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INSIDE

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Cultural diversity training, interpreter services required at rehab facilities

Federal law, Joint Commission standards make it a priority

In these days of changing reimbursement and continual focus on cutting costs, it may seem ridiculous for a rehab facility to spend thousands of dollars on a service that is not reimbursable. However, that's exactly what health care providers, including those in the rehab industry, might have to do if they want to ensure compliance with federal law and accreditation standards.

The service in question relates to interpreter and translation services for people who do not speak English or who are hearing-impaired. While this type of service might not have been given a second thought 10 years ago in many small and medium-sized communities across the nation, it rapidly is becoming essential nearly everywhere. Small towns, suburban communities, and other places that never attracted immigrants in the past now are the destinations of Hispanic, Asian, Eastern European, and other immigrants who are drawn to the area because of jobs in technology, construction, and other fields.

'There is more diversity than there used to be'

"We're seeing a lot of places where the non-English-speaking population used to be migrant — where people would come through, pick crops, and leave — but now they're settling down," says **Cindy Roat**, MPH, a quality assurance specialist for Pacific Interpreters in Portland, OR, and the executive director of Pacific Language Consultants. Roat also is the co-chair of the Board of the National Council on Interpretation in Health Care, also in Portland.

"I still do a lot of consulting around the country, and we've gotten an incredible number of calls coming from the South — North Carolina, South Carolina, and Georgia," Roat adds. "That Spanish-speaking population is now permanent, and we're seeing a lot of secondary relocation of refugee groups, so there is more diversity in those areas than there used to be."

Crozer-Keystone Health System in Upland, PA, has recognized the importance of interpreter / translation services as a way to offer better service to non-English speaking patients, says **Bonnie Breitt**, OTR, MHSA, administrative director of rehabilitation services for four Crozer-Keystone hospitals.

"With the 2000 census numbers, we've seen that our population in this country is changing," Breitt says. "And because rehab services focus so much on the needs of the person being served, we as providers need to be sensitive to the fact that the population we're serving is changing."

In Upper Darby, PA, there's been a significant increase in the Asian population, so the hospital obtained a grant two years ago in order to improve health care among that population. Also, the communities served by Crozer-Keystone have a large Hispanic population, Breitt says.

"We've translated numerous documents into Spanish, although the law only requires individuals to translate 3%," Breitt says. "Also, we've created a systemwide interpretation process so that you can access an interpreter any time in the day or night."

The health system contracts with Phoenix Language Services in Huntington Valley, PA, to provide interpretation and translation services.

"Our interpreters are primarily a conduit of information and also a culture broker," says **Bill Martin**, executive director of Phoenix Language Services.

For instance, interpreters are trained to use the body language that is mandated by various cultures, such as avoiding eye contact with Asian patients, who might view it as a sign of disrespect, Martin says.

In addition to legal and humanitarian reasons, there are some very practical reasons why the hospital pursued interpretation / translation services so aggressively, Breitt says.

"If you believe a patient has understood what you've said, but you've not appropriately assessed the situation, then you may lead the patient to inappropriate care," she explains.

Legal problems sometimes can arise when a hospital relies on a patient's family to translate the patient's questions and answers. For example, at one of the many hospitals receiving translation services by Phoenix Language Services, a woman was scheduled for a tubal ligation to prevent further pregnancies, Martin says.

"The woman's husband was doing the interpreting and had his own agenda," Martin explains. "The nurse realized something was wrong and so we had a professional interpreter sit in to get the woman's perspective, and we found out she didn't want the operation at all; it was her husband's idea."

Most problems with using family members as interpreters are less dramatic. For instance, suppose an older Asian male who is receiving physical therapy is being asked by his therapist to move in a way that the man finds very painful. The patient's daughter, who is interpreting, might not be able to ask him to follow the therapist's directions because she has been taught to respect her elders' right to do as they please, Breitt suggests.

"We probably use interpreter services every day," Breitt adds. "It's expensive and nonreimbursable, but we have to reinforce the importance of this, and it's required."

Using staff as interpreters may be risky

According to Title 6 of the federal Civil Rights Act of 1964, all patients who have difficulty with written or spoken English have the right to a qualified interpreter. In the past, hospitals and rehab facilities might have gotten by with having a Spanish-speaking employee serve as an on-call interpreter, but this type of practice may not be adequate, Martin says.

"Interpreters need training in terms of confidentiality and technique, and the phlebotomist or cleaning lady may not know these things," Martin says. "So from a risk-management point of view, the hospital is putting itself at risk for a potential medical malpractice suit if it uses staff

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as interpreters."

