industry leaders in an effort to promote what it calls an "evidence-based rehabilitation culture." The goals are greater disclosure of outcomes information and a standardized outcomes measurement tool that will allow better benchmarking within the rehab industry and a meaningful exchange of data.

Health care purchasers can use those data to make purchasing decisions based on quality as well as cost, says **Gerben DeJong**, director of the NRH Research Center at National Rehab Hospital in Washington, DC, and chair of ACRM's research policy and legislation committee.

"We need in the rehab industry to develop a consolidated performance score . . . a weighted average of several measures," DeJong says. "At some point in the future, it will be important for individual consumers with rehab needs to be able to access [the information] via the Internet."

He says the Function Independence Measure, an 18-item assessment tool used by more than 1,300 hospitals nationwide, offers a good starting point. "But it's focused on a fairly limited repertoire of skills. There are a lot of people who think we need to look beyond that. Just because a person acquires these skills, how does it translate to social performance and social role? Nor does the FIM speak adequately to the many other venues where rehab is currently practiced. . . . It's really an inpatient hospital type of instrument."

DeJong's committee is just beginning its work on this effort, he stresses. The group is creating a vision of where it wants to go, and it wants to reach out to other national groups such as CARF...The Rehabilitation Accreditation Commission, the American Medical Rehab Providers Association, and the American Academy of Physical Medicine and Rehab, among others.

The group hopes to collaborate with other organizations, develop a broad multi-year plan, and perhaps sponsor a national conference. DeJong says these criteria are important to better use outcomes data:

- a commitment to the value of transparency

and the principles of public accountability and disclosure;

- a theory of rehabilitation practice/science;
- a conceptual framework of disability that captures its etiology and consequences;
- a nomenclature and commonly accepted definitions of terms;
- valid, reliable, useful, and agreed-upon measures of function and outcome;
- institution and facility capacities for functional and outcomes data collection;
- large and accessible cross-institutional databases on patient/consumer outcomes;
- full disclosure of standardized risk-adjusted outcomes;
- payment systems that reward quality as well as resource utilization. ■

Translating numbers into useful information

Two hospitals use data to improve performance

Your rehab department has tracked outcomes data for years. In fact, you have two drawers full of quarterly reports to prove it. But have you done anything with the numbers after you've read the reports and filed them away?

Rehab Continuum Report spoke with two hospital administrators whose facilities are using outcomes data as performance measurement tools to help staff and department managers compare their performances with those of their peers and identify best practices and opportunities for improvement.

At Shepherd Spinal Center in Atlanta, the senior management team issues a monthly report that compares outcomes by teams based on 30 variables, says **Gary Ulicny**, PhD, the hospital's president and CEO. A performance improvement team, which includes a physician, developed the list.

The physician-led teams are categorized by type of patient group, such as paraplegics or acquired brain injuries.

Shepherd created its own executive information system about two years ago that tracks the data, using the Functional Independence Measures as a starting point but adding variables looking at functional activities after discharge from the hospital. For example, what kind of ongoing medical care was needed? How much assistance did the patient need from others to perform daily living activities such as getting dressed?

Data are distributed monthly to physicians, although teams are identified by Physician A, Physician B, and other acronyms. "But everybody knows who's who," Ulicny says. "They became pretty competitive. They see it as an opportunity to learn from colleagues."

Shepherd does not tie performance to compensation, he says, but uses the data in the strategic planning process. "What you see in so many hospitals is they get memos saying they need to submit three performance improvement ideas. Many people will grab on to easy or convenient things. We let the data in our report cards be the guide."

The next step for Shepherd is to dissect a couple of programs to determine what contributes to an outcome and what doesn't, Ulicny says. One specific component includes a time-study analysis of all nurses in each of the programs. The analysis will determine how each nurse is using his or her time, whether there is work technicians or assistants can do to free nurses for other duties, and whether other areas for improvement exist.

Put data to work

The hospital has made several improvements based on the outcomes data reported, Ulicny adds. "A couple of years ago, we found that discharge planning had gotten rushed, and [we] were able to retool that significantly," he says.

At National Rehab Hospital in Washington, DC, benchmark data are presented quarterly to administrators and program managers, says **Jackie Ennis**, director of outcomes management. Reports are reviewed by a leadership quality

Executive Summary

Subject:
Outcomes data can measure performance, identify opportunities for improvement.

Essential points:

- ❑ One facility has based performance goals on outcomes data.
- ❑ Another shares the data with staff and payers.

council — which includes the hospital's president, administrator, vice president of nursing, head of clinical services, and head of outpatient services — as well as by medical directors and department managers.

