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INSIDE

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Reality sets in as rehab facilities struggle with using IRF-PAI tool

Collaborating with coders is crucial

As rehab facilities nationwide adjust to using the inpatient rehabilitation facilities patient assessment instrument (IRF-PAI), a few irksome problems have arisen, and it would appear that the Centers for Medicare and Medicaid Services (CMS) has no immediate plans to resolve these issues.

The American Medical Rehab Providers Association (AMRPA) of Washington, DC, has written letters to CMS with suggestions on how the tool, a data collection instrument used to classify patients for payment purposes, can be improved and made more efficient. For example, AMRPA has suggested that CMS eliminate the medical needs and quality indicators items because they already are voluntary and some of them do not reflect specific rehab issues. CMS, in a recent response, disagreed with this advice and said that plans were to continue to include the information. **(See article on AMRPA's suggestions and CMS' response, p. 87.)**

Rehab facilities initially welcomed IRF-PAI

Most rehab facilities were so relieved at not being forced to use the assessment tool CMS originally proposed that the IRF-PAI was at first welcomed, notes **Peggy Kirk**, BSN, vice president of operations of day rehab and former corporate director for inpatient services at the Rehabilitation Institute of Chicago (RIC).

Nonetheless, RIC staff found that implementing IRF-PAI has taken significant training time and has required the facility to develop new systems and processes for collecting information, Kirk says.

"We formerly collected similar information for UDS [Uniform Data System for Medical Rehabilitation of Buffalo, NY], which is true for many in the industry, but we had to rethink who was collecting the information and how to match the changes in scoring rules and ensure the accuracy of the data," Kirk says.

Kirk says she agrees with many of the suggestions AMRPA has made with regard to improving the tool. "We'd like to see them delete unnecessary items that don't relate to grouping and payment," Kirk explains.

Kessler Institute for Rehabilitation of West Orange, NJ, has fully implemented the tool since Jan. 1, 2002, for all Medicare patients, and mostly the change went smoothly, says **Joan Alverzo**, CRRN, MSN, vice president of clinical support services.

UB-92 conflicts with IRF-PAI

"We're generally pleased CMS chose to use the functional independence measure [FIM] scores," Alverzo says. "But there are some problems with the new regulations, and the first one has to do with the UB-92 billing document and the kind of language it requires regarding coding as compared with the IRF-PAI document."

This is apparently a common concern among rehab providers, as the UB-92 document existed since before the inpatient rehabilitation prospective payment system (PPS) and it has not been updated to reflect changes in the assessment tool.

"So we have two systems that don't connect in how we code patients," Alverzo says. "CMS is in the process of reviewing that, but currently we're using two different nomenclatures or taxonomies of documents."

Kirk also notes that the discharge disposition and patient assessment instrument are very different from the coding CMS requires for the UB-92 bill, and this means it is not easy for facilities to translate the assessment data into a coding and billing system.

"So we struggle with that," Kirk says. "The language and things adopted in the PAI don't line up with the other things that are required. You try to be efficient, and it impedes you from being as efficient as you would like."

In a recent letter to AMRPA, CMS acknowledges that there are some issues surrounding potential duplication and overlap with the UB-92.

"This is an issue that touches all our payment systems," CMS writes. "However, CMS considers it to be premature to make modifications to the instrument."

CMS adds, "Potential of collection processes is only one of the issues that must be considered in instrument revision."

Also, CMS plans to maintain the internal consistency of the instrument for a minimum of 12-18 months so data may be collected for the purposes of monitoring the system and assessing potential modifications to the instrument, the CMS letter states.

Making the transition to PPS was not as difficult as some rehab providers might have anticipated, despite the problems with the IRF-PAI.

"Compared with the transition to skilled nursing PPS, the rehab PPS was light-years easier," says **Melinda Clark**, president of SSM Rehab of St. Louis.

"As far as the IRF-PAI tool itself, we had to have internal checks and balances and audit functions in place to ensure staff aren't making errors," Clark says. "But we thought it was going to be a lot worse than it was."

SSM Rehab put together a team that focuses on PPS and IRF-PAI, and there's an auditing process that independently catches errors before the information is sent to CMS, Clark adds.

"We were very pragmatic in the way we approached the change and did historical work on the patients we admit. We looked at the coding processes to make sure we had the right checks and balances and time lines," Clark says.