The 1964 Civil Rights Act has always had guidelines for providing language access to non-English-speaking patients, who fall under its umbrella because refugees are entitled to eight months of Medicaid when they arrive in the United States. But the law's intent was reinforced in 2000 when the OCR issued a memo making it clear that health care providers must make interpretation and translation services available to patients, Roat says.

"This caused all sorts of brouhaha around the country, and doctors were saying they couldn't do it," Roat adds. "They can look at this in terms of the cost of providing an interpreter, or they can look at the cost of not providing an interpreter: How can you provide quality health care to a patient with whom you cannot communicate clearly?"

In addition, research suggests that patients receive better health care when qualified interpreter services are available to them.[1-3]

References

1. Leman P. Interpreter use in an inner city accident and emergency department. *J Accid Emerg Med* 1997; 14:98-100.
2. Hornberger JC, Gibson CD, Wood W, et al. Eliminating language barriers for non-English-speaking patients. *Med Care* 1996; 34845-856.
3. Pochhacker F. Language barriers in Vienna hospitals. *Ethn Health* 2000; 5:113-119. ■

How to benefit from interpretation services

Everything from cards to telephonic interpretation

Here are some examples of interpretation and translation services and cultural diversity training that a rehabilitation facility might employ:

• **In-person interpretation by a professional.** Among the most costly of interpretation services, this sometimes is the best solution. The interpreter, usually contracting with the facility through an interpretation service, will meet with the patient and health care provider during regular or emergency medical sessions.

For example, interpreters from Phoenix Language Services in Huntington Valley, PA, often meet with rehab patients and therapists for each of the first few 45-minute to 1-hour sessions, because that's when most of the therapy information is being given, says **Bill Martin**, the agency's executive director.

"To make it cost-effective, we might not have the interpreter go there during every session," Martin explains. "The interpreter becomes an important part of the patient's therapy because the patient identifies more with the interpreter than with the therapist."

Other instances when it might be better to have an interpreter present are when it's the patient's first time in the hospital and when the physician has bad medical news for the patient, says **Cindy Roat**, MPH, a quality assurance specialist for Pacific Interpreters in Portland, OR, and the executive director of Pacific Language Consultants. Roat also is the co-chair of the Board of the National Council on Interpretation in Health Care, also in Portland.

The chief advantages to using a contract interpreter service rather than staff are that such services typically train interpreters in cultural issues that might affect a patient's health care. Another advantage is that these services have access to interpreters of dozens of languages, so that when a facility admits a patient who speaks an African tribal language or a certain Chinese dialect, then the service likely can provide help.

• **Telephonic interpretation services.** Interpreter services provided over a telephone may be useful when a rehab facility is located in a rural or suburban area where professional interpreters are not available or when the patient needs emergency care and there is not enough time for an interpreter to arrive on the scene.

Telephonic interpretation services also are a less costly alternative to in-person interpretation. Because there are more competitors providing this service, the costs have declined, Roat says.

"There's a lot of discussion within the industry about when it's better to use on-site and when it's better to use telephonic interpretation services," Roat says. "There is an agreement that sometimes telephonic is the best choice."

For example, if a clinician needs to call a patient at home, then the clinician could easily have an interpreter connected to the call. Also, if a rehab facility's interpreter service does not have anyone who can speak a particular patient's language, then the facility could call a national interpretation company and use its telephonic service, Roat says.

Examples of when telephonic interpretation

might not work well include when a patient is hard of hearing or when patients come from a cultural background in which telephones are not used, Roat explains. "A lot of elderly patients come from parts of the world where they didn't use a telephone until they were adults, and they may find it harder to receive health care over a telephone."

Telephonic interpretation services could be provided through headsets or telephones that are set up for a conference call in which the clinician, the patient, and the interpreter are all connected to the same line, or they could be conducted through a single telephone line that is shared and passed between the clinician and the patient. The latter scenario is not ideal, Roat says.

"Passing a telephone back and forth between patient and clinician forces the interpreter into the role of mediator, and that's not a good thing," Roat says.

The best method is remote simultaneous interpretation, which is similar to what the United Nations uses, Roat says. With this method, the patient and the clinician each have a headset telephone that communicates directly with the interpreter. As the clinician speaks, the interpreter simultaneously interprets for the patient, and the reverse happens when the patient speaks.

• **Translation services.** Crozer-Keystone Health System in Upland, PA, provides a variety of translation services to patients. For example, numerous clinical documents have been translated into Spanish, and some signs will be translated into Vietnamese for one of the system's hospitals.

