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INSIDE

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Rehabilitation facilities handle chronic pain in many different ways

Try cognitive-behavioral, holistic, or psychological approach

Rehabilitation facilities have a good opportunity to capitalize on a growing specialty area of treating chronic pain patients, both among their typical patient populations and in providing a program for workers' compensation cases and the community at large.

Studies show that about two-thirds of spinal cord injury patients experience chronic pain, and a majority of traumatic brain injury patients also suffer from pain.[1,2] Also, more rehab facilities are looking for niche markets to serve as obtaining reimbursement becomes more challenging. Treating patients for chronic pain, including those referred by workers' compensation, is one way of becoming more competitive. It's also a way for rehab providers to meet the needs of the rapidly increasing population of elderly people. Chronic pain problems increase as people age, and those people will need a health care provider who can help them manage their pain.

Executive Summary

Subject:
Chronic pain programs can provide rehab facilities with a niche market share that can only grow in coming years.

Essential points:
- ❑ Older people experience pain more frequently, and this population will increase in the next decade.
- ❑ Chronic pain programs require a multidisciplinary team approach, using expertise that rehab facilities often already have on staff.
- ❑ Such a program could focus on a patient's physical, psychological, and spiritual well-being, using a holistic or cognitive-behavioral approach.

One national survey found that one in five older Americans takes analgesic pain medication several times a week or more, and most of those people had taken prescription pain medications for more than six months.[3,4] Other studies estimate that up to 80% of people in nursing homes suffer from untreated pain.[3,5-7]

The American Geriatrics Society of New York City in recent years has focused on educating health care providers about the severe consequences of untreated chronic pain and how to assess and treat pain. **(See guidelines for managing chronic pain, inserted in this issue.)**

Treating chronic pain in a rehabilitation setting requires a multidisciplinary team approach, says **Laura Schneeweis**, MS, OTR, pain program manager at Northridge (CA) Hospital Medical Center. The hospital has a 26-bed rehab facility that provides both inpatient and outpatient chronic pain programs.

"The goal of our program is to enable each individual patient to return to meaningful daily functioning and to enhance the patient's ability to effectively control their pain," Schneeweis says. Northridge's program accomplishes that goal by following a cognitive-behavioral approach.

Other chronic pain programs take a holistic approach, focusing on helping patients cope with pain through interventions directed at the physical, psychological, emotional, and spiritual realms.

Pain patients experience social, work losses

"They are not just physical beings affected by pain," explains **Jevelyn Verbic**, RN, clinical nurse coordinator at Marianjoy RehabLink in Wheaton, IL. "They have psychological pain losses, work-related social issues, and we help them rebuild a life because they'll never be what they were before they had this pain." Marianjoy RehabLink is a freestanding rehab hospital with stroke, head injury, spinal cord, pediatric, and neuromuscular programs.

A third chronic pain treatment approach involves the use of psychological interventions.

"Generally, this is teaching the person what we call self-regulation skills for pain so the person could use mental distraction or relaxation or they could restructure the way they look at things to decrease or cope with pain better," says **Ralph Bruno**, PhD, rehabilitation psychologist at Walton Rehabilitation Hospital in Augusta, GA.

What programs offer patients

Pain programs offer patients much-needed acceptance. Many chronic pain patients feel as though no one understands their suffering because they may look healthy on the outside. Many people have trouble believing that someone who looks healthy is experiencing chronic pain. Even health care professionals think poorly of chronic pain patients, Verbic says.

For instance, Marianjoy RehabLink conducted an informal survey of health care professionals in its facility, asking them to name three words that came to their minds when they thought about a chronic pain patient. The top three words chosen were *malingerer*, *drug seeker*, and *faker*.

"That was amazing to me," Verbic notes. "Not even health care professionals understand chronic pain, and there's a bad stigma out there."