Advance planning pays off

Glancy Rehabilitation Center, which is part of the Gwinnett Hospital System in Duluth, GA, spent more than two years planning and preparing for the PPS change, and the advance efforts have paid off, says **Mona Lippitt**, assistant director of Glancy Rehabilitation Center - Inpatient and Outpatient Rehab Program.

With the use of a multidisciplinary PPS team that included staff from billing, coding, and medical records, the rehab facility made a smooth transition into PPS and using the IRF-PAI tool, Lippitt says.

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"We hired a nurse to be the PPS coordinator, and she has done a beautiful job," Lippitt says. "Her role is to coordinate the whole process, communicate with all disciplines, and meet daily with a medical records coder to review the documentation."

If the PPS coordinator sees a discrepancy in the IRF-PAI documentation, she will talk with the staff who completed the information and correct it before it's sent to CMS, Lippitt adds.

Despite some improvements that could be made to the IRF-PAI, its problems are not AMRPA's top priority, says **Carolyn Zollar**, JD, vice president for government relations at AMRPA.

For the most part, CMS has responded well to AMRPA's suggestions regarding PPS, so while rehab providers would like to see the IRF-PAI honed to be more efficient and unburdensome, it's not as big a problem as the 75% rule that rehab providers must follow, says **Kenneth W. Aitchison**, chief executive officer of Kessler Rehabilitation Corp. in West Orange, NJ. Aitchison also is the chairman of the AMRPA PPS task force.

The 75% rule is an exclusion criterion used to determine whether a rehab facility qualifies to be excluded from inpatient acute PPS. The rule requires rehab facilities to have at least 75% of patients within a recent 12-month reporting period to have a diagnosis in one of 10 categories: stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of the femur, brain injury, polyarthritis, neurological disorders, and burns.

AMRPA is more concerned about whether CMS will follow its suggestions to change the rehab 75% rule, which has been increasingly difficult for rehab facilities to adhere to since PPS was implemented, Aitchison says.

"The 75% rule is a far more important issue that has, frankly, the attention of virtually everyone in the field," Aitchison says.

AMRPA had requested that CMS review and reconsider the 75% rule in light of the other demands placed on rehab facilities operating under PPS. CMS has responded by asking regional offices and fiscal intermediaries how they collect data for the 75% rule, Aitchison and Zollar say.

"I fully expect that there will be sufficient information into CMS sometime in the third quarter where they can begin to come to a conclusion," Aitchison says. "The bottom line is that all patients being served in a rehab facility should be served in a rehab facility." ■

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AMRPA suggests ways to improve IRF-PAI

CMS responds to pointed letter

In the early months of making the transition to the inpatient rehabilitation facilities patient assessment instrument (IRF-PAI), rehab facilities across the country found that there were some problems with the tool, and they notified the American Medical Rehabilitation Providers Association (AMRPA) of Washington, DC, about their concerns.

AMRPA wrote the Centers for Medicare and Medicaid Services (CMS), requesting that some adjustments be made to the assessment tool in order to better improve efficiency and quality.

Here are some of the key points from the April 24 letter that AMRPA sent CMS, as well as CMS' June response:

AMRPA points out in an April letter that some of the items on IRF-PAI are not necessary for a rehab facility to complete in order to receive payment, and therefore these items should be deleted from the form. According to AMRPA, these unnecessary items include:

• **Admission information:**

— Item 14: Admission information;

— Item 15: Admit from;

— Items 16 and 17: Pre-hospital living setting and pre-hospital living with;

— Items 18 and 19: Pre-hospital vocational category and pre-hospital vocational effort.

CMS responds: "CMS is concerned with AMRPA's proposal to eliminate elements from the instrument because they are not directly related to payment, thus reducing burden. Many of the elements identified in the AMRPA letter are necessary to maintain the overall integrity of the instrument, facilitate matching with the administrative files, support the research protocol, and maintain consistency with data previously collected for monitoring purposes."

CMS further states that any changes to the instrument would be premature.

• **Payer information**: Primary source and secondary source should be combined to read "Payment Source."

• **Medical needs and quality indicators:** AMRPA supports keeping these items voluntary, but also recommends that they be deleted from the manual, page II - 27 and Section IV.