Cards spell foreign words phonetically

Crozer-Keystone staff also may use interpretation cards describing access procedures and language cards that provide basic communication between patients and staff. The language cards display translations from 11 languages. The foreign words printed on the cards are spelled phonetically so staff can more easily pronounce the words, says **Bonnie Breitt**, OTR, MHSA, administrative director of rehabilitation services for four Crozer-Keystone hospitals.

The language card messages ask patients about pain or whether they're hungry, Breitt adds.

• **Cultural diversity training/conferences.** Crozer-Keystone staff are educated about the importance of using an interpreter and about the kinds of problems that occur when a clinician fails to call for an interpreter. They also are told about some specific cultural beliefs among patients from different ethnic and religious backgrounds, Breitt says.

At Delaware County Memorial Hospital in Upper Darby, PA, there is an Asian Awareness Day, in which management selects a particular Asian culture to highlight. Staff are taught about the culture's food and activities. At other Crozer-Keystone hospitals, the staff celebrate Black History Month, and the rehab staff create an educational program including posters, listings of area museums with information about black history, and information about African-American food, Breitt says.

"I think it's important in rehab that we look to the needs of the person being served," Breitt says, adding that these needs include the need to be fully understood by health care providers. ■

Here's a list of interpreter and translation resources

Internet has variety of free material

For more information about health care interpretation and translation services, check out these organizations and their web sites:

• **Cross Cultural Health Care Program**, Pacific Medical Center, 1200 12th Ave. South, Seattle, WA 98144. Telephone: (206) 621-4161. Web site: www.xculture.org/. The web site contains information about books, videos, articles, training, and seminars, and it has free profiles of a variety of ethnic communities.

• **Diversity Rx**, Resources for Cross Cultural Health Care, 8915 Sudbury Road, Silver Spring, MD 20902. Telephone: (301) 588-6051. Web site: www.DiversityRx.org/. The web site lists interpretation best practices and training sites.

• **Interpreters Division of the American Translators Association**, 225 Reinekers Lane, Suite 590, Alexandria, VA 22314. Telephone: (703) 683-6100. Fax: (703) 683-6122. Web sites: www.ata-divisions.org/ID/ and www.atanet.org/. The sites have information on how to find an interpreter, as well as a directory of articles, laws, and training sites.

• **National Council on Interpreting in Health Care.** Web site: www.ncihc.org/. The web site

contains a plethora of information, including links to other web sites about interpreting and translation.

Contact information for the two co-chairs of the Board of Directors is:

Shiva Bidar-Sielaff, MA, Interpreter Services/Minority Community Relations, University of Wisconsin Hospital and Clinics, 600 Highland Ave., Room G5/220A, Madison, WI 53792. Telephone: (608) 265-7424. Fax: (608) 263-7422. E-mail: s.bidar-sielaff@ncihc.org.

Cynthia E. Roat, Pacific Interpreters, 10548 Evanston Ave. N., Seattle, WA 98133. Telephone: (800) 311-1232, ext. 5638. Fax: (206) 362-7238. E-mail: c.roat@ncihc.org.

• **Society of Medical Interpreters**, P.O. Box 3304, Seattle, WA 98104-3304. Web site: www.sominet.org/. The organization represents interpreters in northwestern North America, from California to Vancouver, British Columbia. ■

New program helps satisfy HIPAA security rules

Encryption technology maintains confidentiality

While the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has the primary goal of making health insurance portable for thousands of Americans, the act also mandates new security standards and electronic data interchange requirements. These requirements are having far-reaching effects on the entire health care industry, to say the least, including the professionals who manage occupational health clinics.

A new software application called ZixMail, developed by Dallas-based ZixIt Corporation, is designed to help ensure compliance with those security regulations. The product, introduced at several beta sites during the year 2000, was formally launched this spring.

"In addition to meeting confidentiality requirements, it is important for us to facilitate efficiencies for cost savings that the increased use of technology affords," notes **Pat Feyen**, director of sales in ZixIt's health care division. "We are behind the curve in this regard compared to many other industries. This was one of the goals of HIPAA, in addition to developing standards to protect security, confidentiality, and integrity of private information."

HIPAA's security standards address administrative procedures, physical safeguards of information in computer systems, technical security, and technical security mechanisms, notes Feyen, who served as president and CEO for the Texas and Oklahoma region of PacifiCare Health before joining ZixIt. "There have to be policies and procedures in place within the affected entity," he explains. "They have to be approved by the security committee, people must be in place who are accountable for compliance, and you have to track access to 'individually identifiable health information' to desktops and to the database. If there is a way a reader can identify me with related health data, it has to be protected."

Encryption required

HIPAA requires this information to be encrypted before it can be moved electronically over the Internet, notes Feyen. "That's the part of the process we bring value to," he notes.