Chronic pain programs can help combat this stigma by educating staff about pain, its consequences, and its treatment. Comprehensive pain management programs can help improve chronic pain patients' quality of life and reduce their dependence on opioid medications. One study of a multimodal pain rehabilitation program showed that patients reported a significant reduction in pain levels and in opioid use, as well as increased sleep, after the program. Those improvements continued during a follow-up period.[8]

In recent years, there has been a growing medical consensus that managing chronic pain requires a special expertise and is best approached in multidisciplinary treatment programs that focus on the pain itself and the impact of pain on a patient's social, work, psychological, and spiritual life.[9]

COMING IN FUTURE MONTHS

- Is a long-term acute care program right for your facility?
- Rewarding workers can lead to happy, productive staff
- Improve patient quality of life based on survey showing what they really want
- Design alternative staffing model based on a seven-day week
- Try these creative methods for treatment planning

Rehab facilities already have physical therapists and occupational therapists, and they often have a psychologist, social worker, physiatrist, nurses, and other health care professionals on staff. Facilities with that staffing mix are in an ideal situation to take on the project of starting a pain management program. Such a program likely will include attention to psychological, social, behavioral-cognitive, and other interventions that can help patients better cope with and manage their chronic pain. **(See story on features of a chronic pain program, at right.)**

The multidisciplinary approach works best because people with long-term chronic pain typically become depressed and more socially isolated if their pain and its side effects are untreated, says Verbic.

"The longer the person has pain, the more each problem will be increased, so they'll have psychological problems such as anger issues or loss issues. And mentally they're not getting as much stimulation because they've isolated themselves, and they have concentration issues," she explains. "We're helping these patients get their lives back, and we're helping them do it for themselves instead of going from one physician to another."

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Here are key strategies for chronic pain programs

Focus on psychological, spiritual, and physical

Starting a chronic pain program requires a commitment to creating a multidisciplinary team and an exploration of various types of cognitive and alternative therapies. *Rehab Continuum Report* asked rehab pain specialists at three different facilities to explain how their programs work. Here are the strategies they outlined for managing a chronic pain program:

❑ **Create separate inpatient and outpatient programs.**

Northridge (CA) Hospital Medical Center has standard pain management programs for both inpatient and outpatient care. In the outpatient program, patients visit the facility for eight weeks, five days each week, and three to six hours each day. Their weekly schedules typically include three educational group sessions with a physical therapist, three with an occupational therapist, and one with a recreational therapist, says **Laura Schneeweis**, MS, OTR, pain program manager.

The programs also include two sessions of pool therapy, including a relaxation class in the pool, biofeedback, and several educational classes and support groups run by a psychologist, says **Heidi Race**, MA, OTR, occupational therapist.

"The emphasis in all the therapies is on having patients learn how to manage their pain," Race says. "We teach patients exercises and stretches they can do when discharged from the program so they don't need us anymore."

For example, an occupational therapist might teach patients how to open the refrigerator, how to make a bed, and how to lift items off of a counter in away that doesn't exacerbate back pain.

"We teach proper body mechanics: posture, energy conservation, goal-setting, and assertiveness training, with a goal of carrying on with activities of daily life," Race explains.

A pain program physiatrist will see patients about every other week to monitor medication management and therapeutic intervention, Schneeweis says. "Patients also participate in psychology groups throughout the week and are seen one time a week for individual psychotherapy with a psychologist," she adds.

The inpatient program is for patients who need more structure and therapy, including individual

therapy, Schneeweis says. "Patients who don't have the physical tolerance to drive themselves to and from their homes may be recommended for the inpatient program. They may have medication issues, such as some are highly addicted to the meds, and our goal is to detox and make them less dependent, and that's done on an inpatient basis."

Also, patients who have been in an outpatient program but failed to progress to independence may be recommended for the inpatient program.

❑ **Teach patients to eliminate pain behaviors.**

People who experience chronic pain often have fallen into the habit of indirectly expressing their discomfort through what are called "pain behaviors." These could include moaning, groaning, rubbing painful areas, facial grimacing, and wearing a brace or other support when it's no longer necessary physically.

Pain behaviors also include bracing behaviors, where a patient stands or sits in unnatural postures to avoid pain. But in the long run these only maintain their painful condition, says **Ralph Bruno**, PhD, rehabilitation psychologist at Walton Rehabilitation Hospital in Augusta, GA.

As a psychologist, Bruno shows patients how to study their pain behaviors and attitudes. "This is where the person's life is focused on pain and what they talk about are treatments that failed and physicians who didn't give them something they needed and all various aspects of pain, as it consumes their lives."

Occupational therapists and physical therapists at Northridge point out pain behaviors to patients, but not in an obtrusive way, Race says. For instance, Northridge therapists will keep a mirror nearby, so when patients begin to exhibit a pain behavior, therapists can pull out the mirror and show them their facial expressions. Therapists also will point out any of the other physical pain behaviors patients express.

