

Lessons Learned Through Leadership

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What is leadership? To create something new and bring it to fruition? To carve a path for others to follow? To see the future before its time? Fortunately, my career in physical medicine and rehabilitation (PM&R) has been all that and more. My personal philosophy is to understand function and to measure it so as to ultimately improve the patient's quality of life. My career has had fundamental challenges and great opportunities, which I can summarize as follows:

- Convincing PM&R clinicians to recognize both the importance of measurement and measuring the results of their efforts.
- Helping clinicians understand scientific measurement of latent traits, including functional independence, pain, and quality of life.

LOOKING BACK: A UNIQUE PERSPECTIVE

Having been elected president of the American Academy of Physical Medicine and Rehabilitation in 1975, I had the unique advantage of serving at approximately the midpoint of our 75-year history. When I completed my residency, physiatry was just 20 years old. Upon assuming office, I had practiced for 17 years. During my term in office (1975-1976), our nation was busy celebrating its bicentennial and the independent living movement was gaining steam. The 38 years that followed were to be among the most productive and life changing of my career. As we celebrate our 75th anniversary, I am proud to recall the challenges we faced and how our specialty and its leaders grew.

EDUCATION AND TRAINING

I am a third-generation African American physician. My father was a physician, as was my grandfather. I expected to be a general practitioner. After graduation from New York University School of Medicine in 1952 and a year of internship at a Long Island, New York, hospital, I joined my father in general practice. Within a year, however, I was drafted into the army. While in the military, I chose to pursue a 3-year residency training in PM&R at Walter Reed Army Hospital in Washington, DC. I accompanied the internist, neurologist, orthopedic surgeon, and rheumatologist on their rounds and perceived PM&R to be the general practice of the specialties. After Walter Reed, I transferred to the Letterman Army Hospital in San Francisco, where, upon completing my military commitment, I was honorably discharged with the rank of major.

CHALLENGES FACED

Once out of the service, I accepted a position as a physiatrist at Yale University School of Medicine and Yale-New Haven Hospital, where I practiced for 7 years. In 1968, on the recommendation of Frank Krusen, MD, I was offered and accepted a position as department chief of rehabilitation medicine at Tufts University in Boston, where I stayed until 1976. This was the time when problem-oriented medical records and SOAP (subjective, objective, assessment, plan) charting as well as team conferences were prevalent. Each of the clinical therapists (PT, OT, SLP), along with nurses, social workers, dieticians, and resident physicians were expected to write complete SOAP notes on every patient. As director, in preparation for patient team conferences, I read and commented on their SOAP notes, which was much too time consuming. While sitting in my office, surrounded by

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piles of paper charts, I said to myself, “There has got to be a better way.” We were a team in name only. After reading all those notes, it was apparent that we were silos of separate bits of information, each dutifully carrying out our tasks, each using his or her own profession’s language to describe the same patients. The challenge I faced daily was: How could all that information be put together quickly to come up with a common plan of action? An answer began to take root, one that would ultimately change the direction of my career.

All patients, no matter what their diagnoses, problems, or conditions, came to our rehabilitation center in need. By using his or her special knowledge and talents, each of our clinicians provided care and treatment, so that, on discharge, patients were improved and restored to better levels of health and self-sufficiency. Although we (the clinicians), our patients, and their families, all knew the services that we provided had value, it was vague as to what that specific value was. Would it be possible to define and measure that value? I began to realize that no matter what problem or condition patients presented to us, be it stroke or spinal cord injury or hip replacement, what we did, in essence, came down to improving their functional health and independence.

Function was the common denominator; however, the word “function” could mean many different things. I came to realize universal terminology and definitions needed to be created for function, accompanied by measurement standards that every member of the rehabilitation team could understand. Not surprisingly, I was met with great resistance. I was warned by my psychiatric colleagues that we did not have a reliable and scientifically based method to measure the characteristics of function as we did for other vital signs, such as blood pressure or temperature. In other words, it was not deemed possible to measure function. At that time, I did not take action toward my goal.

In 1977, I accepted a similar position at Brown University. I stayed there until 1983, when I received an offer to join the Rehabilitation Department at the State University of New York (SUNY) at Buffalo, where, at the invitation and encouragement of Glen Gresham, MD, I would now have the opportunity to pursue measurement of function.

CHALLENGES IN THE EARLY 1980s: DIAGNOSIS-RELATED GROUPS AND THE COMING OF PROSPECTIVE PAYMENT

In the early 1980s, the Health Care Financing Administration (today known as Centers for Medicare and Medicaid Services) implemented new cost controls on hospitals by presetting reimbursement levels for diagnosis-related groups (DRGs). Initially, inpatient rehabilitation facilities were exempt from the new regulation, but I knew it was only a matter of time before rehabilitation would be similarly affected. Medical rehabilitation was the low-hanging fruit on

the tree. Rehabilitation can be a resource-intensive, time-consuming, and costly endeavor; if we did not come up with a way to measure and prove the value of what we were providing for our patients, we would be at great risk to lose reimbursement for our services. We needed to find a way to measure the value of what we were doing. We needed to measure the unmeasurable. We began the work of defining and measuring function.

CREATION OF THE FIM[®] INSTRUMENT AND A UNIFORM DATA SET FOR MEDICAL REHABILITATION

With sponsorship from the American Congress of Rehabilitation Medicine and the American Academy of Physical Medicine and Rehabilitation, Byron Hamilton, MD, PhD, and I, along with key representatives of the rehabilitation community nationwide, formed a task force to develop a uniform data set for medical rehabilitation. Our goal was to develop a minimum data set that would be appropriate, to include only key patient functional attributes, those that were common and useful, that would be discipline free and acceptable to clinicians, administrators, and researchers. The task force also had to create a rating scale to measure the items. Finally, the tool, ultimately called the FIM[®] instrument (“FIM”) (Uniform Data System for Medical Rehabilitation [UDSMR], Amherst NY) had to be designed to be administered quickly and consistently, and demonstrated to be a valid and reliable measure. The FIM instrument would be used to track a patient’s level of function and functional independence from the initiation of inpatient rehabilitation hospital care through discharge and follow-up. Periodic reassessment would measure changes in patient performance over time and would provide data to determine rehabilitation outcomes.

The task force reviewed 36 published and unpublished functional assessment instruments, including the Barthel Index, to identify potential items and rating scales. Initially, the task force planned to only include physical functional items but, after much discussion and review, determined that it was essential to also include cognitive functional items. It was reasoned that, in some cases, cognitive factors could be as responsible or even more responsible for dependency than physical factors. The items selected for the FIM instrument assessed self-care, sphincter control, transfers, locomotion, communication, and social cognition. Although initially a 4-level rating scale was proposed, ultimately a 7-level rating scale was adopted to allow for improved sensitivity and tracking of functional changes of patients in rehabilitation.

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