The strength of encryption in ZixMail will meet and exceed HIPAA standards and requirements, says Feyen. "Its other aspects as a business tool make it more efficient," he adds.

Here's how it works: The program is installed on a desktop computer, which takes less than 10 minutes. "It can be downloaded from our web site [www.zixit.com]; if the client is a large company, we can work with the system administrator to 'push' it to each computer," Feyen explains.

The users then create a password, and if they are using Microsoft Outlook or Lotus Notes e-mail programs, nothing else changes. "ZixMail is integrated with those programs," Feyen says. "You simply create an e-mail and grab all the attachments you need, as usual. Then, instead of clicking the 'send' button, you click a red 'Z' button, type in your pass phrase, and then hit 'send.'"

What happens then is a bit more complicated. In the world of encryption, there are both public and private keys. ZixIt stores and manages all of the public keys on its worldwide signature server in Dallas. "So, when I send you an e-mail and hit the red 'Z,' the message goes to the server, which grabs the recipient's public key and encrypts the message and attachments so they can be sent point to point," Feyen explains.

The private key is inherent in the software when

it's downloaded. "The only thing that will open the file is your matching private key," says Feyen. "That triggers the decryption of the message."

Unlike earlier encryption programs, ZixMail can be used by individuals who have not downloaded the program themselves, Feyen observes. "You can send your information to anyone. If the receiver has not installed ZixMail, the system knows that. Since the recipient does not have a public key, we use the worldwide signature public key, send it to the sender's desktop, encrypt the message, then send it back to the server and store it for anywhere from one to 21 days. The receiver is notified that they have a secure message waiting for them. They open it, click on the hyperlink, and through our secured connection it will go to the server and they can read or cut and paste and download the attachment. All of this happens instantaneously."

In this manner, says Feyen, the sender complies with HIPAA regulations by securing the message. The reply is encrypted as well. "But you can't initiate a new message unless you have installed ZixMail," he adds.

Addressing challenges

There are no universal standards when it comes to encryption technology, says Feyen, which causes some difficult challenges. "A lot of products are exclusive; that is, you can't talk to another institution if they are not using the same program you are. We've addressed the issues of interoperability and compatibility."

ZixMail also provides a certified receipt. "When I send you a message, I can check a box that says I want certified receipts notifying me of the exact time and date that you opened the message. I get a note back with that information. This is important, because there are time requirements for responding to claims, submitting credentialing information for physicians, and so on."

Feyen notes that ZixMail also is quite affordable. "The charge is only $24 per year per e-mail address," he says.

Of course, because ZixIt's health care initiative with ZixMail was just launched in March, the jury of users is still out. One such user, **Paul Porter**, security architect for United Health Care in Minnetonka, MN, is pleased with the results so far.

"From our standpoint, this one just works," he says, while noting that ZixMail is not yet considered to be an "authorized product" for United Health. "We don't yet have a formal relationship; we're still beta-testing," Porter explains.

Porter is testing ZixMail in several different groups, including the security group. "There's a tremendous need for secure messaging." he notes. "There are clearly some trade-offs one has to take a look at, and that's why we're trying to look at several systems. For example, once messages are encrypted, it's difficult, if not impossible, to discover viruses."

But, he adds, in light of HIPAA, encryption is a must. "This company [ZixIt] has done some non-standard things, and we have to wrestle with those issues," he says. "However, the other programs are not as automatic and user-friendly." ■

Need More Information?

- **Pat Feyen**, Director of Sales, Healthcare Division, ZixIt Corporation, 2711 North Haskell Ave., Suite 2300 LB36, Dallas, TX 75204-2960. Telephone: (214) 370-2005.
- **Paul Porter**, United Healthcare, Minnetonka, MN. Telephone: (952) 936-1300.

Weighty problem: Obesity raises risk of MSD injuries

Hospitals seek ergo equipment for bariatric patients

The rise in obesity in America has increased the risk of injury for health care workers and has created an ergonomic challenge, as hospitals treat patients who exceed the weight limits of traditional lift equipment.

Hospitals that provide services to bariatric patients, such as gastric bypass surgery, have a clear need for special ergonomics equipment. But because morbidly obese individuals often have serious health conditions, other hospitals are increasingly likely to treat these patients.

Hospitals should be aware of the limits of their transfer equipment, usually from 300 to 500 pounds, and should have a contingency plan for coping with larger patients, says **Guy Fragala**, PhD, PE, CSP, director of environmental health and safety at the University of Massachusetts

Medical Center in Worcester. "If they get a patient who comes in and they don't have the proper equipment to deal with it, they're going to have injuries," he says.