Data are "cut" by impairment group, Ennis says. Measurements are grouped by these patient types: stroke recovery, orthopedic impairments and disabilities, spinal cord injury, and traumatic brain injury. National Rehab also tracks results within the MEDSTAR health system, the integrated delivery system it belongs to, she says.

"We try to determine how outcomes are affected by participating in other points of the system of care . . . not just by cost but by functional gains." For example, data tracked for a stroke patient might look not only at acute care rehab costs, but outpatient costs and home health costs as well, she explains.

What do the numbers mean?

Both Ennis and Ulicny say their hospitals have shared outcomes data with payers and have sorted data by payer membership. Payers are particularly interested if you can isolate outcomes to their membership, they say. Their goal is to assign meaning to the numbers.

"Those of us in the field have the tendency to produce lots of numbers; drop the data, and run," Ennis says. "I think it's really important to add value to the outcomes data by focusing on meaning and implication. What does the data mean

in context of daily operations or in a strategic context, even if you're simply posing the question with data."

For example, in one presentation Ennis made to medical residents on staff, she presented data demonstrating that elderly spinal cord patients had shorter lengths of stay than non-elderly spinal cord patients.

"On the surface, this seemed counterintuitive," she says. But during the presentation, medical residents in the audience suggested that many of the non-elderly spinal cord patients were involved in accidents resulting from urban violence, which likely affect the severity of the injury and thus recovery time.

"We went away from the meeting with four requests to look at the data for spinal cord patients in a different way," she says. ■

Rehab prospective pay inches closer to reality

FIM measures included in latest MDS-PAC draft

The Health Care Financing Administration (HCFA) is one step closer this month to having the tools in place to implement a prospective payment system (PPS) for the rehab industry.

The latest draft of the Minimum Data Set-Post Acute Care (MDS-PAC), which will be used as the patient assessment instrument for the prospective payment system, was on schedule to be presented to HCFA by March 31. It likely will contain measures that should appease fans of the Functional Independence Measure (FIM).

As *Rehab Continuum Report* went to press, officials associated with the MDS-PAC project and the Buffalo, NY-based company that administers FIM — the most widely used assessment measure for inpatient rehab patients — said they had suggested a number of revisions to better incorporate essential elements of the 18-item FIM. Rehab industry groups such as the American Medical Rehabilitation Providers in Washington, DC, had lobbied for the inclusion of FIM data because they are widely used among rehabilitation facilities (about 1,300 across the country) and because there are FIM data for 85% to 90% of Medicare patients.

"With the current draft, we're comfortable that most of the essential elements [of FIM] are there now," says **Anne Deutsch**, RN, MS, CRRN, research analyst for the Uniform Data System for Medical Rehabilitation (UDS), which administers the FIM.

UDS officials went through draft seven of the MDS-PAC and used FIM data to identify areas

Executive Summary

Subject:
Release of the latest draft of the patient assessment tool for the rehab prospective payment system

Essential points:
- ❑ The draft was due to the Health Care Financing Administration (HCFA) by March 31.
- ❑ A patient classification system will be developed this spring; the final draft is due by April 2000.

they thought could be improved, Deutsch says. For example, an item originally listed under the category of "bathing" on the MDS-PAC draft instrument now has been broken into two separate items — a "bathing" item and a "tub transfer" item — to mirror the FIM instrument.

In late February, officials at the Research and Training Institute at Hebrew Rehabilitation Center for the Aged in Roslindale, MA, were finalizing work on draft eight of the MDS-PAC. The 127 facilities that served as testing sites for MDS-PAC were scheduled to get all remaining data to Hebrew by the second week in March, says **Pauline Belleville-Taylor**, RN, MS, CS, project director at The Research and Training Institute at Hebrew Rehabilitation Center.

Belleville-Taylor says it is too early to comment on the feedback received from the test sites. The goal is to shorten the form so it can be completed in one hour. She says therapists at the test sites are becoming more aware of a patient's functional status based on the patient's entire activities, not just the activities observed while the patient is in therapy.

"Now that these therapists are involved in an assessment instrument where you have to talk to the nursing staff, . . . they are getting more complex information," she says. "They may find out that on the night shift, a person gets a little bit disoriented and may need physical assistance in ambulation. This type of information makes a therapist look at what a patient can accomplish in the whole 24-hour time frame."

Final report a year away

The Hebrew Rehabilitation Center contract is for developing only the assessment instrument. HCFA will use the data from the MDS-PAC tests to establish patient classification groups for inpatient rehabilitation hospitals.

