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INSIDE

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Rehab facilities will have a variety of challenges under new privacy regs

AHA says changes are needed in standards

With the rehabilitation prospective payment system (PPS) and work force hiring concerns at the top of rehab facilities' priority lists, there may not be much time to prepare staff for the changes required by the final Standards for Privacy of Individually Identifiable Health Information from the U.S. Department of Health and Human Services (HHS).

However, rehab industry leaders say facilities will need to educate staff and become more sensitive to patient privacy issues if they are to follow federal regulations developed as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

"I think the oral communication aspect of the privacy rules will be the most challenging because we're worried about possible breaches of that in hallways and cafeterias and elevators," says **Pamela Rezac**, EdD, FACHE, president and chief executive officer of Avera Sacred Heart Health Services of Yankton, SD. Rezac is the 2002 chair of the American Hospital Association's Section for Long-Term Care and Rehabilitation.

Executive Summary

Subject:
The new privacy regulations spell major paperwork hassles and other problems for rehabilitation providers.

Essential points:

- ❏ Staff will need to be taught how to be sensitive to the possibility of privacy breaches during oral communications.
- ❏ When rehab patients are referred to other services and providers, the current regulations require a special business associate contract to be in place before the patient's health information can be discussed.
- ❏ Health care providers object to the regulation's stringent requirement for patients to sign prior consent with regard to the disclosure of their health information.

Since the rehab industry typically has a longer length of stay and a more mobile patient population than do acute care hospitals, there's an increased possibility of patient information getting into the wrong hands, says **Robert Main**, president and chief executive officer of Siskin Hospital for Physical Rehabilitation in Chattanooga, TN. Main also is chairman of the board of the American Medical Rehabilitation Providers Association (AMRPA) in Washington, DC.

"The hallmark of rehab is teamwork, and there are many different providers involved in treatment, and all of them need to be mindful of HIPAA regulations," Main says. "During conversations in departments, they need to be careful about saying anything in front of patients."

HIPAA is going to be an enormous issue for all providers, says **Carolyn Zollar**, JD, AMRPA vice president for government relations.

"We're concerned about smaller providers and the extra burden that is involved with HIPAA," Zollar says. "So we're very interested in seeing what proposals the administration has to simplify and alleviate some of this burden."

The American Hospital Association (AHA) and other health care industry organizations wrote a letter to HHS Secretary Tommy Thompson in the fall, asking Thompson to consider several areas of concern about the privacy regulations and to make changes before the April 2003 deadline. These areas of concern include consent, research, minimum necessary requirement for use of private health information, provisions concerning business associates and marketing, oral communications, unlimited access to records, and state law applicability.

Then, in December, AHA wrote directly to President George W. Bush, urging that HHS issue a notice of proposed rulemaking to fix those portions of HIPAA medical privacy rules that have the greatest potential to undermine patient care and hospital operations.

"HHS' now nearly eight-month delay in issuing new rules to fix the privacy rules' serious and unintended consequences has contributed substantially to hospitals' mounting anxieties about the fast-approaching compliance deadline," AHA wrote in the letter to Bush.

In January 2002, HHS announced that the department would be publishing some changes to the privacy regulations, but provided no details.

Contracts required for sharing information

Rehab providers may be particularly concerned about the business provider provision.

"There are so many different entities involved in a patient's care, and they need to have information about the patient," Rezac says. "In an effort to continue the continuum of care, we don't want to hamper the flow of that information."

However, the regulations as written would appear to do exactly that. AHA claims in the letter to Bush that the business associate contract requirement is redundant and unnecessary.

"If we wanted to make arrangements with a vocational rehab facility so that the patient could then have the vocational training that can be provided by a state-sponsored rehab, then we have to have some particular specific business associate arrangement with them in order to share information," Rezac says.

"In the past you could call on the phone and maybe discuss the case situation without a business associate contract," she adds.

While it won't hurt rehab facilities to have formal business associate contracts, it could hamper communication and leave providers bogged down in paperwork before they can have a discussion about a patient, Rezac explains. "It will slow the process down."

Besides vocational rehab, other potential business associates would be durable medical equipment suppliers, home care agencies, and long-term care facilities. Whenever a patient needs to use a company that is outside the rehab provider's normal circle of referrals, it will require additional time-consuming paperwork.