That is exactly what happened at Pitt County Memorial Hospital in Greenville, NC, when health care workers needed to care for a 600-pound patient. "We were in no way prepared. We had people injured," recalls **Patricia Dalton**, RN, COHN-S, administrator of occupational health at the hospital, which is part of the University Health Systems of Eastern Carolina. "It was just a nightmare."

The hospital immediately formed an interdisciplinary team to look into the issues and equipment needed for treating the bariatric patient.

How strong is your lift equipment?

The first stumbling block is finding appropriate equipment. When Northeast Georgia Medical Center in Gainesville began offering a gastric bypass procedure, physicians and managers anticipated that patients would not exceed 450 pounds. Lift equipment had a maximum weight of 600 pounds. But the hospital has handled patients of 650 pounds and higher.

"A lot of times, you can't see all the needs that are going to present themselves until you get into it," says employee health manager **Barbara Bevilaqua**, RN, COHN-S. "We're always looking for new equipment."

Ergonomics experts advise hospitals to locate a source of equipment and to have a contingency plan, even if the current patient population doesn't include bariatric patients. **(See resource list on p. 112.)**

"[Health care workers] should never try to move bariatric patients without assistance technology," says **John Lloyd**, PhD(c), MErgS, CPE, director of the biomechanics research lab at the James A. Haley Veterans' Hospital in Tampa, FL. "The patient could become combative, or the situation could change in the middle of a procedure in which they become more dependent or less dependent."

Although the number of such patients nationwide is small, transfers of bariatric patients are "responsible for a large number of injuries among nursing professionals," he says.

Hospital staff should be aware of the weight limitations of their current lift and transfer equipment and should consider the options of renting equipment or buying special devices.

"There are many companies that can get the equipment to you in just a couple of hours," says Lloyd, who coordinated the development of a Technology Resource Guide for the VA's Patient Safety Center in Tampa.

Patients may not know their actual weight

Lloyd also cautions employee health professionals to determine the true weight of the patient, either from available medical records or a bed-based scale.

"We had a patient at the VA nursing home in Tampa who came in and claimed to be 1,000 pounds. As a result, the staff refrained from using some of the handling equipment," he says. "When we were actually able to weigh the person, we found out he was only 450, and we have equipment to handle that."

Some hospitals have turned to innovation to solve ergonomic problems.

At Pitt County Memorial Hospital, engineers in plant operations worked together with an in-house ergonomist to design a motorized patient transfer device to assist in the transfer of bariatric patients from ambulances to the hospital. The device is self-propelled and adjustable.

"We would have bought them if there had been anything on the market that worked," says Dalton. "We couldn't wait until they were designed."

Dalton also discovered a product that uses seven-inch straps beneath the patient and allows for incremental movement. The product, made by AryCare of Shalotte, NC, makes it possible to turn the patient easily for skin care or bed changes.

"The straps stay under the patient all the time on the bed," says **Gene Smith**, president and CEO of AryCare and designer of the product. "They are coated with lambs' wool. We've had patients on these straps for 10 years who have never had bed sores."

At Salem (OR) Hospital, **Mary Ellen Ramseyer**, RN, manager of employee health, discovered the Hover Matt air mattress, which is useful in turning or moving a patient in bed or for lateral transfers, she says.

"In a normal situation, with a 200-pound person on a Hover Matt, it becomes extremely easy for one person to move that person," she says. "It doesn't take much effort at all."

Custom mats can be ordered for larger beds, or nurses can use two regular-sized mats, she says.

(Continued on page 113)

Ergonomic resources for bariatric patients

Following is a list of products designed to accommodate bariatric patients, compiled from information from individual manufacturers and the Technology Resource Guide of the James A. Haley Veterans Hospital Patient Safety Center in Tampa, FL. For more information, visit the center's web site, www.patientsafetycenter.com, and click on "Technology Resource Guide."

• **AryCare Patient Support Systems**, 146 Wall St., P.O. Box 220, Shalotte, NC 28459. Telephone: (800) 342-9018 or (910) 754-6476. Fax: (910) 754-9249.

The AryLift is designed to be positioned over a patient's bed and can be used to help reposition, bathe, weigh, or transfer a patient. AryLifts use 7-inch straps to allow gentle movement and repositioning. Models 707B ($9,880) and 707A (for home care, $8,580) can handle patients up to 500 pounds. Model C1000 ($28,500) is designed for use with patients who weigh up to 1,000 pounds. They include a portable shower hose and drain pan and a built-in scale.

• **Columbus McKinnon Corporation**, Mobility Products Division, 140 John James Audubon Parkway, Amherst, NY 14228-1197. Telephone: (800) 888-0985. Fax: (716) 689-5624. Web site: www.cmworks.com.

