

Rehabilitation

A publication from the Kessler Institute for Rehabilitation



Helping cancer patients meet the rehabilitation challenge

► Kathleen Francis, M.D.

Many people face a hard reality after winning a battle with cancer: The disease may be gone, but there are serious and permanent effects from both the cancer and the cure.

Thanks to advances in diagnosis and treatment and to lifestyle changes, the number of people who survive cancer is increasing. Cure rates and life expectancies have been improving dramatically since the 1990s. The five-year survival rate for all cancers combined is now 62 percent.

Even patients who will finally succumb to cancer are now surviving years longer than they once did. Often, these patients' functional deficits don't get the attention they

deserve, because their primary caregivers are understandably focused on battling malignant cells. But their cancer has become, in effect, a chronic disease, and treatment should include helping them achieve optimal quality of life. Rehabilitation services, both inpatient and outpatient, have a role to play in this effort.

Cancer's lingering effects

Chronic conditions seen in cancer patients, whether or not they are in remission, may include weakness, pain and difficulty with walking, and deficits in other activities of daily living. There also can be skin breakdown and problems with

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Focus on

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New faces, same core values

► *Bruce M. Gans, M.D.*

The old adage that change is the only constant has been much on my mind. That's because the Kessler Rehabilitation Corporation recently underwent a major change. Last September, our company was acquired by Select Medical Corporation, a national leader in long-term acute care and outpatient rehabilitation, with more than 75 hospitals in 24 states and more than 800 rehab clinics in the U.S. and Canada.

That sale brought personal changes as well as corporate ones: I moved out of my old office on a Friday and was open for business in my new office—in our flagship hospital in West Orange, New Jersey—on Tuesday, under new ownership and with additional responsibilities.

But despite the whirlwind of new faces, policies and procedures, I have been struck by how all of these many changes are enhancing Kessler's core strengths. It turns out that Select Medical's top executives have previously owned and operated rehab hospital companies. That gives them a tremendous depth of experience and tradition in working with rehabilitation specialists and facilities, an added plus that makes for an even better corporate fit.

They also appreciate the pivotal role of the physician in the delivery of health care. That's not to say that they don't value our other professionals—the nurses and therapists we depend on—but it does mean they understand the physician's key position in designing and implementing treatment and taking overall responsibility for the care our patients receive.

Our new owners also share our vision of excellence of care and are moving forward with us to broaden our clinical programs. With a commitment to substantially improve our facilities, they will help us grow our capacity to continue to deliver premium patient care.

They are just as committed to furthering Kessler's long-standing tradition in research and education. We will continue to have a close relationship with Kessler Medical Rehabilitation Research and Education Corporation (KMRREC), as well as with UMDNJ-New Jersey Medical School, to maintain our highly visible, national role in programs that provide cutting-edge research and educate clinicians.

And Select Medical's values echo our own. That became clear during the first meeting our physician leaders had with Rocco Ortenzio, Select Medical's executive chairman. He told us that after 35 years as a health care provider, he still considers it a privilege to provide care and services to patients.

That was a very powerful statement, a signal that this new corporate entity will view patient care in the same terms that we have all along. The Kessler name is still over our door, and we still retain the pride of recognition as one of the country's top rehabilitation providers. That pride is now shared by new owners who want to help us enhance our leadership going forward.

—Bruce M. Gans, M.D., Editor-in-Chief

Our new owners share
our vision of excellence
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Improving rehabilitation care with information technology

► Robert Krotenberg, M.D.

Today's nearly limitless uses of information technology make it an invaluable tool for optimizing patient care in acute rehabilitation facilities. Information technology not only makes physicians, therapists and other providers more efficient, it also gives doctors and facilities access to a wealth of clinical data.

National databases serve as one invaluable source of clinical data. For instance, physiatrists can now access databases that gather clinical information on a national basis for rehabilitation patients. Organizations compile and report these data based on the patient's diagnosis and functional status. IRF-PAI forms, which are required by Medicare for all rehabilitation patients, are used to compile the data. These forms are also useful patient evaluation tools that can help clinicians assess and measure the functional status of rehabilitation patients using a standardized numerical scoring system. The data also can help physicians gain a clearer idea of the expected time frame for treatment and aid them in setting individual outcome goals for patients, based on the standardized numerical scores.

Measuring performance

Physiatrists and administrators also can make use of national clinical databases that compare the performance of their facility against other rehabilitation facilities. This includes national data on outcomes measures such as the national aver-

age length of hospital stay, by diagnosis. With this information, rehabilitation facilities are able to measure their effectiveness against peer institutions by key criteria and identify areas for improvement.