The health care industry told Thompson in the letter, dated Oct. 23, 2001, that the contracting

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requirements of the business associate rule are unnecessarily burdensome.

Another major concern raised by the health care industry involves the effect the privacy rule might have on oral communications between staff and providers.

"We remain concerned that the rule could inhibit oral communications which are a part of TPO [treatment, payment, and health care operations]," the letter to Thompson states. "Covered entities should be able to freely engage in communications in the health care setting that are necessary for TPO."

At Avera Sacred Heart Health Services, there is a "Bee Alert" program that is designed to make staff more aware that there needs to be respect for patients' privacy during oral communications, Rezac says.

"We've had it for five years, and we'll promote it as we move into issues of oral communication," Rezac says. "Our worry is that there will be some type of interpretation in times to come that is different from our understanding now."

For instance, will HHS impose penalties for organizations found out of compliance, and how conservatively should rehab providers interpret these privacy regulations?

"We're being very watchful and studying it very closely," Rezac says.

Main wonders whether rehab providers will need to take extra privacy precautions when patients are taken outside the facility for certain medical procedures or for community re-entry projects.

"Whenever the patient and medical record are taken outside of the hospital for procedures not performed here, we need to be sure they are protected," Main says.

Other situations where privacy might now become a concern involve group therapy sessions where patients and therapists discuss adjustment or a person's particular disability, he notes.

"There are going to be situations we're confronted with that typically won't happen in an acute care hospital," Main says.

The health care industry also is greatly concerned about how the regulations require consent from patients and what type of impact the rules might have on research. Both issues will affect rehab providers, as well as acute care hospitals.

"We continue to urge that the department fix the underlying policy problem with the prior consent requirement through new rulemaking by returning to the regulatory consent approach taken in the proposed rule," the letter to Thompson says. "That is, covered entities should be able to use and disclose personally identifiable health information (PHI) for treatment, payment, and health care operations without obtaining prior consent."

As far as research is concerned, some rehab providers have shared their patient databases with researchers to permit follow-up of patient treatment outcomes. The AHA and others in the health care industry fear that there will be a chilling effect on this practice under the final rule.

"The rule's authorization provisions are overly prescriptive, unworkable for many types of research, and unnecessary where a subject is already providing informed consent to participate in research," states the letter to Thompson. "The rule's overly narrow exception for public health disclosures does not permit a workable system of voluntary post-marketing surveillance or voluntary health and exposure registries."

While the health care industry waits to see whether HHS will modify the final privacy rule and to see how the regulations will be interpreted, it's still a good idea to begin to prepare for the necessary changes and staff education, Main says.

"We have an active committee working on this," he says.

Siskin Hospital has required staff to attend eight to 10 inservices a month through the fall and winter in an effort to prepare employees for PPS. Now the hospital will need to add additional inservices to cover HIPAA and the privacy requirements.

"Most definitely there will be many, many inservices," Main says. ■

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Space suits, video games may be in rehab's future

Investigators develop new high-tech tools

Cerebral palsy, spinal cord injury, and other rehab patients may one day have new and innovative tools to help them improve function, thanks to research that's now under way.

Among the new technology being studied is a device that works in a similar way to a Russian space suit that was used on the Mir space station. Another project involves a wheelchair that is interfaced with a computer racing game. A third area of new research involves assessing muscle activity in patients who have hip joint fractures, and a fourth study will evaluate a new rehab strategy, called intentional focus, to determine whether it improves outcomes for stroke patients.

While the research areas are diverse, the investigators share a common goal of improving rehabilitation for future patients. Here's a look at several promising research projects and potential new rehab tools:

• **Axial load suit project:** No longer called the "space suit project," as the actual Mir space station suit was returned to the National Aeronautics and Space Administration (NASA), the suit project is under way at the Rehabilitation Institute of Michigan in Detroit.

"We're still looking at reasons why a suit might be effective, although we're not using the actual space suit," says **Kim Dunleavy**, PT, MS, OCS, a clinical associate at the Rehabilitation Institute of Michigan and an assistant professor at Wayne State University.