The CM Assist 600 Mobile Lift ($4,975), a battery-powered mobile unit, was specially designed for bariatric patients and has a weight capacity of up to 600 pounds. It is available with a digital scale.

• **Stretchair Patient Transfer Systems**, Largo FL. Telephone: (800) 237-1162 or (727) 531-2444. Fax: (727) 536-0666. Web site: www.stretchair.com.

The MC-800 Stretchair ($3,990), with a weight capacity of 800 pounds, can be adjusted to function as a wheelchair, stretcher, or bed.

• **Hill-Rom Co.**, 1069 State Route 46, Batesville, IN 47006. Telephone: (800) 445-3730. Web site: www.hill-rom.com.

The Magnum II Bariatric Patient Care System ($25,000) is a specially designed bed that can fold into a chair and can be used for transport. The bed also includes a patient scale and an X-ray cassette for upper-body X-rays. It has a low-air-loss surface, providing a cooling effect.

• **Patient Handling Technologies**, 603 North Second St., Allentown, PA 18102. Telephone: (800) 471-2776 or (610) 432-8753. Fax: (610) 433-9107. Web site: www.hovermatt.com.

When the HoverMatt mattress ($3,495) is inflated, it releases air from perforations in the underside, reducing friction and making lateral transfers easier. The company asserts that a lateral transfer with a HoverMatt involves 93% less force than with a draw sheet. The mattress does not have a weight limit; larger sizes are available for obese patients. Daily rental is available for $35 to $45 a day.

• **SIZEWise Rentals**, 7924 Stateline Road, Prairie Village, KS 66208. Telephone: (800) 814-9389. Fax: 913-652-6704. Web site: www.sizewiserentals.com.

The Bari-Lift & Transfer mechanical lift has weight limits of 750 pounds (lift) and 1,000 pounds (transfer). The Bari-Rehab Platform, a bed that can fold into a seated position, has extra width and length and a weight capacity of 1000 pounds. SIZEWise guarantees delivery within 24 hours and will provide emergency placement of equipment within two hours (plus travel time).

• **Wheelchairs of Kansas**, 204 W. 2nd St., Ellis, KS 67637. Telephone: (800) 537-6454. Fax: (800) 337-2447. Web site: www.wheelchairsofkansas. com.

The BCW Lift and Transfer ($7,380) has weight capacities of 750 pounds (lift) and 1,000 pounds (transfer). The Mighty Rest Rehab Bed ($6,100 to $7,700, depending on size and other factors), with a weight capacity of 1,000 pounds, has electric drive modules and can be used for transport. The company's other products include power chairs, wheelchairs, and chairs for use in bathing and toileting. The company specializes in products geared toward bariatric patients. ■

Equipment innovations are likely to improve as companies strive to meet the needs of this portion of the patient population. Almost one-fourth of Americans have a body mass index above 30, according to federal health surveys. People with a body mass index above 30 are considered morbidly obese.

Health care workers also need education on good body mechanics, how to use lift equipment, and team work to minimize the chance of injury, says **Rick Barker**, CPE, manager of patient and caregiver safety for Hill-Rom in Batesville, IN, which produces a bariatric bed and chair device.

The serious health care needs of bariatric patients make the availability of lifts and transfers even more important, notes Dalton.

"If you're going to accept these patients — whether they're coming here for that [gastric bypass] procedure or not — these are not healthy people," she says. "They might just as well show up on your doorstep for an appendectomy, heart attack, or stroke. You can't say you're not going to take them, because there's no one else to take them." ■

Data, data everywhere, but what do they mean?

Don't let volume be a distraction

Health care organizations are experiencing the mixed blessing of the best of times and the worst of times: Data are everywhere, providing a rich opportunity to streamline operations, improve outcomes, and save money.

But it's also a time when the sheer volume of requests for data and the necessity to report the results to various audiences are vexing many a hospital administrator.

"We work with hundreds of hospitals, and it is very common for all of them to gather data, try to explain them in too short a time, and not do anything with them afterwards," says **Angie Merkel**, MBA, director of the Ann Arbor, MI-based consulting firm The Medstat Group. "And as data become more important to the hospitals and more departments and people depend on them, more reports are generated."

The topic was a popular one at Medstat's recent client conference. "Every head in this presentation was nodding," says Merkel. "Everyone understands and identifies with this challenge. Hospitals have a lot of sources of information and data and many users and many audiences with varied levels of sophistication. Most hospitals have to gather data and present them in a meaningful manner to many audiences so they can understand them, internalize them, and put them to use. It's a real challenge."