The rationale is that people with chronic pain tend to isolate themselves socially by complaining about their pain and exhibiting pain behaviors. "For example, if you want to go to dinner with a friend and you have two friends to choose from, are you going to pick the friend who complains, 'My back hurts,' throughout the dinner, or will you choose the friend who doesn't talk about it?" Schneeweis asks.

The chronic pain team acknowledges patients' pain, but team members discourage any talk of it during the program. "People by nature complain about everything, and, yes, they complain about their pain," Schneeweis says. "A lot of them have been in pain for a long time, and it's difficult for them to let go of it."

❑ **Use psychological interventions.**

Walton Rehabilitation Hospital's chronic pain program teaches patients self-regulation skills for pain. These help distract patients from their pain, giving them new coping skills, Bruno says. "Distraction helps a person focus on something else so the pain goes into the background. The relaxation training helps a person reduce the autonomic hyperarousal, which accompanies most chronically painful states," he adds. "And it helps to turn down all the symptoms associated with distress, which includes increased muscle tension, heart rate, and blood pressure."

The Walton program also teaches patients how to reduce their fear and anxiety, because those emotions can exacerbate pain symptoms, Bruno says. "A lot of times, having the fear of increased pain is what keeps people from being active, and one main symptom of chronic pain is the disuse syndrome, in which a person has been inactive for so long that the body is starting to decline, with muscle loss, strength loss, and organ decline."

A facility that helps set goals

Marianjoy RehabLink in Wheaton, IL, has a program that covers psychological losses that are related to chronic pain. For instance, a patient may have lost his or her ability to work full time, says **Jevelyn Verbic**, RN, clinical nurse coordinator at Marianjoy RehabLink.

Chronic pain patients often lack adequate physical, social, and mental stimulation because they've isolated themselves. They have spiritual crises, prompted by the "Why me?" question, and their identities are in flux. "Most of the people who come into this program can't be what they used to be, such as a nurse or doctor or construction worker," Verbic says. "We encourage patients to set their own goals and look at themselves physically, spiritually, and emotionally."

The Marianjoy RehabLink program lasts five weeks, a total of 21 days, so patients are asked to write goals for what they want to be doing differently in five weeks.

❑ **Help patients change their focus.**

Walton Rehab's program teaches patients to shift their concentration and attention to the other aspects of their daily lives, as a way of helping them become re-engaged with routines other

(Continued on page 37)

REHABILITATION
OUTCOMES REVIEW™

Increase patient satisfaction with comprehensive program

Hospital also uses 'comfort zone' measures

When patients and their families walk into a rehabilitation facility or a hospital, one of the first things they'll do is either look for the floor or department they need to find or ask someone for directions to get there. If they feel that it's easy to find the right place, then they'll have a pretty good first impression of the facility.

If they can't find the direction signs or quickly obtain directions from staff, they may become frustrated and have a poor first impression of the facility, says **Carol Martin**, RN, BSBA, director of cardiopulmonary / rehabilitation services for Brockton (MA) Hospital. The hospital has 291 beds, rehab services, and a skilled nursing facility.

Good or bad initial first impressions will be reflected in patient satisfaction surveys. That's one reason Brockton Hospital created a comprehensive patient satisfaction program addressing all of the little, but important, facets of a patient's hospital stay. "If a patient needs instructions, the building staff provides it. If the air conditioning doesn't work well in the room, then we bring in a fan. We try to handle everything before complaints get out of hand," Martin says. Brockton Hospital started the patient satisfaction program after receiving a dismal customer satisfaction score on a survey conducted by Press, Ganey Associates of South Bend, IN.

The initial score, based on a 1998 survey, placed the hospital in the 34th percentile, meaning nearly two-thirds of the other hospitals surveyed scored higher. After the hospital started its new program targeting patient satisfaction, the scores rose, and finally, in October 1999, the hospital's score placed it above the 90th percentile. Press, Ganey recognized the hospital's success by naming it one of the finalists receiving the 1999 "Client Success Story" award.

The hospital has reaped some tangible benefits from the higher satisfaction rating. For example, a physician group from the other side of town recently switched from working with another hospital to referring exclusively to Brockton Hospital. "One reason they cited for the change was our high customer satisfaction," Martin explains.