Other databases compile patient

record that the patient began locomotion in a wheelchair, progressed to ambulation with a walker, then was able to walk with a straight cane. Because this information is recorded electronically, all providers have instant access to complete and up-to-date patient information. Physicians can even use the system to check on a patient, review patient records and place official orders from anywhere in the world through the Internet.

Minimizing error

Computer programs such as these also help avoid medical errors by providing a system of checks and edits. This includes comparing the dosage of a prescribed medication against a proper dose range and

checking for drug interactions. The program will also generate clinical advice; for example, it might suggest that a potassium level test be performed on a patient for whom digitalis is prescribed. At discharge, computerized summaries integrate all the patient information into discharge summaries that would normally have to be written by each provider.

As these and other advances in information technology continue to develop, the future will undoubtedly bring even greater improvements to rehabilitation patient care through the use of data.

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satisfaction data for rehabilitation centers. These facilities can easily generate "report cards" on everything from the quality of the food to satisfaction with patient rooms to grades for physicians and nurses. These data can further be broken down by diagnosis, so that rehabilitation facilities can rate patient satisfaction with specific programs and departments in their facility.

Electronic medical records also enhance patient care and outcomes. These records integrate data from all areas of the facility, including the pharmacy and laboratory, as well as physical, occupational and speech therapy. The patient's status and daily progress are entered into the main system, using PDAs or computer terminals. The patient's physical therapist, for instance, would

Growing force of consumer coalition can help amputees—and physicians

Seeking strength in numbers, a Kessler medical director also finds new insights into patients with limb loss

Consider this sobering statistic, says Terrence Sheehan, M.D., medical director of the Kessler-Adventist Rehabilitation Hospital in Rockville, Maryland: Due to the graying of the American population and rising rates of cancer and diabetes, the number of amputees over age 60 in the U.S. is expected to double within the next 10 to 20 years.

At the same time, some public and private payers are threatening to curtail access to acute rehabilitation for limb-loss patients. These insurers mistakenly believe that amputees can regain function with only outpatient or home-based therapy and care, and may even restrict—if not do away with altogether—patients' prosthetic benefits.

To confront those clinical and financial concerns, Dr. Sheehan is now working closely with the Amputee Coalition of America (ACA), a national consumer membership group funded through the CDC. The ACA is an increasingly vocal advocate for legislation and regulations to help limb-loss patients get the tools and benefits they need, including acute rehabilitation and follow-up services.

At the same time, the ACA is reaching out to amputees on a very personal level, with information that Dr. Sheehan—who sits on the ACA's Medical Advisory Committee—says has helped him provide more comprehensive and sensitive patient care.

Focus on Rehabilitation recently asked Dr. Sheehan about his work with the ACA and the challenge of caring for amputees.

FOCUS: How long have you been working with the coalition, and what other specialties are represented on its advisory committee?



It has been enlightening to work with an amputees' coalition, says Terrence Sheehan, M.D. (left), shown with certified prosthetist/orthotist Mike Corcoran, patient Leonid Usherenko and physical therapist Sandy Shehadeh.

SHEEHAN: I've been on the committee for more than a year. There is one other physiatrist, who represents the military, as well as podiatrists, surgeons, nurses and both consumer and disability advocates. Essentially, we are a resource for the coalition in meeting the clinical needs of amputees.

FOCUS: How important is it for those patients to have a strong advocacy group?

SHEEHAN: I think it's essential because health care for limb-loss patients has become increasingly fragmented—a trend we need to reverse. We've all seen the benefits that building coalitions has brought spinal cord injury patients, and that needs to happen as well for amputees.

Limb-loss patients who can access acute rehab with follow-up clinic services can enjoy real success in using a prosthesis and resuming their lives. But that access is being cut back, with patients instead

being sent straight home or into a nursing home. They aren't able to get the education and rehabilitation they need—and their prostheses end up in a closet, never to be used.

Without a strong coalition, patients won't have coverage. And without coverage, they won't regain function.

FOCUS: What do physiatrists gain from working closely with a consumer group?

SHEEHAN: Consumer advocacy can make a huge difference in the kind of care that we can provide. Patients who lack acute rehab coverage can't benefit from the team approach that is the real strength of our specialty—the therapists who can work with patients on endurance and conditioning, or the prosthetists they need for casting and fit.

