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## INSIDE



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# Rehab facility has made 21st century move to seamless electronic record

*Focus is on quality, efficiency, safety*

Transcribed notes are going the way of the dinosaur at Glancy Rehab Center of Duluth, GA. The rehab facility, which is part of the Lawrenceville, GA-based Gwinnett Hospital System, has plunged ahead with a paperless documentation system dubbed QUEST, which stands for Quality, Uniformity, Efficiency, Safety through Technology.

"We began this project to improve safety for our patients, improve timely access to information, and to improve patient, associate, and physician satisfaction," says **Jo Driscoll**, RN, senior project manager of Gwinnett Hospital System.

For instance, an electronic physician order entry and medical documentation system will eliminate some of the more common medical errors caused by incorrect interpretation of clinician handwriting, Driscoll says.

"We want to improve patient care, and we can do it through technology," she says.

Driscoll predicts that many hospitals across the United States will move in the direction of electronic medical records in the next decade.

## *Change to electronic system takes lots of work*

At Glancy Rehab Center, documentation traditionally has been entirely handwritten, and in the inpatient setting there have not even been transcribed notes and reports, says **Katrina Stone**, MA, education coordinator / post acute services for Glancy's inpatient program. So the change to an electronic system has been a lot of work, especially in the beginning, Stone says.

The first phase of the hospital system's and rehab center's switch to electronic documentation was launched in March. By August, the system had about 50% of its data loaded in the computer system, Driscoll says.

In two subsequent phases, the transfer will include having all physician order entries made electronically, and finally, having all therapists

document electronically, Driscoll says.

Here's how the hospital system and rehab center have developed and implemented the switch to a paperless documentation system:

• **Building the electronic infrastructure.**

The hospital system purchased Sunrise Clinical Manager (SCM) software from Eclipsys Corp. of Boca Raton, FL, in which to build a database to execute the system, Driscoll says.

Developing an electronic data system requires input from all areas of the health care organization, including Stone as a rehab representative, because there are so many special needs for each clinical area.

"In March, 18 team members were chosen from the various departments throughout the hospital to represent their areas in building the system," Driscoll says. "We also have a steering committee to oversee the implementation of the software."

After setting expectations and providing team-building sessions, an Eclipsys consultant was brought in for training. Then team members were given assignments to collect the data needed to build the system for their areas.

The first assignment had team members return to their departments to create their own departmental team. Stone pulled together representatives from each rehab discipline and spoke to them about the rehab facility's current documentation process and how it might be made more efficient through an electronic system.

### *Order results will be available on-line*

• **Phase one: Orders and results.**

In the first phase, which will be implemented in late summer of 2003, the move to an electronic documentation system involves loading data into the software program so there will be order management, and results of those orders will be available on-line, Driscoll says.

All orders will be entered into the SCM system, and the requisition will be sent electronically to the ancillary departments. The results of those orders, along with transcription, will flow into SCM from the ancillary systems. This will make the information readily available to physicians who need to access the data, Driscoll explains.

If a physician at the rehab unit wants to check on a patient from a remote location, the physician can look at the file via the internet, provided he or she has the correct access and security rights to view that patient file, Driscoll says.

### *Developing common terminology*

• **Adjust rehab culture and terminology.**

"We had to go back into our departments and come up with common language across rehab and identify what we call something in rehab vs. what we call the same thing in acute care and sports medicine," Stone says. "We've created common terms to place in the database."

This is a complex task, because the terminology that will be used by all rehab staff needs to make sense to everyone. Some staff will have to get used to using a new word or description for an activity. Plus, the new terminology will need to be used by physicians, who traditionally have been able to write whatever they please on their orders, leaving other staff to decipher their meaning, Stone says.

The ultimate goal is for all rehab staffers to be on one page in how they understand the documentation instructions and terminology.

"We're trying to build Gwinnett's culture into the framework of an electronic clinical system so that it makes sense to the staff," Stone says. "We're using our rehab terminology, acronyms and policies and procedures, so that our staff — when they are oriented to this — will say, 'This is logical and I can follow it.'"

Obviously there will be some major changes. For instance, paper process flowcharts that now run up to four pages in length will be reduced with an electronic medical record, Stone adds.

"We'll do significant simplification as well as enhance patient care time," Stone says.

• **Phase two: Physician orders.**

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meets monthly to discuss any electronic documentation issue that requires physician input, Stone says.

"The physician coordinator facilitates this meeting — and we're not leaving them out of the loop," Stone says. "Physicians are an integral part of planning."

Physician buy-in is crucial because the second phase will require them to enter all orders electronically, eliminating the paper order forms. The second phase also will have nurse practitioners and physician assistants keying in orders electronically as appropriate for the physicians they represent.

"In rehab, the unit clerks, staff who take verbal orders over the phone, and the physicians will input the orders electronically," Stone says. "All caregivers will be able to read those orders, and other people can screen them as appropriate for the patient's care."