Making patients happy

Raising a facility's patient satisfaction scores isn't easy, but it can be done with methodical attention to all services and care, including those that staff often deem unimportant. Martin offers these descriptions of some of the changes Brockton Hospital made as part of the project:

1. **Form teams.** The hospital put together five active teams to work on different areas that would contribute to improving patient satisfaction. All staff are encouraged to participate on a team or a subcommittee, and if they participate, they are expected to attend all meetings. The teams included:

- **Measurement team.** This team analyzes patient satisfaction scores and determines how the hospital could raise them through quality improvement initiatives. One objective is to make priorities and develop action plans specific to nursing units. Team members look for plans that will give the hospital the most improvement for the least amount of money.
- **Communications team.** This team is in charge of getting out the news about how the hospital is doing with the various quality improvement initiatives. For instance, the hospital has a newsletter

that highlights employee achievements, and the team has developed a bereavement letter sent by the hospital's chief executive officer to every employee who has lost a family member.

• **Standards and value team.** This team constantly reinforces the hospital's standards and values by holding events that reinforce them. When the hospital's patient satisfaction score reached the 90th percentile, the team spearheaded a celebration. It also kicked off the hospital's "WE CARE" campaign, which stands for welcome, empathy, caring, accountability, respect, and excellence.

The team educates staff about what is acceptable WE CARE behavior and what isn't. For instance, the team tells employees that letting a phone ring five times or longer is not answering it quickly enough. "We want to treat people as we want them to treat us," Martin says. "People are held accountable on their evaluation for those behaviors."

• **Reward and recognition team.** This team sets up the employee recognition programs and determines awards. One such award is the "Pacesetter of the Month" honor, given to the employee who most exemplifies the values the hospital wants in an employee. Those values relate to patient satisfaction.

The monthly awards for the Pacesetter honor include an anniversary clock and a personal letter from the hospital's president. The reward and recognition team, a hospital vice president, and the entire department gather around the employee to announce that he or she has won. Then, the employee's photograph is hung in the main lobby.

The 12 monthly Pacesetters are entered in a contest to see who will be named "Pacesetter of the Year." The winner, chosen by the team, receives a private, nearby parking space, coupons for entertainment items, and a gift certificate to use on a weekend trip.

• **Removal of irritants team.** This team looks for all the little things that might irritate patients and corrects them whenever possible. Sometimes the problems are so minor that — without the team focusing on this area — no one would have known they were sore points with patients.

One such example is that the hospital's emergency department didn't have any pillows. Previously, the department had supplied pillows, but they would often end up somewhere else in the hospital and never reappear. The team solved the problem by ordering green pillow cases. The housekeeping staff make sure there are enough of these pillows each day. If pillows disappear, they can be found easily because of the unique green color and then returned to the emergency department after washing.

2. **Make sure patients are comfortable.** The hospital's director of facilities became personally involved in making sure patients were comfortable in their rooms, implementing a "Comfort Zone" program. As part of that, he has assigned facilities workers to visit each new patient, handling a total of 20 to 60 admissions. They show patients how to use their call buttons, how to operate the television, and how to make sure their bed adjustments work.

Also, workers show patients how to adjust the temperature through the room's individual controls. If the patient's air conditioning isn't sufficiently cooling the room, the worker will bring in a fan. These visits take place within 24 hours of admission. The workers also ask patients if they are bothered by ambient noises or anything else related to their rooms.

"We've had several comments on patient surveys where people say, 'Even the maintenance man came in and asked me if things were OK,'" Martin recalls. "It made a big impact on patients that a nonmedical person checked on them."

3. **Remove irritants.** The hospital put together an entire team, consisting of managers and employees from the areas of maintenance, dietary, purchasing, housekeeping, emergency room, quality control, and medical/surgical, to work on removing patient irritants. The team met weekly, analyzed the patient satisfaction survey, and then interviewed patients, nurses, phlebotomists, clerks, and other staff to find out what most irritates patients.

The team first notified a particular hospital it planned to visit and then went to that unit to interview staff about both patient irritants and problems they themselves might encounter. "We brought coffee and bagels and sat in the nursing lounge," Martin says. "We spoke to respiratory therapists and social workers and others and said, 'What gets in the way of your doing your job?'"

Team members learned that patients were very concerned about privacy. For example, when a dietary aide delivered a tray to their room, they didn't want the aide to just walk in without first knocking.

"You want the staff to respect patients," Martin says.

Another privacy issue was that sinks were outside of the bathrooms in patient rooms. This meant patients had to wash up at the sink without the privacy of a door to shut. "So we installed a curtain around the sinks," Martin says.

They also learned that patients complained of receiving cold food. This resulted from the meals all being delivered within the same half hour, which meant that the staff didn't have time to deliver all the meals straight from the kitchen and instead had to leave some on a cart long enough for the food to cool. The hospital's dietitian solved this problem by staggering meal delivery times, so all the dinners could be delivered while hot.