In the CMS letter to AMRPA, the agency says this section is entirely voluntary and that the sections were maintained on the IRF-PAI as place holders.

"Because agencies do not have to complete these, we feel that maintaining these sections on the IRF-PAI is important," CMS writes. "As placeholders, these sections reinforce the commitment that CMS is making to quality issues."

• **Function modifiers and functional independence measure (FIM) instrument**: AMRPA's members have suggested that changes be made to the items dealing with eating, dressing, grooming, bowel/bladder management, transfers, and locomotion. For example, item 39 (D&E) for dressing upper/lower could be divided into two separate activities and two separate time frames.

Also, there is a problem with items 29 and 31 for bowel/bladder management because independent rehab facilities have no ability to collect a seven-day assessment period of this information from the hospital from which the patient was transferred to the rehab facility.

CMS reviewed AMRPA's request for clarification of the function modifiers and has decided that clarifications will be provided to rehab facilities through CMS' section on the most frequently asked questions.

• **Coding:** Coding continues to be a problem for rehab facilities making the switch to IRF-PAI. Among the problems are these:

— Does V461 apply to patients on C-PAP or Bi-Pap?

— Can dysphasia be coded if identified by the speech therapist?

CMS acknowledges these suggestions and continues to review them, according to the June 2002 letter to AMRPA.

AMRPA protests unnecessary challenges

• **Discharge information:** AMRPA recommends that item 41 (Discharge against medical advice) and manual page II-23, which is not related to the payment system, be deleted and that item 43 (Program interruption dates) and manual pages II-23 be amended to parallel the definition of an interrupted stay.

Also, item 44A (Discharge to living setting), manual pages II 24-25, does not parallel the types of discharge settings that have an impact on payment, AMRPA says.

"This has presented many unnecessary challenges for providers," AMRPA writes. "They must develop painstaking audit procedures to ensure the codes on the PAI correspond to the UB-92."

In response to AMRPA's suggestions of making changes to the manual pages in section II, CMS writes, "In general, these recommendations are related to the perception that the items collected are not direct payment items and are therefore not relevant."

However, these variables were maintained as part of the negotiations between CMS and the Uniform Data System for Medical Rehabilitation of Buffalo, NY, the company that created the FIM instrument, CMS adds. "In addition, these represent variables that are relevant to additional research and monitoring of the implementation of the inpatient rehabilitation prospective payment system." ■

Ohio researchers examine childhood brain trauma

Who recovers from mild injuries, and who suffers?

Rehab professionals have noted for some time that the majority of head injuries are mild, but even these can become a major health problem, causing victims persistent problems.

It's estimated that mild head injuries or concussions account for more than 80% of all childhood head injuries, and these types of injuries might be on the rise.

"I haven't seen anything in epidemiology about an increase in concussions children suffer, but there is an increase in major sports injuries from soccer, skateboarding, and scooters," notes **Keith Yeates**, PhD, associate professor of pediatrics and psychology at The Ohio State University and associate director for the Center for Injury Research and Policy at the Children's Research Institute of Columbus, OH. Yeates also is the director of pediatric neuropsychology at the Children's Hospital in Columbus.

"The controversy about concussions, and it's been going on for some time, is that there seem to be a sort of small but definite group of people who report a variety of persistent problems, including inattention, forgetfulness, increased fatigue, headaches, and more irritability and personality changes," Yeates says. "So there doesn't seem to be much question that there are some folks who after a mild concussion have those kinds of problems, but the controversy is, why do they have those problems?"

Some experts say this is a psychological phenomenon and not a result of the brain injury, while others say it reflects some underlying brain dysfunction, Yeates says.

The latter theory has some support from other research findings that children have persistent problems following mild brain injuries, and that is what Yeates and fellow investigators intend to study: What are the effects of mild brain injuries or concussions on children and adolescents?

The Center for Injury Research and Policy has been awarded a $3.5 million grant from the National Institute of Child Health and Human Development to study the long-term effects of mild brain injuries in children. Yeates will lead the five-year study and work in conjunction with Case Western Reserve University and Rainbow Babies and Children's Hospital in Cleveland.

"Our goal is to get an idea of how those problems occur and to get a better handle on how injury-related factors and non-injury related factors predict occurrences of problems after a concussion," Yeates says.