Plus, when clinicians order a lab test or therapy intervention, they will easily be able to see the results. On the electronic screen, a physician who is reviewing a patient's chart will see green or red flags indicating a result or that a document is available in the file, Stone says.

The color of the flag will indicate a normal order or result vs. an out-of-range result or stat order.

Once physicians have fully implemented the new electronic documentation system, the rehab facility and hospital will have greater efficiency and more accurate data, leading to increased patient safety, Driscoll says.

Currently, when a physician orders a medication, it has to go on paper and be sent through the pneumatic tube to the pharmacy and be verified, passing through several hands along the way. This creates a greater potential for misinterpretation and error, Driscoll says.

"With the electronic physician order entry system, the physician will enter the medication order into SCM and it will go directly to the pharmacy, reducing handling and lag time, which will reduce errors," Driscoll adds.

• **Phase three: Therapist documentation.**

When the final phase is implemented, all clinical and support staff will be using electronic charts and notes, including rehab notes, nursing notes, and flow sheets, Driscoll says.

"When we have all three phases completed, the only thing in the paper chart will be consent forms that patients sign, along with other documents that are not included in the SCM system," Driscoll says. "Our goal is to eventually have an electronic medical record for each patient in our system."

Therapists will be able to pull up all charts on the computer, do their charting in the electronic format, review other therapy charts, and easily understand all of the information, Stone says.

"The system allows a facility to establish charting standards with certain rehab treatments, choices, and responses set up in text boxes and pull-down lists to assist the clinician with their charting," Driscoll says. "It will make it more efficient and safer for patients."

Since the electronic format will include information cues and shortcuts, there will not be a great need for staff to type in text. The system will utilize touch-screen technology that keeps someone moving quickly through the required computer fields, Stone says.

All electronic charts will require passwords and identity log-in so that the patient information meets the new privacy regulations and cannot be accessed by unauthorized personnel, Driscoll says. ■

## Need More Information?


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***Special Report: Closer Look at TBI Treatment***

# Venerable TBI program continues innovations

*Facility renowned for Return to Driving program*

*[Editor's note: This is the second in a two-part series about traumatic brain injury (TBI) treatment and advances in understanding and services among rehab facilities and providers. In last month's issue, there were articles about a rehab facility that treats TBI patients holistically and another TBI program that trains staff on behavioral management skills.*

*This month we will discuss one facility's multi-tiered approach to treatment, which includes involvement of a neuro-optometrist.]*

Treating traumatic brain injury (TBI) patients poses a wide variety of challenges that require continual collaboration between physicians, therapists, psychologists, and other clinicians.

Making this continuum of care work efficiently also may require rehab staff to think and work together in a multi-tiered approach that addresses behavior, mood, and cognition, as well as physical difficulties, says **Jonathan Fellus**, MD, neurologist and director of Brain Injury Services for Kessler Institute for Rehabilitation in West Orange, NJ. Fellus also is a clinical assistant professor at New Jersey Medical School in Newark.

"We approach TBI treatment from the angle of cognitive therapy, medication, behavioral management, counseling to help people comes to terms with their disability, and a lot of education to help patients gain insight," Fellus says.

Kessler Institute first formalized its TBI rehab around 1980, making it one of the first rehab facilities in the United States to have a dedicated TBI unit. The institute has a 36-bed TBI unit and a 16-bed satellite, as well as a subacute brain injury unit, an extensive outpatient program, a formal cognitive remediation program, and a renowned Return to Driving project. For the past five years, the institute has been recognized by the state of New Jersey as a "Model System of Care."

"We do a great deal of research and have products focused on developing better and more efficient ways of delivering care, including programs such as going to patients' homes and identifying social and interpersonal barriers or hurdles that make it difficult for patients to interact with family or community," Fellus says.

The TBI staff include cognitive therapists, neuropsychologists, a neurologist, a physiatrist, neuropsychiatry, neuro-optometry, therapists, a dietitian, and nurses. There also are therapists specializing in spasticity management. **(See related story on some special TBI rehab roles in the unit, p. 113.)**

Each person's role is important to helping patients understand their limitations and improve, Fellus says. For example, the dietitian's role is crucial because post-traumatic weight gain is a hormonal problem that often occurs in brain injury patients, Fellus says.

Likewise, each member of the staff and each separate program contributes to the patient's recovery and acceptance. Fellus outlines several parts of the program's multi-tiered approach to treatment:

• **Return to Driving project.**

This two-stepped program provides an analysis of skills, such as the patient's reaction time, information processing, and perception, and it has a behind-the-wheel test in which a patient's skills are observed on the road.

Soon it may be possible to have the behind-the-wheel test without therapists having to take a patient on the actual road, Fellus says.