Patients complained that the coffee tasted terrible: It was too watery and weak. Staff began to make it stronger, and the complaints stopped.

4. **Welcome all patients and visitors at the door.** The team decided that first impressions are very important, so they gave all managers an assignment to spend time in major entrance areas of the hospital to assist visitors and patients.

Managers each have one hour a week in which to play host or hostess. They welcome people at the emergency department entrance and the main entrance, and they escort people who need help in finding where they are going.

"We each have one hour a week we own for life, and if I can't make it to my hour, I have to find my own coverage," Martin says. "This has been really effective."

While the hospital can't pinpoint this program as a specific cause of greater patient satisfaction, it clearly adds to the whole perception of quality in the facility, and it has made managers more sensitive to patients' and visitors' needs. "So now when I see someone who looks like they're lost, I will take that person to their destination," Martin adds. "Everyone has become more helpful, because it's catchy."

When hourly workers see their managers providing this hosting service, they realize how important customer service is to their own jobs.

At first, managers resented this time away from their "real work." But after they became used to the idea of this one hour a week of service, they grew to look forward to it, Martin says.

Plus, the hourly commitment is part of their job performance evaluations, and no one is exempt. "We had vice presidents doing it," Martin says. "One vice president of finance was carrying a baby carrier and showing someone how to get to the maternity department."

5. **Reward staff.** Rewarding staff does not directly relate to patient satisfaction, but it can have an indirect effect. Satisfied employees, who feel their own contribution to an organization is noticed and appreciated, will be more likely to go out of their way to make patients comfortable.

The hospital's reward and recognition team has worked on a variety of ways to show employees how important their contributions are to patient satisfaction and quality care.

Awards go to employees who have perfect attendance for a month and to those who provide beyond-the-call-of-duty service to patients and their families. The "Associate Excellence" award goes to employees who are caught in the act of doing something extraordinary. One such honor went to a registration clerk who helped a woman whose son had just died from a gunshot wound. The woman was leaving the hospital alone and waiting for a bus to take her home. The clerk followed the woman and brought her back inside, giving her coffee and a bagel and letting her use the telephone to have a friend or family member come and pick her up. The clerk's co-worker told a supervisor about what she had done, and the supervisor nominated her for the award.

A "Manager's Choice" award is presented to managers who show extraordinary leadership skills. They receive a plaque.

All honors and recognition relate to quality care and patient satisfaction. "This is all about putting the patient first," Martin says. "It's not as difficult as one would imagine to understand and focus on what patients need and want, but implementing measures to make sure every patient is treated that way is by no means an easy task." ■

Need More Information?

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CARF strengthens definition of diversity

The board of CARF…The Rehabilitation Accreditation Commission of Tucson, AZ, has revised its definition of diversity, indicating the organization's interest in emphasizing its importance.

The revised definition is that diversity is "differences due to cognitive or physical ability, culture, ethnicity, religion, economic status, gender, age, or sexual orientation."

This new language is published in the new glossaries of CARF's standards manuals and will be applied to on-site surveys after July 1, 2000.

"The CARF trustees strongly believe that a diverse environment and nondiscrimination practices are essential to quality programs," says **Donald E. Galvin**, PhD, president and chief executive officer of CARF.

"Prejudice has no place in employment or service delivery," he adds.

CARF's accrediting divisions currently apply standards relating to diversity and nondiscrimination at each site survey. The organization encourages rehab facilities to be sensitive to patients' different racial, ethnic, and cultural beliefs.

Requirements

The *1999 Behavioral Health Standards Manual* requires organizations to demonstrate they do not discriminate in employment, compensation, place of work, or promotion.

Also, health care facilities must provide each patient served some information about the organization's nondiscrimination practices. The information should be communicated in a manner that is easy for the patients to understand.

The manual also advises organizational leadership to advocate for the removal of architectural, attitudinal, communication, employment, and other barriers to a nondiscriminatory policy. Each year, the organization must identify and address those barriers by implementing a written plan for accessibility improvement.

For more information about this policy or other accreditation issues, contact CARF at 4891 E. Grant Road, Tucson, AZ 85712; call (520) 325-1044, ext. 107; or visit the CARF Web site at http://www.carf.org. ■

(Continued from page 32)

than those involving pain. The Walton team includes nurses and physicians who provide medical management of pain. "Patients know their pain is being taken care of, but their mental focus has been swallowed by dealing with pain, so we gradually get them to focus on the routine and pleasurable aspects of life with friends and family rather than to just talk about their pain," Bruno says.