Advocacy also has a big impact on the kind of devices our patients will be able to use. Some patients with a below-knee amputation may

have coverage for only one prosthesis in their lifetime—when prostheses wear out in just two to five years! Or patients may have no prosthetic benefits at all, at a time when technological advances have pushed the price of these devices to as much as \$40,000 each.

FOCUS: Has working with the ACA affected your life as a doctor?

SHEEHAN: Yes. It has made me more aware of the patient's point of view. In caring for patients' surgery sites and shaping the residual limb to get it prosthetic-ready, I see the medical issues involved. I work with others who participate in their care—surgeons, nurses, and physical and occupational therapists, as well as patients' families. But through the ACA, I've seen more clearly that patients have their own agenda for adjusting to this major change. Their concerns include "How am I going to drive?", "How can I find a vendor of prosthetics?" and "How can I adapt my house and get support for my spouse?" Now I can share with them a useful packet of ACA information called "Because We Care" (on the web at www.amputee-coalition.org/aca_bwc.html) and encourage them to sign up for a number of ACA programs and discounts.

That combination—of clinical care and personal information—really empowers a person who's been injured or impaired.

FOCUS: What is the biggest challenge facing physicians who care for amputees?

SHEEHAN: I'd say it's maintaining our team approach, whether it's in inpatient or outpatient rehab. Being able to do that often comes down to finances. If medical and rehab professionals are able to bill for their services in a multidisciplinary setting, care for amputees will be much more effective. As physicians, we need to build and lead those teams.

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Treating pain with opioids

► Joseph P. Valenza, M.D.

Many patients today live with excruciating—but treatable—pain. For patients with chronic, nonmalignant pain, the goal is to optimize function, and pain management is critical to achieve that goal. Medication is only one possible treatment, however, along with surgery to treat the underlying problem, physical therapy and anesthetic and psychological intervention. Effective pain management therefore requires a multidisciplinary approach.

If pain medication is required, Kessler adheres to the World Health Organization guidelines. Treatment begins with acetaminophen, NSAIDs or COX₂ drugs. Adjuvant drugs, e.g., Neurontin, Elavil or Gabitril, if pain persists. When more control is required, opioid mixtures, i.e., Percocet or Vicodin, could be considered. For individuals experiencing around-the-clock pain, long-acting opioids, such as the Duragesic patch, Oxycontin or Kadian may be used, along with a short-action drug such as Percocet or Vicodin for breakthrough pain.

Despite the effectiveness of opioids, however, many physicians are reluctant to use them. Barriers include fear of government investigation for possible overprescribing, lack of training on proper drug protocols and lack of understanding about addiction, dependency and withdrawal. The result is poor pain control, even in cancer patients.

Pain control is increasingly seen as a patient's right, and doctors have even been sued for not prescribing pain medications appropriately. This is particularly true in cases where acute pain evolved into chronic pain because of lack of

management. Several organizations have therefore addressed these pain issues and, as a result, pain is now considered the fifth vital sign. The Joint Commission on Accreditation of Healthcare Organizations, for instance, now requires that pain be evaluated in every patient.

Knowing the benefits and drawbacks of opioids is a key to pain management. For example, we know that if there is no history of drug addiction, the patient may become physically dependent, but the risk of becoming addicted to prescribed medications is very low. At Kessler, each pain patient undergoes a toxicology screen for illic-

it substances and a thorough drug history before opioids are prescribed.

It is now believed that tolerance to the analgesic effect of opioids is rare. Rather, the increased perception of pain some patients may feel over time is secondary to their increased activity. Also, patients tend to rate the pain at a higher level as time progresses. Lowering the dose or giving patients a short drug holiday may help them to better evaluate the continued effectiveness of the medications. Side effects of opioids are also a consideration, but most are mild and easily managed. Finally, we also know that opioids cause no long-term harm to organs, including the liver.

Eliminating common misconceptions can help both physicians and patients overcome barriers to effective pain management.

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Physicians' reluctance to use opioids can lead to poor pain control.

Looking for objectivity—and sanity

► *Bruce M. Gans, M.D.*

Those of us in the psychiatry community are facing a challenge that is both ironic and infuriating: At the same time that our research efforts are providing new tools to improve the care of people with disabilities, our industry's regulators seem to be seeking ways to deny patients the benefits of our care. Recently, those obstacles—from both federal and local regulators—have coalesced into what many of us see as the gravest assault on rehabilitation since Medicare was created almost 40 years ago.

From bad to worse?

We have long advocated changing Medicare's unfair and outdated "75 percent rule," affecting which patients are eligible for inpatient rehabilitation. We have told the Centers for Medicare and Medicaid Services (CMS) that its criteria have not kept pace with either medical advances or evolving patients' needs.