"We're moving ahead technologically and are looking at virtual reality simulators that are cutting-edge," Fellus explains. "We're testing how accurately a virtual reality machine is at predicting a safe return to driving. This may be able to eliminate the need for actual road testing."

## *New drug improves cognitive efficiency*

• **Helping patients cope with fatigue.**

Depending on whether patients suffer from a traumatic brain injury or from another type of brain injury, such as stroke, aneurysm, toxic exposure, or anoxia-ischemia from cardiac arrest, the pattern of each patient's recovery varies.

"But they share behavioral features like agitation and depression, and certainly short-term memory is almost always affected," Fellus says. "Fatigue is one of the least studied but most common symptoms."

The standard therapeutic approach is to teach patients how to rest and conserve energy, and physicians may prescribe the classic stimulants, Fellus says.

Through some new research, the institute has found that a new agent called Modafinil has a unique mechanism of action that appears to improve cognitive efficiency, Fellus says.

"So it helps with fatigue in a direct sense, but it may have an indirect benefit to fatigue by making it so that our brains require less work to accomplish the same tasks," Fellus says.

Patients taking Modafinil have been shown on a functional MRI to use less brain energy when accomplishing tasks, resulting in an efficiency that reduces fatigue.

• **Working collaboratively with physicians on treatment of comorbidities.**

Fellus' review of medications frequently reveals that brain injury patients are being treated with medications that will hinder their brain recovery process.

"For instance, all too often people are left on seizure medications because of the fear they are still at risk," Fellus says. "This is even when they may never have had a seizure, or they had one in the first few days when they were medically unstable."

Although it's true there might be some increased risk for a seizure, it's also true that the risk usually does not warrant the cost of keeping patients on these medications, Fellus says.

"These medications work by suppressing brain activity in a nonspecific way," Fellus explains. "The American Academy of Physical Medicine and Rehabilitation and the American Academy of Neurosurgery recommend that patients be on seizure medications for one week after a brain trauma, and then they should be discontinued."

Also, there are certain psychiatric medications that will suppress brain activity, as do some blood pressure medications. The older antidepressants also have the side effect of reducing the chemical in the brain that's important for memory, although the newer antidepressants do not have this drawback, Fellus says.

"These are a few examples of medications that have been associated with slowed recovery or reduced outcomes," Fellus says. "So you first want to do a good analysis of the medications a brain injury patient is on and then take the patient off the offending medications."

However, this is not always easy to achieve. Rehab physicians will need to communicate with a patient's other doctors and offer suggestions for medication substitutes because physicians, including psychiatrists, often do not know how the medications they prescribe impact brain function, Fellus says.

"They don't really have the training, and this is why you need a neuropsychiatrist or neuropsychologist or dedicated rehab physician to help protect the patient from the more invasive or aggressive treatments," Fellus adds.

"We really don't have a lot of tricks in our bag that we can use to speed recovery from brain injury," Fellus explains. "So whenever possible, the least we can do is remove the offending agents and give the brain the best chance possible to recover on its own."

- **Addressing a patient's substance abuse.**

It's well-documented that among TBI patients, 50% or more often have problems with alcohol or drug use, Fellus says.

This is why it's important for rehab clinicians to refer patients who have a history of substance abuse to addiction counselors, psychiatrists, or support groups to help prevent the patient from having a second brain injury.

"Statistically, once you've had one brain injury, you're at a much greater risk for a second one, and once you've had two, you have exponential risk," Fellus says. "Brain injury patients are at risk for many reasons and engage in risky behaviors statistically, such as driving fast, taking drugs, getting into arguments and fights in bars."

This impulsivity, added to a brain injury patient's poor judgment, slow reflexes, and tardy reaction time, all conspire to place the patient at greater risk for a second brain injury, Fellus says.

Educating patients about how continued substance use might contribute to their having a second brain injury is one of the greatest services a rehab team can provide, he adds. ■

# TBI units need special staff skills, programs

*Have you heard of neuro-optometry?*

Traumatic brain injury (TBI) affects patients' lives in so many different physical, cognitive, and behavioral ways that often a rehab team will include some nontraditional members and some unusual approaches to treatment.

At Kessler Institute for Rehabilitation in West Orange, NJ, the TBI program includes wheelchair, brace, and spasticity clinics, as well as an outpatient cognitive therapy program, among other components of its comprehensive approach, says **Jonathan Fellus**, MD, neurologist and director of Brain Injury Services for Kessler Institute. Fellus also is a clinical assistant professor at New Jersey Medical School in Newark.

Brain-injured patients generally are medically stabilized in the acute care hospital, and then are admitted to the special care unit, where therapy may be provided in smaller, less-distracting, one-on-one sessions that are designed to help patients who have limited ability to maintain attention and endurance. Then they are moved to the progressive care unit, a more complex and social environment where they will gain awareness, insight, and judgment, Fellus says.