"Adults have been shown to be slower to go back to work with more work-related disability. For whatever reason, they have the symptoms and they have some significant disability or problems in day-to-day life as a result or consequence of those problems," Yeates adds. "We don't know if children miss more school or go to the doctor more often."

The research might lend support to one of the theories regarding mild brain injury, although Yeates hypothesizes that the two schools of thought are not mutually exclusive.

"At different times, some symptoms may be more physiological and others may be psychological," Yeates says. "My theory is that post-concussion symptoms, particularly the physical and some cognitive, are more likely to have a physiological basis soon after the injury occurred, and that some emotional and behavioral symptoms that occur later after the injury may have more psychological components."

Since there likely are multiple causes for the symptoms, they aren't simple to treat and also present a challenge for research.

With adults who have had minor brain injuries, there is the problem of secondary gain that may make it difficult to determine the basis for persistent problems, and this is another reason why researchers are particularly interested in studying a population of children, Yeates says.

For example, adults may be suing someone over the brain injury, so there is some motivation to claim disability, Yeates says.

"Kids can be a topic of litigation as well, and I've been involved in these cases, but I think when that happens it's the parents and adults who are motivated financially and not the kids," Yeates adds. "So I do think perhaps the children will provide a clearer test to the answer of these questions."

One of the questions families will be asked during the mild brain injury study will be whether the family is involved in litigation because of the injury. This will help investigators determine whether there is a difference in problems reported by children who are involved in litigation and those who are not, Yeates adds.

Here are some details about how the study will work:

• **Recruiting:** Plans are to recruit 200 children, ages 8 to 15, who have had mild concussions and 100 children in the same age range who have had minor orthopedic injuries that do not involve head injury. The orthopedic injury subjects will be the comparison group.

"One of the questions is whether there are any specific issues with head injury vs. other sorts of injury," Yeates says.

Children will be recruited from both the Children's Hospital in Columbus and the Rainbow Babies and Children's Hospital in Cleveland.

All of the children included in the study group will have had an injury of blunt trauma to the head that resulted in the loss of consciousness and a Glasgow coma score that ranges from 13-15, which is the mildest of brain injuries. If the Glasgow coma score is 15 by the time the child is seen in the emergency room, then the child will be included in the study only if the child had symptoms of vomiting, amnesia, vertigo, dizziness, or another alteration of mental status or functioning, Yeates says.

"We're trying to avoid recruiting children who've just had bumps to the head," he adds.

Recruitment began late last year and will continue over the next 2.5 years, with a goal of having all subjects recruited within three years, Yeates says.

The only children who will be eliminated from the study because of the cause of their injuries are those whose injury was a result of their ingesting alcohol and those who were physically abused. "There's good literature to suggest that alcohol would affect the outcome of traumatic brain injury," Yeates says.

"We don't want other injuries that might have an effect on the central nervous system, like shock or hypertension, and we want the injury to be a concussion and not a real serious injury otherwise," Yeates explains.

Also, children with severe psychiatric disorders will be excluded from the study, and all children in the study will need to have use of their preferred arm because the study will test that function.

• **Baseline assessment:** Children will receive a baseline assessment within two weeks of the injury. All children will receive an MRI that will look for brain lesions. About 20% of children are expected to have brain lesions, and that's one of the injury-related factors investigators are interested in studying, Yeates says.

"We are interested to see if they're more likely to have post-concussion symptoms and worse outcomes than those without lesions," he explains.

Parents will be asked for background data about the family environment, social environment, resources available in the community, and stresses that affect the family. They'll be assessed for their own psychological functioning and their attitudes toward illness.

Some parents may reinforce sick behavior

"We're interested in how these types of factors either lessen an injury or heighten it," Yeates says. "We have a measure called the illness behavioral encouragement scale, which is based on the notion that some parents — not necessarily consciously, but indirectly — may reinforce sick behavior."

By using this scale, investigators might determine whether parents who are more likely to reinforce ill behavior from their children will report more symptoms and whether parents with greater resources and fewer stresses report fewer effects from the injury.

• **Ongoing assessments:** Children will be followed for a year after their injuries, with symptom assessments conducted at one month and full assessments at three and 12 months post-injury.