For example, the hospital had one elderly patient whose children met with the pain team at discharge and said, "We want to thank you for giving our mother back to us. Before, when we called her up, she'd only talk about how this medicine doesn't help and about her pain and all the people who hadn't helped her."

The woman hadn't realized that she allowed her pain to consume her life to the point that she couldn't relate to people anymore, including her own children.

"With coaxing and practice, we helped her understand there was a certain amount of pain she needed to live with," Bruno says. "And we helped her focus on the positive aspects of her life, and so after the program she'd call and talk with her children about their families and the different activities she was doing."

❑ **Develop a physical reactivity program.**

Physical therapists can develop a "physical reactivity" program in which they start patients at the level they can best handle when they enter the program and gradually increase their activity level to above their beginning pain threshold, Bruno says. "They also work on posture and body mechanics and gait, so patients can walk more evenly."

Occupational therapists will work on the patient's physical capabilities during functional tasks, including cooking, placing pots and pans in cupboards, and working at one's job without a pain flare-up. Therapists might even visit a patient's job site and make recommendations for modifications and adaptive behaviors one could use while performing a job; or therapists might provide patients with work simulation tasks that build strength and endurance, Bruno suggests.

❑ **Provide a pain support group.**

"Many of the people we work with are going to have lifelong problems with their pain, and this provides them with a way in which they can be reminded of their techniques if they backslide or don't apply what they learn," Bruno says.

Support groups also give patients encouragement when they maintain or reach their goals. At Walton Rehab, the support group is run by graduates of the chronic pain program, with a nurse as a facilitator.

"Sometimes it's just a matter of giving a person some encouragement and reminding them to not dwell on their pain," Bruno says. "Other times a person feels like he can't drive here and there and do things, and someone will say, 'I was in your shape three months ago, and now I go where I want to, and here's how I do it.'"

Support groups also might help patients work on assertiveness. Patients can prevent injuries or strains that may cause pain flare-ups by asking for help in an assertive manner, Verbic says. For example, when chronic pain patients go to the grocery store, they should ask store employees to take the groceries to their cars without fearing they are bothering the employees. They also should be able to ask for that help without going into detail about their injury and pain. "You need to say, 'I need my groceries taken out to the car,'" she explains.

❑ **Obtain reimbursement for the program.**

Marianjoy RehabLink typically has no trouble obtaining reimbursement for its program from private insurers and workers' compensation cases, Verbic says. "We work with the payer source to see what we could provide them in insurance coverage, and we try to sell the program as a package."

Northridge obtains a preauthorization from payers, including Medicare, for all patients who are referred to the program; unless patients have adequate reimbursement, they are not enrolled, Schneeweis says.

Walton Rehab has a case manager who works with insurance carriers to make sure all visits are covered and all services approved, Bruno says. "Different payers have been receptive, and others are not receptive to having patients rehabilitated for pain," he adds. "We try to lay out the best case possible in our evaluation, and then we demonstrate through our program that we're effective by keeping data on the progress patients make."

❑ **Use alternative treatments when needed.**

Walton Rehab's program uses no acupuncture, herbal remedies, or magnets. It does incorporate biofeedback equipment to monitor the level of arousal patients have and to show them how they can physiologically alter themselves through relaxation and mental-focusing procedures. "The

Need More Information?

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equipment gives them a sense of self-control because so many of them have lost themselves to their pain," Bruno says.

Northridge uses biofeedback, heat and cold therapies, and ultrasound treatment at the acute stages of pain but offers no acupuncture, says Schneeweis.

"Ultrasound is used for patients who might never have had any exposure to it before, but the emphasis is on fitness, flexibility, and creating a home program they can take away with them," Race says.

Marianjoy RehabLink might refer patients to acupuncture treatment if physicians and patients feel there will be a benefit. The facility also uses biofeedback to teach patients how to relax.

"They hook it up to the area of injury, and they measure the muscle activity, because the more muscle activity, the more pain," Verbic says. "Then the biofeedback technician tries to find a relaxation tool that helps to bring that muscle activity down and bring the pain down." The tool might be a 15-minute relaxation tape.