But not all hospitals are up to the challenge, Merkel says. If your hospital can't manage data effectively, "you can't use your data as a quality improvement tool," she points out.

Andree Joyeaux, director of communications at Medstat, says that it's just as bad to have the right data presented poorly as it is to have poor data presented well. "Or you can have the right data, well-presented, but without action steps. If you fall down on any one component, you lose the use of them."

There's no point in doing all the work to collect data if you can't use them, says **Judy Sikes**, PhD, CPHQ, director of accreditation / medical staff services at Parkview Medical Center in Pueblo, CO. Sikes gave a presentation at the Medstat conference based on her experience at Parkview, a 305-bed hospital.

"There is so much information and only 15 minutes to talk about it," she says. "We have a very involved board, but I don't think they have enough information to be a resource."

Remedial classes were held at the conference to get attendees up to speed. Sikes did inservices on how to analyze a chart and asked board members what they needed to help make the data more meaningful. "Until that happened, I would spend all this time putting these data together into these nice reports. I'd give it to them and even though they cared, it was just too much information in too short a period of time, with too little supporting information."

An example is the ORYX indicator on mortalities for acute myocardial infarctions (AMI). "I would present data that shows we were 1% lower than the national average [of 4%] and to comparable ORYX data," says Sikes. "They'd think that was great. But it's not enough. We want to look at that 3% and see what we can do better."

Another type of data used is the documentation of the Glascow Coma Scale for head injury patients in the emergency department. The hospital was about 42% compliant.

"I looked at that and thought we could do better, but if you look at the national data, [that rate

is] 37%, and [the rate for] ORYX data is 30%," she says. "You have to question if this is an important indicator, because it's just not enough to be better than the rest."

Looking deeper into the data, Sikes and her team found that there was a problem in data collection. "When discharging people, we had put a code of 20 for discharge to home, but that was coming across as discharge to acute care bed in our software."

A manual chart review changed the data to show Parkview was doing even better than the 45%. "We are still working on it, but we think now we are at 58% to 60% compliant. We don't have a lot of cases. There are a lot of exclusions for this indicator. But the board can really get into this story. It's not just, 'We're at 42% — end of story.' They understand that it's not enough to just be better."

Present more than just numbers

The goal can't simply be to reach 100% compliance for every target, Sikes explains. "The goal has to be doing better than we did last time."

The number is important, she admits, "but it is more than simply a number. We have to try to think of the difference between numerative and analytic statistics. If you say we are at 3% mortality rate and want to know all about that 3%, you can find out how many patients came from out of town, who were the insurers, who were the physicians, and whether they got early referrals. We can find out maybe that a lot of these mortalities were people who missed physician appointments. Maybe reducing that number further is as easy as instituting a reminder program."

When board members hear more than numbers, Sikes adds, "they are more likely to help with resources and direction."

Another trick Sikes has learned is to weed out extraneous data. She sat down with the CEO and the vice president of medical affairs to try to come up with a way to provide more information in less time. "We just have to weed out the nonessential numbers. We can't ask board members to take home everything. What is the information that is really vital?"

She took a typical ORYX report and looked at it. "One data collection tool indicates the day of the week that an AMI patient came in. That's five pages of graphs, but it doesn't make a difference. I'd rather give them something about what causes the 3%."

Sikes asked department heads what might be potential causes for those mortalities. It's really hard to get physicians to commit their time to serving on committees, she says. "But if you can take them data that are valid, they will look at them and respond. Show them what will make a difference to even one patient, show it concisely, and they will look at it."

Parkview now has more physician participation on the quality improvement committee than ever before. "One physician even wants to work on a policy on wrong-site surgeries and sentinel events. We've never even had this happen here, but he wants to create a system to make sure it never does."

If you don't look at data from all sides, you can't find relevant information, Sikes argues. "You have to collect and report these data for [the Joint Commission on Accreditation of Healthcare Organizations] anyway. You might as well make a difference with them. When we first started doing this in 1998, everyone collected data, but 90% wasn't earth-shattering — things like how many phone calls do you get a day. Now we ask the people who do the jobs what data are important."

With such small profit margins in health care and declining reimbursements, "you can't afford to stay in business if you aren't doing productive things that make your organization better."

Easing the documentation burden

There are morale reasons for making the data count, too, she adds. "We have a shortage of nurses around the country, and there is more documentation and paperwork they have to do than ever. If you ask them to collect more data, but ensure [the information] is meaningful and will help the patient, they will do it. If not, they won't like it."

Taking a single piece of data and acting on it without looking deeper into its meanings can lead to mistakes, too, says Sikes. "Your decisions may not be valid if you don't have the whole picture. You can actually do harm if you only look at one characteristic of a piece of data."