Suit combats effects of weightlessness

"The Russians developed the suit to minimize the effects of antigravity in space because a lot of cosmonauts were coming back with major muscle loss and osteoporosis," Dunleavy explains. "The body adapts to the effects of forces placed on it, so if you take gravity away, the body depletes itself."

The project began when NASA loaned the institute the Adeli space suit, which has a series of stretch cords in the exoskeleton that can be tightened to produce an axial load that mimics the effect of gravity, explains **Nancy McNevin**, PhD, a kinesiologist and director of the Brasza Motion Analysis Lab at the institute.

"The suit has been studied in Poland and Russia, and they've found some support for the theory that it improves functional ambulation in cerebral palsy children," McNevin says. "However, we wanted to look at it ourselves, because it hasn't been clinically assessed and the evidence is more anecdotal."

So McNevin and colleagues studied the suit's impact with stroke patients and found that it did result in changes in balance and muscle recruitment patterns, McNevin says.

"There was a change in the enhanced center integration, and these were all positive changes, significant changes," McNevin says.

Later this year, investigators hope to begin to study incomplete spinal cord injury patients to see whether the same benefits will occur with that population, McNevin says.

Since the original space suit no longer is available, the institute enlisted the help of a graduate student who is creating an exoskeleton that will allow therapists to fine-tune the forces on different body segments, McNevin says.

"If they need more upper-body support, we can adjust for that," she adds. "But if they're wheelchair-bound, it won't work, because they have to have some sensory motor control in their legs."

Investigators also will evaluate the principles behind the suit to determine which types of patients would benefit from this type of therapy, Dunleavy says.

"The suit itself is fairly unique, but the principles behind it are being used by lots of therapists around the country," Dunleavy explains. "It's the principle of trunk stability enhanced by compression or loading and using tactile input, the sensory input to improve muscle contractions and stability."

The suit has the potential to be a useful tool in rehab therapy, especially with certain types of patients. Rehab providers already probably have had patients who have gone overseas to Poland to use the Adeli suit in hopes of improving their function beyond what traditional rehab has offered them, Dunleavy notes.

• **GameWheels:** A technology similar to GameWheels was tested at the veterans Wheelchair Games held in New York City last summer and was featured in published research in 2000 and 2001.

The high-tech device essentially has a platform

with a slight wheelchair ramp and two rollers that restrain the back wheels of the wheelchair. A groove in the front of the ramp holds the front casters of the wheelchair and keeps it stable, explains **Shirley Fitzgerald**, PhD, associate director of research at the Department of Veterans Affaris R&D Center for Excellence for Wheelchairs and Related Technology in Pittsburgh.

"Think of a treadmill and how a person who is walking on one is able to walk in place," Fitzgerald says. "This is the same idea of a roller system, so that the platform allows the wheelchair user to propel without going anywhere."

The platform is interfaced with the computer and a racing software system that gives the wheelchair participant the illusion of racing while manually rolling the wheelchair in place on the platform.

GameWheels suitable for exercise

"We are able to elicit an exercise response by use of the game," Fitzgerald says. "Our research has shown that a person's heart rate, as well as their oxygen consumption, have reached levels that are considered exercise thresholds."

Investigators then assessed whether the participants could maintain that level of exercise for 20 minutes or longer, and they demonstrated that people playing the GameWheels system were able to maintain their exercise and maintain cardiovascular levels that are beneficial to promoting fitness over an extended period of time, Fitzgerald says.

Participants in phase two of the study included 10 manual wheelchair users whose mean age was 41.9 years and who had either a spinal cord injury, multiple sclerosis, or a spinal cord disease.[1] In another study, fifteen volunteers of a mean age of 36.6 years worked out with the device, using their own wheelchairs, and participating in tests that required them to propel to 2 mph followed by 20-minute rest periods.[2]

Investigators were concerned that participants might sustain some secondary injuries, such as carpal tunnel syndrome, if they were to propel the wheelchair using incorrect posture. So they developed a device called SmartWheel to evaluate the kinetic forces being used to propel the wheels, Fitzgerald says.

"By putting these SmartWheels on the wheelchair, we were able to get a sense of what the forces were acting on the person's shoulder and wrist joints," Fitzgerald explains.