Marianjoy RehabLink also is developing a wellness center in which patients would have access to a variety of alternative treatments, including massage therapy, chiropractic medicine, T'ai chi, and other options. ■

Program for unconscious patients cuts LOS, costs

It's a response enhancement program

A small percentage of brain injury survivors remain unconscious after their injury, sometimes staying in a coma or other unconscious state for months. Brooks Rehabilitation Hospital in Jacksonville, FL, has developed a response enhancement program that more accurately identifies those patients' levels of consciousness and provides more efficient and effective care.

"These patients are suspected to have what we call a 'disorder of consciousness,'" says **Cynthia Beaulieu**, PhD, ABPP-Cn, senior clinical neuropsychologist for the hospital. "Trying to diagnose a disorder of consciousness is very tedious because there are so few things you can look at as to whether or not a patient is responding to what's expected. We have to determine a valid diagnosis before deciding whether they should remain at the rehab hospital or go into a long-term care facility."

Correctly diagnosing and treating the patient can save health care resources and time, Beaulieu says. Brooks Rehabilitation Hospital has compared length of stay (LOS) and outcomes data to patient outcomes data for 1997, the year before the program started.

The findings show a significant decrease in LOS once the program began. For example, in 1997, the hospital had five patients with disorders of consciousness; in 1998, there were six. The total rehab LOS, not adjusted for the greater number of patients in 1998, was a month less for the 1997 patients. The 1997 patients spent 100.8 days in rehab in a consciousness disorder state, and the 1998 patients who went through the special program spent 70.7 days while in that state. Some of those patients subsequently were referred to a long-term care facility, and some were referred to the rehab hospital's brain injury program, depending on whether they had regained consciousness.

The response enhancement program also was successful in improving the amount of time it took for patients to transition into the brain injury program. In 1997, three patients were transferred into the brain injury program, and it took them a total of 54.4 days to make the transition. After the program began, three patients took a total of 27.2 days to transition into the brain injury program.

"By solely structuring the way we assessed

and collected the data on these patients, we were able to cut the time in half," Beaulieu says. "The important thing is to identify those patients who will not benefit from rehab yet and get them into a less costly level of care."

The hospital's program addresses how to correctly identify, treat, and refer. "You need to feel comfortable that you are sending them into the level of care they need rather than having lingering questions regarding their level of consciousness," she says.

Before the program, clinicians were overly cautious in deciding that a patient was not rehab-ready and, therefore, should be sent to a long-term care facility, Beaulieu says. After the program began, the hospital sent patients who were not emerging from their unconscious states to long-term care facilities in about half the time it sent the patients who had not been part of the program.

Program has cost-shifting advantages

Beaulieu says the hospital has not yet analyzed all of the cost data but has found that more health care dollars are saved for patients to use after they emerge from the consciousness disorder state under the program. Before the program, about two-thirds of the patients' total charges were accounted for when the patient was in the consciousness disorder phase. After the program, less than half of the charges were accrued during that phase. That means patients with dollar caps on their health care insurance will have more money for rehabilitation if they regain consciousness, as some do, and those who do not will have more money for long-term care.

"We became more efficient in how we were using their money and using less of it when they were in the disorder of consciousness phase," she says. "Part of the program was to standardize who did what and when it was done, so it's the same people from day to day doing the same thing at the same time." Before the program, any therapist could have performed stimulation on a patient, and the record of what they did would not be seen by all disciplines involved with the patient, she adds. "Now everyone is aware of what everyone else is doing and what the results are."

Beaulieu offers this look at how the program works:

• **Improve assessment process.** The hospital formed a committee to determine the central modalities that are most crucial for determining the patient's ability to respond to the environment. The committee included Beaulieu as well as representatives from nursing, physical medicine rehab, and occupational, physical, recreational, and speech therapy.

The Brooks consciousness disorder team met weekly, discussing and searching for answers to these types of questions: What stimuli are best for determining a patient's ability to respond to the environment? How frequently do you have to assess the patient's responses to these stimuli? Once a week or twice a week? How often should the data be collected?

The team found that therapists often were overlapping each other in testing patients. Two therapists would apply the same form of stimulation at different times on different days and report very different results that could not be interpreted clinically. So the team developed stimulation protocols that control for how the stimulation is administered, who administers it, when it's administered, and how the patient's responses are scored.

The job of the rehab staff is to assess which state of consciousness best matches a particular patient's behaviors. The various states include:

— coma state, in which a patient shows no response to outside stimuli other than minimal reflexive action or a response to deep pain;

— vegetative state, in which the patient's eyes might open spontaneously or other small indications might reveal that the patient is responding to stimuli, such as grasping a finger when placed in the patient's hand or blinking in response to facial stimulation;

— minimally conscious syndrome, in which a patient shows a pattern of response to stimuli and may respond inconsistently to simple commands such as "shake my hand" or "open your mouth."