The problem, Sikes says, is that there is too much paper and too little time. Also, different stakeholders often need different materials. While process improvement committees may need to see some data monthly, the whole board may only need to see them annually. Physicians may want to see quarterly data.

"I've taught classes on data collection for years," says Sikes. "I have found it's a real waste of time to use nonpertinent examples, both in teaching and in reporting." For instance, when she first started teaching senior managers, most of the examples were about manufacturing. "That was really hard to translate for us. But once you make it interesting, they are more likely to learn."

Now she uses a particular committee's or department's own reports for teaching. The same goes for reporting. Why give a surgeon information on claims denials? If it doesn't speak to the listener, he or she won't hear it. "All the data we take are tailored to the audience we take them to," she adds.

Make sure the design of your reports is appropriate. Sikes says to make sure that extensive use of graphs and charts is made with a short analysis, pertinent information, and any recommendations included. Sikes' phrasing is boxed and follows these lines: "We looked at this data and found X. Therefore we met with X and discovered X. Based on that information, we recommend the following action: XX."

How can you tell if you need to overhaul your data collection and analysis systems? Here are three signs, says Sikes:

1. You spend more time discussing what the word "ORYX" means than what the process is.

2. You report data, but you don't address them.

3. Reports go into a "Reading — for future review" file (a.k.a. "Not Important").

If you need more indications that something is wrong with your data reporting and analysis system, does this scenario sound familiar? You report your data quarterly, make copies of graph pages, allow 15 minutes at a board meeting to present and answer the questions, and get very few questions because no one understands the material. ■

Need More Information?

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CMS: Patients should get pain management info

A statement from the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) is adding more pressure on health care providers to improve their pain management programs. Health care facilities already were facing pressure from the Joint Commission on Accreditation of Healthcare Organizations' new pain management standards.

CMS' action is not new, but the agency recently released an opinion underscoring what it has expected from health care providers all along. The CMS opinion stated that information about

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pain management must be conveyed to patients. The opinion came as an answer to a petition to CMS from a coalition of patient advocacy groups.

In response, CMS sent a letter that clarifies its position on pain management. **Jeffrey L. Kang**, MD, MPH, director of the Office for Clinical Standards and Quality at CMS, wrote that patients have a right to be informed of all aspects of their medical care, including pain management. Not only is pain management included under medical care, he said, but it is a "critical aspect of care."

Kang says the agency's surveyors will discuss pain management as part of their survey to assess compliance with state and federal laws. The petition came from a coalition that includes Americans for Better Care of the Dying, the American Academy of Pain Management, the American Pain Foundation, Compassion in Dying, the Medicare Rights Center, and Partnership for Caring (formerly Choice in Dying).

The coalition petitioned CMS to amend its Patient's Rights Conditions of Participation to require Medicare and Medicaid providers to:

- inform patients of their pain management rights;
- identify pain management as a critical aspect of medical care;
- explicitly acknowledge that patients have the right to make informed pain management decisions;
- inform patients of any pain management rights they may have under state law.

CMS denied the requests made in the petition but made clear that it supports efforts to improve pain management. The only reason CMS rejected the petition, Kang wrote, was that CMS already considers pain management "a critical aspect of care." No change in policy is necessary, he wrote.

Kathryn Tucker, JD, director of legal affairs with the Compassion in Dying Federation in Seattle, says the CMS letter means that all U.S. health care providers who participate in Medicaid or Medicare are operating under equivalent pain management requirements. Prior to CMS' clarification, the coalition was concerned that some facilities not accredited by the Joint Commission would not be held to the same pain management standards.

Tucker says the CMS clarification should urge all health providers to manage pain effectively. Joint Commission-accredited organizations risk losing their accreditation by not complying, and others that are not accredited risk losing their Medicare and Medicaid financing by not complying with CMS' expectations.

Kang wrote in his letter that the Hospital Interpretive Guidelines (issued June 2000) explicitly direct the surveyor to ask if the patient has been notified of his or her right to be informed of his or her health status; has been informed of his or her prognosis; has been involved in care planning and treatment, including pain management; and has been given the opportunity to request or refuse treatment.

"We believe that pain management is included under medical care as it involves the mitigation and treatment of pain, and that by including it in our interpretive guidelines, we have identified its as a critical aspect of care," he added.

When surveyors look at whether facilities meet the requirements of applicable state and federal laws, including the Patient Self-Determination Act (PSDA), "pain management should be discussed. We also believe that it is the clear intention of the PSDA to allow each individual state the flexibility to determine the most effective manner to comply with its own laws regarding the right of each patient to request or reject the use of effective pain management," he wrote. ■