With the feedback from the SmartWheels, investigators have determined that the wheelchair biomechanics work fine while participants are playing the video game, and it seems to be a safe way for people to exercise, Fitzgerald says.

The next step is to manufacture the machine and make it available for rehabilitation centers, Fitzgerald says. "We have found a manufacturer, and GameWheels will be available for purchase sometime in the next year or two."

Future research might involve looking at the device as a training mechanism for the newly injured, Fitzgerald says.

- **Acetabular studies:** Investigators at the Rehabilitation Institute of Michigan have been looking at physical and functional outcomes of patients with hip fractures after surgery.

The acetabular studies mainly involve people who were injured in motor vehicle accidents in which their knee was rammed into the dashboard, causing the femur to go backward into the hip socket and then fracture, Dunleavy explains.

Trying to prevent arthritis

"Specifically what we're looking at is the amount of forces going onto the hip during functional activities, like going up and down steps, normal walking, and standing on one leg," Dunleavy says. "One of the problems with long-term outcomes is that they have a major tendency to develop arthritis."

Arthritis may occur when the muscles around the hip are not absorbing much of the forces impacting the joint, Dunleavy adds.

"Because of the injury and surgery, the muscles might not absorb the forces," Dunleavy says. "So they normally go through rehab for at least a year afterwards, but even at that point there is some residual weakness."

Using a passive motion analysis system that records muscle activation patterns, researchers are trying to determine what the muscle activity is and what types of forces are being taken by the hip joints in a variety of outcomes, Dunleavy says.

"If we can determine exactly which muscles are functioning well and which are not, and the type of forces being absorbed by the hips, then we can adjust protocols to prevent those forces or to maximize the muscle function," Dunleavy says. "We'll probably be finished with data collection by the end of the year on the first piece of the study, and then the next step is to determine treatment protocols."

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• **Intentional focus:** If researchers can determine what it is that people are thinking about when they perform a new skill, they might have a good idea about what type of concentration results in the best outcomes.

At least this is the theory behind intentional focus research conducted at the Rehabilitation Institute of Michigan. Investigators have examined the process using healthy patients and now will be working with stroke patients to see how well intentional focus works with that population, McNevin says.

So far, investigators have a theory that rehab patients who think about the consequences of their actions will learn new skills much faster than if they are thinking about the movement itself, she says.

"If you picked up a golf club and focused on the arms as the coach tells you to do, then you will not do as well as if you focus on what the club head is doing or the anticipated trajectory of the ball," McNevin explains.

Intentional focus is a skill in which a person focuses on the consequences rather than on the body. For example, if a person's goal is to stand still and the person concentrates on the feet, then that will disrupt the performance, she says.

"It makes sense when you think about it, but that's not what we do in rehab," McNevin says. "With the clinical population, there is much more focus on the body, what the body does, and as soon as you have the patient focus on impairment, then it disrupts the coordination of the entire body."

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Performing artists need specialized rehab care

Musicians and dancers seek specialized care

The Rehabilitation Institute of Michigan in Detroit provides area musicians, ice skaters, and dancers with rehabilitation care that is designed specifically to help them heal while continuing to pursue their art.

"The types of injuries your performing artists are going to have are somewhat different from your average sedentary type of individual," says **Kim Dunleavy**, PT, MS, OCS, assistant professor at Wayne State University and a clinical associate at the institute.

"What any performing artist does is very repetitive," Dunleavy explains. "So for both musicians and dancers, the amount of practice and performance they put into doing these same activities means they are very susceptible to building up forces in the body that are unique to their particular professions."

For example, a violinist must keep the head tilted at a certain angle for a long period of time, and the wrists also are in an angulated position for hours at a time, Dunleavy says.

"This means the muscles and tendons going around the wrists are going to be stretched and taking a lot of force," she says.

Likewise, dancers will work in extreme positions of hip turnout and rotations, putting pressure on their ankles to hold unusual positions and to absorb the forces of jumps.

"So the differences in the types of injuries performing artists sustain means that if you do traditional rehab where you just address recovery from acute inflammation and strengthening and making sure their ranges of motions are adequate, that's not enough for this clientele,"

Dunleavy maintains.