Another state that mimics the consciousness disorder states is the "locked-in" syndrome. In this state, patients are conscious but cannot respond to stimuli. They may respond visually and answer questions through eye blinking. This syndrome needs to be ruled out before a diagnosis can be made.

• **Hold team meetings and talk with the family.** Once a patient is referred to the hospital and is a candidate for the response enhancement program, the rehab team meets and conducts a comprehensive evaluation of the patient with all team members present. That way, everyone who will be treating the patient can see which behaviors the patient exhibits, if any. "Also, the team leader will

do a family interview to determine a variety of things about the patient, such as the patient's likes and preferences and dislikes," Beaulieu says. "So when we administer stimuli like music, we can play something the patient favored as opposed to something the patient disliked."

The team leader also finds out what smells are familiar to the patient and what type of textures the patient likes. The family is asked to bring in photos of family members and discuss any nicknames to which the patient might respond.

"We build these into what we do with the patient on a day-to-day basis," Beaulieu says.

• **Administer protocols.** For the first week, the hospital has one therapist administer stimuli protocols in the morning and a different therapist administer them in the afternoon. That gives the team two sets of data per protocol per day, and the team can assess whether therapists are rating the patient consistently and whether there are differences in the morning and afternoon behaviors.

Beaulieu compares those data to what occurs the second week, analyzing whether the patient has made any progress or shown any change in consciousness level. "Depending on these analyses, we determine whether or not our recommendation is for a continued stay, or, if they have gone two to three weeks without any change, then we look at discharge placement. If they change from week to week, we argue with third-party payers to keep them there."

The team keeps the family informed each week of the patient's prognosis and what it means. "So their hope is maintained, but they're not given false or unrealistic expectations," she explains.

• **Teach families to watch for change.** The treatment team encourages families to watch therapists test the patient's response, using stimulation. The team teaches them how one type of hand twitching or grasping might be just a reflexive action, while another indicates a response to the stimuli. "We tell patients that when a patient responds, it's more likely to be due to something the family has done rather than what we do, and that's why we encourage family involvement," Beaulieu says. ■

Need More Information?

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American Geriatrics Society: 10 Ways to Manage Pain

Because chronic pain often is seen as a normal part of aging, it can be disregarded by sufferers and unrecognized by doctors and other health care clinicians. The American Geriatrics Society of New York City formed a special panel on chronic pain in older people and created a list of recommendations for people who experience chronic pain:

✔ **Make pain relief a priority.** Whenever pain is present, providing treatment to relieve the pain is just as important as determining its cause. You should talk to your health care provider whenever you have painful symptoms.

✔ **Use standard pain scales.** Accurately describing pain is often difficult. For that reason, a standard measure such as a word list, visual, or number pain scale should be used to quantify the severity of pain and its response to treatment.

✔ **Use NSAIDs with caution.** Nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen and aspirin, can have significant side effects to varying degrees in older patients.

✔ **For mild to moderate musculoskeletal pain, use acetaminophen first.** Acetaminophen (e.g., Tylenol) often is the drug of choice for relieving mild to moderate musculoskeletal pain (under the direction of your health care provider).

✔ **For more severe pain, use narcotics.** Opioid pain relievers are effective for moderate to severe pain. Ask your health care professional if these pain relievers are appropriate for you.

✔ **What to do when the pain-sensing system goes awry.** There are a variety of non-narcotic analgesics that have proven to be effective in the treatment of some nervous system-related (neuropathic) pain. However, in such situations, doctors must monitor their patients very closely.

✔ **Do not rely on medications alone.** Non-pharmacological approaches include patient and caregiver education, cognitive-behavioral therapy, exercise programs, and other modalities. These approaches can be used alone or in combination with medication and should be part of the care plan for most patients with chronic pain.

✔ **What to do when patients still have pain.** Health care providers should not hesitate to refer patients to multidisciplinary pain management centers when pain relief goals are not being met.

✔ **Make narcotic opioid pain relievers more available.** Regulatory agencies should revise policies to make opioid pain relievers more readily available to older patients in pain who need them.

✔ **Learn as much as possible about pain.** Consumers should learn more about pain management. Also, education should be improved for health care professionals at all levels of training and experience.