"We're interested in both the children's outcomes and how the family and parenting functioning might affect the outcomes of mild head injury," Yeates says.

Both children and their families will be asked about persistent problems that may relate to the brain injury, including the incidence of headaches.

"Headaches are more commonly reported after

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mild head injury than severe injury, and that raises the question of how much of it is psychological," Yeates says. "No one can tell whether someone is having a headache — it's only reported."

Investigators will study whether children who report headaches are less interested in everyday activities, such as riding bikes, playing with other children, etc. Also, researchers will observe whether children who report persistent problems miss more school or see their doctors more frequently.

Parents are not being asked to keep journals because the study will use measurement tools that are more objective so as to minimize reporting bias.

The study will continue through 2006 and possibly longer if additional funding is found. ■

Get word out about most common summer injuries

Sports top list of childhood injuries

The American Academy of Orthopaedic Surgeons (AAOS) of Rosemont, IL, issued its 2002 list of the top activities resulting in injuries of children during the summertime, and bicycling and basketball are at the top.

The other top three sports most often causing injuries to children during the spring and summer are roller sports, soccer, and baseball/softball.

Children are more susceptible to injury because their bones, muscles, tendons, and ligaments are still growing, and they tend to be more active in sports and physical activities in the summer, according to the AAOS.

In 2000, there were about 2.2 million fractures, dislocations, and soft-tissue injuries related to recreational activities among children who were treated at U.S. hospital emergency rooms, doctor's offices, and clinics. This carried an estimated cost of $33 billion.

Bicycling tops the list, with about 415,000 injuries among children ages five to 14 in 2000. These include fractures, dislocations, strains/sprains, and contusions/abrasions to the extremities and trunk.

Basketball follows with 407,000 injuries, and roller sports resulted in more than 297,000 injuries in 2000. In other sports, there were 160,000 injuries from baseball and softball, 185,000 injuries from soccer, and 135,000 injuries from trampolines.

A rise in the number of reported injuries was seen in volleyball, gymnastics, and scooter activities, as well.

The statistics are derived from estimates of hospital emergency room-treated injuries reported through the U.S. Consumer Product Safety Commission's National Electronic Injury Surveillance System.

Rehab providers are encouraged by AAOS to urge children and their guardians to follow these safety guidelines:

- Know and abide by the rules of the sport.
- Wear appropriate gear, such as shin guards for soccer, a hard-shell helmet when facing a baseball pitcher, and a helmet for bike riding.
- Check equipment and know how to use it.
- Warm up before playing.
- Abstain from playing when tired or in pain.

More information about summer sports injuries can be obtained by downloading Prevent Injuries America! information from AAOS' web site at www.aaos.org or by calling (800) 824-BONE. ■

Local program wins loyal following in the market

The little hospital that could, does

It's understandable that a small regional hospital's occupational medicine manager, upon hearing that the market was being invaded by corporate giants, would spend many a sleepless night haunted by visions of lost revenues. But it doesn't have to be that way, argues **Kaylene Sodawasser**, OTR/L, occupational therapy supervisor at St. Anthony Regional Hospital in Carroll, IA.

In the last four years, Sodawasser first helped establish a thriving occupational therapy service in the community, and then successfully staved off competition from the big boys, who entered the market once it was apparent there was a demand for this type of service.

"Historically in rural areas there really was no competition. Probably one PT [physical therapist]

did all the rehab for the area, but within the last five years there has been an increase in both rehab companies and corporate health facilities moving in, probably facilitated by the reimbursement structure," she notes. "They also contracted with a local nursing home we had provided services for, and competitive PT services from outside of our area contracted with local health care organizations."

St. Anthony is an 80-100 bed facility with a connecting nursing home. "We have a fairly large rehab department for a facility this size — four PTs, two assistants, two occupational therapists [OTs], 1.5 OT assistants, and then support staff," notes Sodawasser. St. Anthony offers everything from pediatrics to geriatrics, inpatient and outpatient, as well as contract services.

From the ground up

Five short years ago, St. Anthony didn't even have occupational therapy services. "At that time, they decided as a facility that they needed to provide a more interdisciplinary rehab facility," notes Sodawasser, who joined St. Anthony about four years ago.