"There needs to be a detailed analysis of biomechanics of the type of movement that they're doing," she adds. "And there needs to be re-education of the most efficient position and movement technique."

For example, suppose the rehab patient is a ballet dancer who has knee problems. The way the dancer turns out her hip is using more turnout from the knee rather than from the hip. So the therapist will need to take the dancer through his or her daily ballet positions and make sure the knee is not turning out, Dunleavy explains.

"When you get into treatment techniques, the exercises should be adapted for the positions that the performing artist is going to be creating on a daily basis," Dunleavy says. "In a way, it's like sports, where you need to recreate the sporting activity and strengthen the body for those activities."

The difference is that with performing artists, there is a creative component, which means the performer needs to focus on more information.

'We problem-solve with them'

At the Rehabilitation Institute of Michigan, therapists working with performing artists teach them how to adjust their practice schedules and how to adapt their positions and movements while they are practicing and performing, Dunleavy says.

"We try to work with them and their coaches, teachers, or mentors on their skill or craft in order to find the most efficient way of producing their music or their dance."

The institute has a wooden floor with a spring to it, so dancers and therapists can work on the dancer's jump. There also is a ballet bar and a room that is mirrored on all walls to permit the therapist and performer to see all angles, which makes it easier to correct a movement.

Musicians are asked to bring in their instruments and demonstrate their practice and performing positions.

"We problem-solve with them," Dunleavy says. "We don't profess to be experts in every type of performing art, and we get different types of people: cellists, ballet dancers, Irish dancers, modern dancers, and each type is different and has different methods."

So therapists learn to improvise and rely on the clients to bring their skills to the process of deciding, through mechanical analysis, how to spread out the forces that are injuring their joints and limbs.

The performing arts team includes two physiatrists, physical therapists at both the downtown Detroit and suburban rehab facilities, and occupational therapists who work primarily with the musicians.

Physical therapists generally become performing arts specialists because of their own special interest in the field. Most have been involved in some performing art, such as dancing or skating, Dunleavy says.

"We developed the techniques ourselves, and we have hobbies that have benefited us personally, and these benefit our knowledge in terms of rehab," Dunleavy says.

Also, the performing arts therapists will share with other staff what they know through inservices.

Most of the reimbursement for the service is handled the same as traditional rehab, but there are some differences in how this needs to be documented, Dunleavy says.

Whether the clients are professional or amateur performing artists, they have expectations that their recovery should include their continued ability to perform their craft. Therefore, therapists should not use standard muscle strength and conditioning rating systems to determine when the patient has achieved optimal recovery, Dunleavy says.

Standard criteria not sufficient

For example, a dancer has to be stronger than the normal population, so when a therapist is judging an injured dancer's muscle strength, the therapist should not grade the achievements according to what a normal, non-athletic patient might achieve. A grade 5 for a sedentary 50-year-old would not be the same grade 5 for a strong 20-year-old dancer, Dunleavy says.

The institute has treated a variety of performing artists from across the Detroit metropolitan area, including traveling ballet troupes, professional ice skaters, singers, actors, and symphony musicians, Dunleavy says.

"Except in the major areas of the country, you won't have an entire patient clientele base that consists of performing artists, but there is a need for rehab facilities to at least have some therapists with specialty knowledge about the performing arts," Dunleavy says. ■

Teaching skills every staff educator should master

Staff must learn to assess, tailor, and evaluate

While health care staff frequently are called upon to educate patients, they don't always have the skills to do an effective job. That's why many facilities create inservices, self-learning packets, and other tools that teach staff how to teach.

For example, at Grant/Riverside Methodist Hospital in Columbus, OH, nurses can obtain teaching skills by attending four 30-minute inservices for nursing contact hours. The inservices are offered several times. In October, learning assessment was scheduled six times, and teaching strategies were offered six times in November, says **Mary Szczepanik**, MS, BSN, RN, manager of cancer education, support, and outreach at Grant/Riverside.

What skills do all staff need to learn? "The most important skill is to adequately assess the patient," says Szczepanik. This includes a patient's readiness to learn, learning needs, and possible barriers to learning such as hearing loss or inability to speak English.