After receipt of the MDS-PAC instrument, Washington, DC-based Muse & Associates and Aspen Systems in Rockville, MD, will begin staff time-measurement studies at a sampling of rehab hospitals and units. This is scheduled to take place in spring 1999. Using the MDS-PAC instrument, the researchers will determine a patient classification system based on resource allocation. Their final report is due to HCFA in April 2000.

The Balanced Budget Act of 1997 mandates that a PPS for rehabilitation hospitals and units go into effect Oct. 1, 2000. The budget for the PPS-based reimbursement system will be 98% of what HCFA paid under the Tax Equity and Fiscal Responsibility Act (TEFRA).

In the first year, providers will receive two-thirds of their TEFRA rate and one-third the national rate. The second year, they will receive one-third of their TEFRA rate and two-thirds of the national rate. The third year, the PPS goes into effect 100%. ■

Post-stroke survival for Baby Boomers

Support group helps younger patients adjust

When **Lee Price** was recovering from a stroke in July 1994 at age 46, he felt like an anomaly every time he attended a stroke support group meeting.

"I kept hearing, 'You're so young to have a stroke,'" he recalls. "It made me feel I was alone."

Price translated his frustration into action, founding a stroke support group called Young Enthusiastic Stroke Survivors (YESS), with two other stroke survivors (Ann Guenther, who had already experienced two strokes by age 37, and Sue Benson) and the support of Sharp HealthCare in San Diego.

YESS has taken off beyond the founders' wildest dreams. Organizers say the group's success is proof that these patients have needs other than those addressed by the typical stroke support group.

From the start, the group has been driven by patients, says **Clair Jones**, MS, Sharp's system director of rehab services. Its peer-led element is critical to its success, Jones and Price say. Sharp helped start the group with $2,000 in funds from its Rehab Foundation, provided a room for meetings and a few patient names, and let the group's founders take over.

"At our first meeting, we had four people," Price says. By the next meeting, the group had grown to 10, and by 1997, 180 individuals were participating. As of early 1999, membership totaled 360.

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The average age of YESS membership is 36, although there is no strict age limit. "In fact, we have an 82-year-old member who I would classify as a very young 82," Jones says.

YESS originated with monthly meetings at Sharp and now meets twice a month. One meeting each month consists of a social event or outing, while the other focuses on educational topics. Members include but are not limited to former Sharp patients.

Price stresses that the organization has no elected or appointed officers. Members select the topics for discussion through a yearly brainstorming session. A handful of group members get together and use the list from the session to develop an agenda for the year based on member suggestions and what they feasibly can accomplish.

Stroke survivors run group

Among the more popular previous programs include returning to the work force, with tips on dress and appearance and handling relationships, Price says.

Another popular program featured a breakout session among family members and caregivers of the stroke survivors. Often, these people are shy about venting their concerns in front of the stroke survivor; the program enables them to empathize and exchange ideas with others in similar situations.

Two Sharp recreation therapists help secure speakers for the meetings and help plan social events. "As a facility, we try and play as little a role as possible. We want [patients to take charge] based on our philosophy that people need to get back into the community and manage and control their own destiny," Jones says.

The rewards of seeing stroke survivors succeed once they return to the real world has been the primary benefit of the program, Jones says. A secondary benefit has been the increased visibility and recognition for Sharp as a result of publicity for the group; consumers who ordinarily may not have used the Sharp system now consider it an option.

Price says one of the group's biggest benefits has been to increase self-esteem among its members. The community outings reintroduce stroke survivors to handling social situations. The session on clothing "helps people realize they need to have a little bit of self-pride. Once they've had a stroke, some people think, 'What's the point of getting dressed up?'

"We give them hope," Price concludes. "There's always hope. We see people as survivors, not victims." ■

Rural patients benefit from community outings

Goal: Get them out of house after discharge

To make sure their mostly rural patients won't be confined to their homes after discharge, staff of Southern Regional Rehabilitation Center in Fayetteville, NC, put a heavy emphasis on community outings.

"The reward is that our patients know they can get out and do something after they are discharged," says **Laura Barrett**, associate administrator of Southern Regional, which is part of the Cape Fear Valley Health System.

Barrett says the hospital has not kept records of the community outing program's expenses, but she considers them fairly minimal, comprising only the cost of the bus and other related transportation costs such as gasoline.

"You're using that person [a therapist] eight hours a day and paying them for those eight

Executive Summary

Subject:
Community outings tailored to a rural population

Provider:
Southern Regional Rehab, Fayetteville, NC

Essential points:
- ❑ Each treatment team takes patients out once a week.
- ❑ Outings provide opportunities to practice ambulating over sand, pine needles, and gravel.
- ❑ Low-income patients may borrow equipment.

hours a day, so those expenses would be the same whether they were in the gym working with patients or on patient outings."