When she joined the hospital, the program was in its initial stages. "Because our community has a significant number of larger businesses with manual laborers, I felt that was one area I could help grow the OT department initially," recalls Sodawasser, who had previously run her own OT consulting firm. "I was also experienced in jobsite analysis and ergonomics consulting."

So what had initially started as exclusively an OT department bloomed in a few short years into a very competitive rehab department with a return-to-work program.

How did St. Anthony do it? Basically, the old-fashioned way: cold calling. "We followed the entrepreneurial consulting model," Sodawasser explains. "Primarily I utilized one of the physicians employed by the hospital to work with me and go to places of employment and make them aware of the positive changes that could be achieved — reducing workers' comp costs and using ergonomics to prevent further injury. Normally, we talked to people in human resources and workers' comp coordinators. Once we were able to develop a rapport with them and find out how we could lower their costs, we usually followed up with a meeting with upper management and/or the corporation president."

Initially, Sodawasser recalls, competition was minimal. "It was not until we developed a program and other companies realized there was an opportunity for business here that we had competition," she says.

How did she compete? "Primarily by making sure customer service was taken care of and that we maintained quality services," she says. "We avoided getting too comfortable and backsliding. We make continual phone contacts to ensure our clients are happy."

Contrary to popular belief, smaller local programs have a lot of advantages in the marketplace, says Sodawasser. For one, there's price. "When the big companies came in here, some local firms utilized them at first, even though their prices were higher," she recalls. "But many ended up coming back with us."

St. Anthony also offers a number of value-added services. "We conduct an initial walk-through analysis free of charge, and we provide a number of educational programs free of charge," Sodawasser notes. "You don't see that in these larger companies. We can do it because we have other clinical services that can help absorb the cost. In rural areas, these free services give the customer the confidence that you are not in it just for the money."

Pressing the home team advantage

St. Anthony's revenues as a rehab department have also continued to grow because they provide not only PT professionals, but also an interdisciplinary team. "We have return-to-work, PT, OT professionals, and an exercise physiologist," Sodawasser notes. "We meet on a weekly basis and consult with the private physician."

Being the home team definitely helps, adds Sodawasser. "Our facility has a solid reputation, and people know all the therapists who work here," she notes. "They know your kids, your spouses, and this creates a higher level of trust."

St. Anthony continues to compete successfully. "We just acquired a contract with a larger production company," says Sodawasser. "We were competing with a larger corporate-based physical

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therapy company, but we could definitely provide the service at a much lower cost."

The return-to-work program has held its own, thanks to strong results. "We've worked with a large food warehouse company for a solid three years," Sodawasser relates. "In the first year we cut their workers' comp costs in half."

The downside is that now the staff probably sees only one or two of that company's employees per month, because with all of its injury prevention programs in place there aren't nearly as many injured workers as there used to be.

But the bottom line, says Sodawasser, is that you needn't worry about whether you can compete. "Market the fact that your staff sees a lot of other issues beyond physical therapy — major complications. These other firms are not as qualified as someone in a rural setting who treats it all." ■

Teaching moments create learning opportunities

Watch and listen to clues

Got a minute? Sometimes that's all it takes to educate patients when they are receptive to teaching. Times like these, often referred to as teachable moments, are easy to recognize.

Practitioners can recognize a teachable moment by one of many cues, says **Fran London**, MS, RN, a health education specialist at Phoenix (AZ) Children's Hospital. Cues include:

- **Questions:** The learner asks a question such as, "What's that pill for?"
- **Concern:** The learner expresses a concern. For example, he or she might say, "I'll never be able to do that!"
- **Lack of understanding:** The learner makes a statement that is incorrect such as, "I don't want morphine. I don't want to become a drug addict."

Educators often can tell by looking at people that they are ready to learn. The learner's eyes light up and their ears seem to perk up, says **Naomi Holtz**, RN, BSN, a health education specialist at St. Luke's Regional Medical Center in Sioux City, IA. "They are eager and able to absorb what you have to offer and may be more motivated than usual to change some of their unhealthy behaviors," she says.

When patients ask questions, they are receptive to learning. At that point, they can be given some interventions that they can do to help with the problem. "It's good to give patients little, easily digestible bits of information and then, if possible, reinforce them frequently," says Holtz.