Szczepanik uses the situational leadership model when teaching staff how to evaluate learning readiness, which allows the teacher to determine how ready the patient is to learn based on three criteria:

- willingness and ability to take responsibility for the task;
- recent education and experience in the specific task to be done;
- ability to set realistic goals.

When the teachers get negative results in assessing these criteria, they must be prepared to use a lot of supervision in their teaching. They may simply give the patient one very specific thing to do, making sure the patient is clear on what that task is and how to do it, says Szczepanik.

To assess learning needs, staff must be taught to determine what the patient knows, what is

Every interaction provides opportunity to teach

Listen to patients for educational direction

Most patient and family education is done within the context of casual conversation. Therefore, employees need to be taught how to use conversation to assess learning needs, teach, and evaluate learning, says **Fran London**, MS, RN, a health education specialist at The Emily Center of Phoenix (AZ) Children's Hospital.

"They need to recognize how learners are always providing information about what worries them, what bothers them, what they know, and what they need to know. They need to pick up on those cues and teach from there," she says.

Effectiveness as a teaching method depends on the individual situation. Teaching can take place through explanation, verbal exchange, demonstration, experiential approaches, and behavioral strategies, says **Mary Szczepanik**, MS, BSN, RN, manager of cancer education, support, and outreach at the Columbus, OH-based health care facility. "While explanation is the easiest, it's probably the least effective for a beginning learner or when the patient has to perform a complex task independently like care of a central venous catheter at home," she says.

When patients don't seem to be getting a concept it's time for a staff member to more thoroughly assess the learner's abilities and needs and better individualize the teaching, says London. "This skill takes practice and experience to perfect. Staff need to identify challenges and barriers clearly to figure out how to work around them," she says. Role-playing or actual cases can be used to teach this skill to staff.

Staff members become better teachers when they recognize that every interaction with a patient or family member is part of the teaching process — whether assessment, teaching, or evaluation of understanding, says London. Find out what their priorities are, and individualize the teaching to their abilities and needs, she advises.

Although health care workers complain that they don't have time to teach, every interaction is actually an opportunity to teach. "It is not a question of needing more time, but paying attention to the learner and the learner's needs in the time you have. This is patient-centered care, rather than task-centered care," says London. ■

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misunderstood, and what he or she needs to know to meet the goals of patient and family education, such as informed consent or self-care skills, says **Fran London**, MS, RN, a health education specialist at The Emily Center at Phoenix (AZ) Children's Hospital.

Determining the patient teaching strategy, or how to individualize the teaching, is another basic step staff should master. Staff must learn to determine which teaching tools and method of teaching would work best, and what information should be taught first, says London.

If teaching adults, staff should understand principles of adult learning, says **Leah Kinnaird**, EdD, RN, a consultant with, Creative HealthCare Management in Minneapolis. Adults will have a wealth of experience, which aids retention because they can relate new information to what they already know, but they need to apply the information immediately. "Adults need awards just as much as children, if not more so," she notes.

Teaching works best if a climate for learning is established as well, says Kinnaird. This includes both the physical and psychological environment. "Often this means sitting down with the learner if it is in a patient room, reducing distractions for yourself as well as for the patient, and having a demeanor that engages the patient in wanting to learn," she says.

Body language says as much as the words used, says Kinnaird. Rapport helps create an environment for teaching, so it is a good idea to develop rapport before teaching begins. **(See article on p. 32 for a few teaching tips.)**

Once a lesson has been taught, staff need to know how to evaluate the learning to determine what the learner understands, what he or she can apply, what behaviors are changed as a result of the teaching, and what still needs to be taught, says London.

The importance of documenting the assessment, teaching, and learning evaluation so that the information is shared with health care providers over the continuum of care needs to be stressed. Information on the most effective teaching methods for the patient as well as what he or she knows and still needs to learn should be included in the documentation process, says London.

Staff need to be taught that they are accountable for adherence to Joint Commission standards for patient teaching and that documentation is proof of that adherence. Documentation of teaching also is important for legal protection, says Szczepanik. ■

Establishing an effective peer review process

An examination of the fundamentals

By **Thomas A. Sifner**
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In the constantly evolving health care industry, no single issue commands greater attention or consideration than the peer review process. Today, the peer review process has advanced to the forefront of importance for many health care institutions and entities.