In response, CMS finally has proposed an update that, if adopted, would instead substitute an equally ineffective "65 percent rule" on the nation's roughly 1,200 inpatient rehabilitation facilities. While we assume the agency meant to be helpful, its proposed update would do more harm than good—and land us right back at square one, without adequate methods to define inpatient rehabilitation facilities appropriately nor guidelines to help us identify the patients who should be treated in them.

And, as if CMS's proposed changes aren't bad enough, now it's a one-two punch. Medicare's fiscal intermediaries in several states have published similar—in fact, virtually identical—draft local medical review policies (LMRPs) that prom-

ulgate horrifyingly restrictive medical-necessity determinations for inpatient rehab. Astonishingly, these LMRPs—if they were to take effect—would probably deny inpatient rehabilitation to the majority of patients we currently (and appropriately) admit to our facilities!

In publishing these policies, the carriers have shown themselves to be remarkably insensitive to and naive about the needs of people with serious disabling conditions. Even more frightening, they apparently lack the knowledge and understanding needed to craft reasonable criteria that work. That awareness

We need to defend our specialty's principles, promoting not just medical models of care, but also the need to improve patients' function.

has engendered a sense of crisis in our field—one we are rising to meet.

We have let CMS know that the LMRPs are both deeply flawed and grossly inappropriate. For local carriers to be delineating coverage rules when the federal definition of a rehab facility is in play simply makes no sense. Further, to do so without the meaningful input and participation of true experts in the field of medical rehabilitation is dangerously arrogant. Hopefully, by the time you read this, the psychiatry community's pleas to CMS and the intervention of Congress will have provided some sanity in this crisis.

The field has been advocating an external, independent body to create a blueprint of mechanisms and standards that can begin to serve Medicare beneficiaries properly. We believe the Institute of Medicine (IOM) is just such a body, one that

can be both objective and intelligent. We also expect that the IOM would work with us to incorporate our principles and theoretical framework into care standards and criteria.

Resolving the crisis

By turning to an outside body, we hope to break this logjam between our field and the regulators and achieve what we've asked for all along: an agreed-upon, reasonable set of standards that everyone—physiatrists, the CMS, its local intermediaries and our patients—can agree on. We believe that through expert opinion and a consensus

process (since Class I evidence really does not exist), tools could be developed that would generally and accurately define inpatient rehabilitation facilities (IRFs). Those tools would also make it possible to minimize the number of patients whose admission to

inpatient rehab would be a matter of dispute between the physicians making the decision and an intermediary who might review it.

To bring about these needed developments, we must continue both our local and national advocacy efforts to head off what could be a disastrous "perfect storm" of Medicare policies and operations.

We also need to defend our specialty's principles and values, promoting not only medical models of care, but also the need to improve patients' function within social and community settings. Their access to that care is under siege, calling us to engage with our medical expertise and our social conscience as well.

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How rehabilitation can help people with cancer

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speech, cognition, swallowing, nutrition and respiratory function. For some, lymphedema is also a serious complication.

Injuries to the brain

Many cancer patients face the effects of neurological damage. The disease itself can invade the brain, the spinal cord or the peripheral nerves, leading to permanent weakness and sensory or motor loss. Metastasis to the spine can cause symptoms similar to those in spinal cord injury patients, such as sensory or motor loss and loss of bowel and bladder control.

The treatments for cancer are even more likely than the cancer itself to cause adverse neurological effects, and many of them will leave the patient with serious long-term deficits. Chemotherapy may result in spinal cord effects, but these are often transient. Whole-brain radiation therapy, on the other hand, can lead to permanent cognitive deficits. Brain surgery can cause deficits similar to those seen in stroke patients, including paralysis, speech and cognitive impairment and problems with swallowing.

Pain is also a significant treatment issue for physiatrists who treat cancer patients. Pain may be a result of direct tumor invasion. Metastatic cancer can cause pain if it invades peripheral nerve or neural plexus tissue. Long-term pain from cancer is often due to radiation treatment or surgery or both.

A number of breast cancer surgery patients, for example, will experience chronic pain syndrome due to peripheral skin nerve damage from an operation. This syndrome can result, for example, when cutaneous nerves are cut, causing them to become hypersensitive. Radiation treatment can also cause nerve

damage and neuropathic pain. In addition, amputation patients will often suffer from phantom pains. And a study recently reported in the *New England Journal of Medicine* indicates that although pain occurs in 60 to 90 percent of cancer patients, it is adequately controlled in only 40 to 50 percent.