What educators need to know is that when a teachable moment arises, they need to respond immediately, says London. If a learner has a question, answer it, or if a learner has a misperception, correct it, she advises. An educator may have to use a delaying tactic, such as giving the patient a handout to read and promising to return in 30 minutes to discuss it. However, acting on the teachable moment immediately in some way keeps the moment open, says London.

Many factors can create a teachable moment. It may be a symptom a patient is experiencing or an external experience. It can come in a classroom setting, a clinic, at the bedside, or during a formal teaching setting. For example, there may have been a fatal house fire in the neighborhood, so a person is very receptive to teaching about fire safety at that point, says Holtz.

"Once you recognize a teachable moment, you need to figure out how best to respond," says London. One consideration is how to individualize the presentation of the information to meet the needs of the learner. If a patient has poor eyesight or poor literacy skills, it would be inappropriate to respond with a handout, she says.

"You need to know your patients before you teach them," says **Theresa Towne**, RN, MSN, an inpatient educator at Bayhealth Medical Center in Dover, DE. At Bayhealth, an initial assessment is done when a patient is admitted that includes barriers to learning, such as the inability to speak English and ways the patient likes to learn.

It's always important to really listen to what the patient is saying. "Have a good ear as to what they really need to know," says Towne.

Often the learner tells you either directly or indirectly what he or she needs to know, she says. Learning needs also can be assessed by evaluating the learner's understanding of self-care skills such as medication or diet.

Whenever teaching takes place, whether it is an extended session or a teachable moment, it should be evaluated and documented. "Just because we said it, or gave a handout, there is no guarantee that the learner got it or got it right," says London. Educators should ask the learner to teach the information back to them or demonstrate the skill independently.

It may take several teaching sessions from several different approaches before the learner

understands. That's why all teaching, whether formal or informal, should be documented, says London. The purpose of documentation is to communicate the learner's status to the health care team so each can build on one another's progress and to have a record of the learner's informed consent and readiness for self-care, she explains.

It's important that educators never ignore a teachable moment. Instead of learning the information they are after, patients might learn that the environment at the health care facility is not responsive to patients and the information is not available. Then when educators want to teach, they may find that patients are not ready to learn. Teaching could become a time-consuming chore. "Taking advantage of teachable moments may both save time and improve outcomes," says London. ■

Need More Information?

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AHA offers disaster readiness checklists

Educate both medical and non-clinical personnel

The Chicago-based American Hospital Association (AHA), which represents and serves approximately 5,000 hospitals, health care systems, networks, and other heath care providers, has compiled checklists for disaster planning as well as chemical and biological preparedness.

The association suggests a 13-point checklist for preparing your facility and staff for disaster readiness. This checklist affects all members of a facility's staff, including non-clinical staff members such as security, human resources, information technology, and communications. Employees must be aware of the facility's disaster plan and how it affects them and their role.

The checklist encourages facilities to:

• Focus efforts on creating a general "all-hazards" plan to provide an adaptable framework in a crisis situation.

• Upgrade disaster plans to include components for mass-casualty terrorism, including the potential of chemical and biological incidents.

• Contact your community's emergency response agencies — rescue squad, police and fire departments. Make sure you have the latest contact numbers for key agencies and that, in turn, they have an up-to-date list of critical hospital contacts.

• Develop a plan to support and communicate with the families of staff members. The AHA suggests that staff members need assurances that their families are protected and cared for, especially when an incident involves chemical or biological exposure.

• Develop a simplified patient registration procedure in case of a large number of casualties. During the Sept. 11 attacks, hospitals in New York were inundated with patients almost all at once. Standard registration procedures were time-consuming and impractical.

Study use of couriers, two-way radios

• Review back-up communications capabilities. The AHA recommends paying special attention to Internet-based communication tools and even couriers. Makeshift couriers were used in New York after phone service was interrupted. Other options are two-way radios.

• Make sure essential hospital information systems and data storage have off-site storage and recovery capabilities.

• Prepare to talk to community leaders and lawmakers about how your hospital would deal with a mass-casualty event. The AHA says you also should be prepared to provide a special medical advisory to public officials who may be in contact with different media outlets.

• Review supply and inventory strategy.

Rather than just-in-time supply schedules, make sure there are enough supplies available to care for unexpected patients. Though federal and state resources most likely would be available in a crisis situation, traditional transportation systems could be affected, AHA cautions.