Recently, the Joint Commission on Accreditation of Healthcare Organizations has included peer review in its survey process. More importantly, the process allows the medical staff to ensure quality care through a systematic procedure of reviewing their peers and defining a peer review method. All practitioners should be subjected to a consistent, fair, and well-defined process.

The purpose of this article is to provide guidance for the design of the process and to provide suggestions for an effectively functioning peer review process.

First and foremost, it should be explicitly clear to define those circumstances warranting peer review. These conditions for review should be as specific as possible, and as inclusive as practical. The individual circumstances requiring peer review should be written in the bylaws, policy, or hospital memorandum format, so it is clear to the practitioner which variables he or she is being judged upon. It should be recognized that health care institutions are structured differently, and the design should be specific to the institution. These conditions for review should be as specific as possible, clear, and measurable.

These circumstances can be incorporated within the occurrence screening process. That is, readmissions within 10 days, returns to the OR in the same admission, and admissions within three days of an unscheduled ambulatory care visit are examples requiring further review in the peer review process. Other possible examples include, but are not limited to, perceptions of substandard care, professional incompetence, gross negligence, conduct unbecoming, or increased incidence of patient untoward events, as expressed on patient incident reports.

Specify participants in peer review

Second, the participants in the review process should be specified. Generally, this is best accomplished through a peer review panel or committee. The medical director, chief of staff, or their designee serves as the chairperson of this panel. Each department head or section chief is entitled to nominate individuals for the peer review panel. The goal is to create a cross-section of all specialties, all of whom are equally trained, capable, and qualified to review care rendered by a peer. For purposes of design of the peer review process, a peer should be defined as a professional in the same or related specialty of practice as the individual whose services are being reviewed.

Once a panel or committee is established, the chairman can assign a peer reviewer based on the information about the reviewable event supplied to the committee. The chairman should be acutely aware of any conflicts of interest, personality differences, or professional practice arrangements that may preclude the reviewer from being fair and objective.

Because constructive feedback and/or discipline within health care circles should be timely, specific time guidelines should be established. The committee may want to meet monthly or at the call of the chairman. From that point, 30 days should be allowed for a recommendation involving one of its practitioners.

From time to time, circumstances involving external review may occur. Examples include small specialized sections, such as podiatrists at small community hospitals.

In cases like these, peers knowledgeable and experienced to assess professional competence are not readily available; therefore, these issues would need to be referred for external review. In addition, should a situation exist where those available professionals could not be fair and objective in their review, evaluation should be performed by an external review source. Lastly, should there be a bona fide conflict of interest involving the peers, these cases should be referred away for external review.

The reviewee has the right to due process in peer review. Some hospitals and health care institutions have this process explicitly spelled out in their bylaws or personnel manuals. The reviewee should be presented with the facts concerning his peer review with the opportunity to provide a written synopsis to the peer review panel. The peer review panel should give full and impartial consideration to an oral reply as well.

Equally important as the design of a peer review process is the maintenance of an effectively functioning peer review process.

It is imperative the peer review process function consistently and fairly by adhering to all of the established guidelines and policies that govern its implementation. The established design and standards should meet the organization's goals and objectives for an effective process.

Because all feedback and review should be timely, the established time frames in the design phase should be followed closely. Stipulations for the delay of any peer review should be written into the process, because an occasional delay can be expected in certain circumstances.

Conclusions reached by the individual or panel need to be substantiated by clear reference to current literature and relevant clinical practice guidelines. Use of a numerical scale (1-5), indicating how the practitioner's care would fit in relation to care delivered by one of his peers, has been useful for many institutions. The number one is generally the same standard of care

rendered by his peers, advancing upward to the number five, where the standard of care is far removed from his or her peers under similar circumstances. Be sure to consider personal differences in the delivery method of health care, such as alternative medicine and circumstances surrounding the incident in question.

As is true with all clinical activities within a health care scenario, the peer review process should be incorporated into the organization's performance improvement activities. The culmination of all these data is useful in provider-specific privileging decisions, as well as risk management activities. All performance improvement activity should be ongoing and monitored for efficiency and effectiveness.