Because of the hospital's focus on getting people out into the community, staff strongly encourage patients to go on outings before discharge. In follow-up telephone calls, Southern Regional staff ask whether patients have been active since they left the facility. "We find that the patients are getting out and doing the things they did before their injury or illness," Barrett says.

The hospital draws from 18 counties, most of which are rural. Since many patients live in areas without public transportation, sidewalks, or even paved driveways, outings to local parks are a must. There, staff help patients practice walking or manipulating their wheelchairs on sand, gravel, or pine needles.

Because many patients have low incomes and few resources in their communities, the medical center loans equipment such as portable ramps and wheelchairs to patients who need them on a short-term basis. Patients also may borrow the special sports wheelchairs and hand-cranked bicycles to try athletic activities before purchasing special equipment.

Getting out once a week

Each treatment team takes patients on outings one day a week. The outings focus on whatever activities the group has been working on during therapy and provide a good follow-up to in-hospital treatment, Barrett says.

Staff who accompany the patients are from all disciplines, including nursing, psychology, and neuropsychology. "Everyone on the staff goes. It depends who is available and the needs of the patients," she says.

Each team decides at its weekly meeting who would benefit from an outing and where to go. The staff then set goals for the outing. For instance, if the outing is to a restaurant, a goal might be for a patient with cognitive problems to be able to pay and get the correct change. For an orthopedic patient, a goal might be to get in and out of the restaurant with an assistive device.

Outings are geared toward patient interests. Younger spinal cord injury patients may go to a video arcade and learn to manipulate their wheelchairs around the games and machines. Trips to the hospital chapel or to church are popular with many patients.

"We try to get them back into the things they have done before," Barrett says.

Most of the outings are confined to patients with similar ailments, but sometimes a patient fits in with a different group. For instance, a younger patient with multiple fractures may be grouped with the spinal cord patients instead of the elderly hip replacement patients.

Patients need 'real-world' situations

Barrett has found it effective to take patients into the community rather than simulating the community inside the hospital. "The distractions that go on in the real world are nothing like the controlled environment of the hospital," she explains.

The hospital is located across the street from a shopping center, which gives staff the opportunity to take patients out without using the hospital van.

The number of outings per patient depends on patient needs and lengths of stay. Orthopedic patients take one outing at the most because few are hospitalized for as long as a week. Spinal cord patients take many more outings.

"We make it our expectation from the beginning that they will go, and that is their therapy for the day," Barrett says.

One challenge staff face is combating the misconception among insurance case managers that if patients can go to a restaurant, they are ready to go home, she says. That problem can be solved by educating case managers so they understand the value of the outings.

Setting realistic goals poses another challenge, she says. For instance, patients may be able to transfer independently from a mat table, but if they go to a movie theater with nonremovable armrests and low seats, they face a whole new set of challenges.

"It helps the therapists know what the patients are likely to be facing when they get out," she says. ■

Need More Information?

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Restaurant helps fitness clients stay on track

Facility is part of health club

When clients at Condell Medical Center's Centre Club fitness and rehab center finish a workout session or a health promotion class, they can step next door and enjoy a healthy meal. When the Libertyville, IL, medical center built its Centre Club fitness and rehab center, a 120-seat restaurant and dining room was included.

"The restaurant gives our clients an opportunity to dine out and practice what we preach," says **Steve Aull**, corporate director of fitness and wellness. The restaurant offers a balanced selection of menu items, including heart-healthy low-fat dishes. However, not all offerings are low in calories or fat. "The only reason some people work out is so they can eat what they want."

Facility available to public

The dining facility is rented to members of the health club and the general public. It's been used for Chamber of Commerce dinners, weddings, bar mitzvahs, and other social events. The hospital hosts educational programs there throughout the year. A number of local physicians' groups hold meetings at the restaurant, Aull adds.

The Centre Club provides the food and staff or simply rents out the facility. "It's a nice setting in a smoke-free building, and people like that," he says. The restaurant is on the upper level of the facility. On the lower level is the fitness club for members and a number of outpatient rehab programs, including outpatient physical therapy, sports medicine, and cardiac rehab.

The fitness center's health promotion activities include weight loss programs for people of all ages, executive testing, fitness evaluations, and a women's health program. "We try to offer the softer side of fitness, and our restaurant affords us a good opportunity to do so," Aull says. ■

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