Lymphedema, the result of lymphadenectomy, radiation therapy or metastatic tumor invasion of lymphatics, is another serious chronic condition affecting a significant number of cancer patients. Although lymphedema can rarely be cured, close medical management can help prevent the dangerous

Cancer patients' rehabilitation needs often don't get enough attention, because their caregivers are focused on fighting the malignancy .

complications seen with this condition: disability, disfigurement, weakness, skin breakdown and chronic, recurring infection.

Who needs rehab therapy?

Multiple areas of significant disability are one criterion for admission to inpatient rehabilitation. Many cancer patients meet this requirement with a constellation of rehabilitation problems—including neurological deficits, deconditioning and problems with nutrition, speech, swallowing and mobility.

Cancer patients often require medical supervision, another factor in whether rehabilitation would be beneficial. Medical conditions requiring supervision are wide-ranging and include spasticity, incontinence and cardiac or pulmonary disorders.

The need for a prosthesis, orthosis



or other functional device is another factor in the admission decision. Some cancer patients with neurological deficits may also require careful assessment, particularly in terms of performing daily activities.

Setting goals for treatment

Establishing individual treatment objectives is integral to this process. In patients with poor prognosis and limited life expectancy, for example, rehabilitation goals may be to optimize independence while planning for timely discharge, so as to enhance the patient's quality of life during the remaining time with the family.

For all of these patients, comprehensive inpatient rehabilitation care has demonstrated effectiveness, and research has shown that cancer patients are often excellent candidates for treatment. One study indicates that therapy results in significant functional gain, regardless of the type of cancer. In another study, patients with brain tumors realized improvements comparable to those seen in stroke and traumatic brain injury patients who received rehabilitation therapy. Other studies have shown that the management of many cancer patients requires a team approach that includes both medical and rehabilitation supervision. For these patients, the need for inpatient rehabilitation has been demonstrated, as have the improvements it can bring about in patient outcomes.

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Rehabilitation consult plays critical role in acute patient care

► *Daniel Fechtner, M.D.*

Physiatric consultations in the acute care hospital have been shown to improve patient outcomes. One study, for example, found that rehabilitation consults done within 48 hours of a brain injury resulted in better mobility and shorter lengths of stay.

Identifying rehabilitation needs early—while the patient is still in the hospital and in some cases even if he or she is still medically unstable—can help decrease disability and the level of care needed after discharge. The physiatrist can identify impairments, prioritize rehabilitation care, work closely with other doctors to ensure that the therapy fits into the medical care plan and help choose the best setting for the patient after discharge.

Patients who can benefit

Individuals who have been diagnosed with stroke, amputation, spinal cord injury, cardiac illness, brain injury, arthritic or musculoskeletal pain or multiple trauma can most often benefit from a rehabilitation consult. Geriatric patients with debility from medical problems and patients with multiple disabilities are also likely candidates.

Rehabilitation treatments the physiatrist may order cover a wide

range. Promoting early mobility is one important function of the rehabilitation consult. The physiatrist can educate the patient and the nursing staff on how best to achieve this goal. Suggested solutions may be as simple as prescribing the proper cane, walker or limb brace. Swallowing problems, pressure sore and joint contracture prevention and loss of bowel and bladder control

The physiatrist should be an active member of the multidisciplinary health care team starting early in a patient's hospital stay .

are also issues the physiatrist can help to manage.

The rehabilitation consult can also identify patients who are not candidates for therapy. An unpublished study found that 15 percent of patients seen in such consults did not have therapy prescribed for them at that time. Most were too healthy; a few were too ill.

This indicates that hospital physicians may sometimes overestimate patients' rehabilitation needs, and that some physical and occupational therapy ordered by hospitals may not be necessary. Identifying

those patients who do not require therapy lets therapists spend more time with those who do.

Planning for discharge

Facilitating early discharge planning is another crucial advantage of the rehabilitation consult. Whether the person should return home or be admitted to a rehabilitation hospital, a nursing home, a subacute facility or outpatient treatment depends on a number of issues including level of disability, complexity of medical and nursing needs, ability to participate in rehabilitation and support available at home.

This important decision is best made early by the entire health care team, including the physiatrist and treating doctors, social workers, case workers and family members.

Impairment and disability occur the same time as the medical or surgical event. The physiatrist should therefore be an active member of the multidisciplinary health care team early in a patient's hospital stay to help minimize new disabilities and to begin his or her rehabilitation.

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