If the peer review process is designed properly and functions effectively, it can be a useful and valuable tool for a health care entity. It should not be viewed strictly as a potential disciplinary process, but as a review mechanism to improve patient care. The Joint Commission will assess not only whether a peer review process exists, but how well it is designed and how well it functions. This will challenge all health care facilities to maintain processes that are in the overall best interest of quality patient care. ■

Joint Commission joins Leapfrog Group as partner

Identifying outcome and process measures

The clout of the Leapfrog Group appears to have grown substantially with the addition of the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a formal partner.

The groups had previously had an informal relationship. Under the new arrangement, the Leapfrog Group will seek JCAHO's input on its patient safety initiatives. The Leapfrog Group is a consortium of more than 90 Fortune 500 companies and other large private and public health care purchasers founded by The Business Roundtable. Established in the wake of the 1999 Institute of Medicine report *To Err is Human,* the Leapfrog Group addresses the reduction of errors in the health care industry. (More information on The Leapfrog Group is available at www.leapfrog-group.org.) In November 2000, the group launched a formal effort to educate employees, retirees, and their families about medical errors and the importance of hospital efforts to make advances in patient safety, and to reward hospitals for their efforts in improving patient safety.

Money is the root of the Leapfrog Group's power. Leapfrog purchasers provide health benefits to more than 26 million Americans and spend more than $46 billion on health care annually. By threatening to withhold their purchasing dollars from health care providers that do not comply with its mandates, the Leapfrog Group's members can exert tremendous influence.

Dennis S. O'Leary, MD, president of the Joint Commission, released a statement saying the goals of the two groups are compatible, if not actually synonymous.

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"The Leapfrog Group's work symbolizes the priority accorded to patient safety by those key stakeholders — purchasers, accreditors, and health care providers — who eventually will have the greatest impact in making improvements happen," he says.

The collaboration already has begun, O'Leary says. The Joint Commission has begun work with Leapfrog leaders to identify a specific set of intensive care unit-related outcome and process measures. He says these measures eventually may be used to supplement or even replace the current Leapfrog measures, which recommend that hospitals have board-certified or board-eligible intensivists.

In addition to becoming a formal partner with The Leapfrog Group, the Joint Commission is involved in collaborative activities with various other groups that share its emphasis on patient safety. With the U.S. Pharmacopoeia, the Joint Commission leads a coalition of more than a dozen health care professionals and provider organizations that have developed principles for constructing patient-safety reporting programs. The Joint Commission also participates in a Medication Error Coalition whose efforts have resulted in the introduction of legislation that would provide funding to secure technologies that will support patient safety in hospitals and assure appropriate training of staff to use the technology. ■

Emergencies, staffing to get top focus

Surveyors will focus on hazard vulnerability

The events of Sept. 11 are rippling through the health care system in a number of ways, and it appears they will lead to some changes in the way Joint Commission surveyors look at health care providers this year.

At the recent annual conference for Joint Commission surveyors in Chicago, one of the featured speakers was **Len Aubrey**, CEO of New York University's Downtown Hospital, the hospital nearest to the World Trade Center and the facility most directly affected by the emergency. According to a report provided by the Joint Commission, Aubrey stressed the importance of emergency preparedness and disaster training of all medical staff, not just the emergency department.

Surveyors attending the conference were told that "emergency management and preparedness will be one area that surveyors will focus on in 2002." **Joe Cappiello**, vice president of accreditation field operations for the Joint Commission, says surveyors will focus on hazard vulnerability assessments that identify all potential hazards to the organization and how those hazards can affect the organization directly and indirectly. Surveyors also will look at how well the organization is involved in community emergency planning and practice drills, communication and planning in cooperation with other area health care organizations, and the organization's scalable command structure. The scalable command structure refers to the organization's ability to flex to the magnitude of a particular disaster.

The Joint Commission reports that another area of focus for 2002 will be the new staffing effectiveness standards, HR.2.1, which go into effect for hospitals in July 2002 and tentatively for nonhospital programs by January 2003. Pilot testing of the draft standards has been conducted at 43 hospitals and five long-term care and assisted living organizations. ■