• Prepare to protect the physical security of the hospital by limiting access to the facility.

• Make sure your facility is part of the National Disaster Medical System. Review who the contact is in your organization and who the federal coordinator is in your area. AHA also suggests that if your facility is located within an urban area, you should determine whether there is a Metropolitan Medical Response System plan in your community and how it works with your disaster plan.

• Ensure that staff report unexpected illness patterns to the public health department, and, if appropriate, to the Centers for Disease Control and Prevention in Atlanta.

• Inventory your staff. In a national emergency, the government may call up armed forces reserves, and the Department of Health and Human Services' Office of Emergency Preparedness may need to call up response teams. Find out what your polices are for job retention and benefit continuation and how activation will affect operations.

Checklist highlights strengths, weaknesses

The AHA also offers an extensive chemical and bioterrorism preparedness checklist. The checklist is a series of questions, to which you can answer "Yes," "No," or "Don't Know," which prompts some action to be taken. The list covers Joint Commission inspections; communications and public affairs; supplies, pharmaceuticals, and equipment; hospital capacity; treatment procedures; facility management and security; and diagnostic capabilities. Other topics included in the overall checklist include facility management and security; psychiatric services and crisis counseling; and the diagnostic capabilities of the facility.

The largest section of the checklist involves training and personnel. This section includes questions on training staff for emergency preparedness and bioterrorism. The list breaks down who should be trained, from housekeeping staff and security to pastoral care and administrative staff. The list asks educators or those in charge of disaster planning to record the number of employees available in each department and the number that have been trained. It also prompts the user to categorize the different types of education currently available, both in-house and from outside vendors. Some of the staff training questions include:

• Does your facility / system have a method for assessing emergency preparedness training and continuing education needs based on the roles / responsibilities of staff members?

• Have all staff members received training on selection and use of appropriate personal protective equipment?

• Has the system / facility implemented activities to educate health care providers and laboratory workers on topics regarding specific procedures for handling biological and chemical incidents?

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• Do training programs include a description of the civilian incident command system, i.e., familiarization with the procedures of external organizations involved in response actions?

The complete checklists and additional planning information, are available online at www.aha.org/emergency/readiness/MaDisasterB0921.asp and www.aha.org/emergency/Content/MaAtChecklistB1003.doc. ■

HHS urges safeguarding of ventilation systems

More help is available for managers trying to revamp their emergency preparedness plans in light of potential terrorist attacks. The Department of Health and Human Services (HHS) has released new guidelines for protecting ventilation systems in commercial and government buildings from chemical, biological, and radiological attacks.

The guidelines provide recommendations that address the physical security of ventilation systems, airflow and filtration, systems maintenance, program administration, and maintenance staff training. In announcing the release of the guidelines, HHS Secretary **Tommy G. Thompson** said the guidelines offer "practical advice to building owners, managers and maintenance staffs on the steps they can take to protect their ventilation systems."

Tailor measures to fit building

The Centers for Disease Control and Prevention's National Institute for Occupational Safety and Health (NIOSH) prepared the guidelines with input and review by the Office of Homeland Security's (OHS) Interagency Workgroup on Building Air Protection and more than 30 other federal agencies, state and local organizations, and professional associations. OHS Director Tom Ridge announced that the guidance "offers reasonable and practical measures to reduce the likelihood of a contaminant attack and to minimize the impact if one occurs."

The guidelines recommend that security measures be adopted for air intakes and return-air grilles, and that access to building operations systems and building design information should be restricted. The information also recommends that the emergency capabilities of systems' operational controls should be assessed, filter efficiency should be closely evaluated, buildings' emergency plans should be updated, and preventive maintenance procedures should be adopted. The document also cautions against detrimental actions, such as permanently sealing outdoor air intakes.

According to the guidelines, protective measures should be tailored to fit the individual building based on several factors, including the perceived risk associated with the building and its tenants, engineering and architectural feasibility, and cost. "Guidance for Protecting Building Environments from Airborne Chemical, Biological, or Radiological Attacks," DHHS (NIOSH) Publication No. 2002-139, is available on the NIOSH Web page at www.cdc.gov/niosh. Copies also can be obtained by calling the NIOSH toll-free information number, (800) 35-NIOSH (800-356-4674). ■