After they are discharged from the inpatient

brain injury unit, the patient may go home or begin outpatient therapy, or he or she could be referred to a day hospital to receive outpatient therapies several times a week. But once the TBI staff determine a patient is ready, the patient will be referred to the outpatient cognitive therapy program.

A typical week in the cognitive therapy program will include daily attendance from 10 a.m. to 3 p.m. with a full day of individual and group therapy, some neuropsychological counseling, and eventually sessions with a vocational counselor.

"They may do work trials within the building with the maintenance or kitchen staff," Fellus says. "We've even had a couple of doctors as patients who as part of their cognitive therapy were sent to work with the physicians here, and they'd go on rounds and have cases to discuss."

The goal of the cognitive program is to keep patients under one roof three to five times a week for four to 16 weeks, Fellus notes.

Patients progress from level one, which is basic, to level two, which is mainstream, to level three, which is when they return only for tuning up their new skills or to receive ongoing counseling while returning to work or school, Fellus says.

"We're dealing here with a very heterogeneous group of people, from the laborer to the white-collar professional, and we can't address all of their needs in a group session," Fellus says. "Because the outpatient cognitive program is primarily run by a neuropsychologist, there is a great deal of individualized behavioral modification going on."

One unique member of the TBI team is a rehabilitative neuro-optometrist who works with therapists in helping to realign visual information the patient sees by placing a prism lens over the patient's existing lens or fitting a patient's glasses with a prism lens, says Fellus.

Common visual problems that occur after a brain injury are blurred vision, perception and balance difficulties, and headaches and attention deficits that occur as a result of vision changes.

The neuro-optometrist and occupational therapist will work together to devise an exercise regimen that incorporates visual vestibular integration, which is how the eyes feed the balance mechanism and interact there, Fellus says.

"We have at least three different systems that help us keep our balance, including the inner ear balance that is always being matched with what our eyes are seeing and that is matched with our body's position in space," Fellus explains. "There's a complex interaction between the three systems, and neuro-optometry is good at helping to coordinate them."

Typically, at Kessler Institute, the occupational therapist will do a brief vision screening test and then let the patient's physician know when a referral to the neuro-optometrist is indicated.

Another unusual TBI team member is a nurse case manager with TBI experience who is dedicated to obtaining insurance clearance for the TBI cognitive program.

Because each payer has its own complex set of rules, a great deal of staff time is required to explain the program and obtain funding, Fellus says.

"You have to be creative in moving benefits around," Fellus says. "If someone has unlimited physical therapy coverage but not a scratch on the body, then trying to get the insurance company to move that money to cover cognitive treatment is a worthy challenge."

So far, the nurse case manager has been successful in the role, and the dedicated staff hours have paid dividends for the patient and program alike, Fellus adds. ■

### Need More Information?

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# Final HIPAA privacy rule will be less burdensome

*Now the serious work begins on compliance*

When the U.S. Department of Health and Human Services (HHS) recently issued the final privacy rule required by the Health Insurance Portability and Accountability Act (HIPAA), some provisions that had caused consternation over the past year were reworked significantly or deleted altogether. The most significant change involved whether explicit

written consent would be required from patients for the disclosure of medical information during routine health care. Previous versions of the rule had required that providers obtain written consent from the patient for the use of protected medical information during treatment, and treatment could not proceed without that permission. But in the final HIPAA rule, HHS took a less strict stance and said that such explicit consent is not necessary.

Instead, covered entities will have to provide patients with a written statement that explains the provider's privacy practices and the patient's individual privacy rights. HHS still wants providers to try to obtain a patient's written acknowledgment of that statement, but if that is not possible or practical, it is sufficient to show that the provider made a good-faith effort to do so.

**Barrie K. Handy**, JD, an attorney with the law firm of Davis Wright Tremaine in Seattle, says HHS has responded to concerns that the notice of privacy practices was too long.

"The preamble encourages use of a 'layered notice' — a short, summary notice that is placed on top of a longer notice containing all the required elements," he says. "This grant of authority, though it comes in the preamble rather than in the rule itself, will be welcome news to a vast number of plans and providers."

In addition, the final rule allows disclosure for treatment, payment, and certain health care operations of other covered entities; reduces accountable disclosures; and permits an extra year to achieve compliance for pre-existing business associate agreements. Covered entities, meaning nearly anyone who transmits patient information to another party, will have until April 14, 2003, to comply with HIPAA.

When giving the patient notice of privacy practices, the patient's acknowledgment must be in writing, but the rules do not prescribe a form or require the individual's signature to be on the notice itself. Instead, a covered health provider may, for example, have the individual sign a separate sheet or simply initial a cover sheet of the notice.

Handy says that in emergency situations, the notice must be provided as soon as is reasonably practical, and an acknowledgment is not required. If a provider cannot obtain the written acknowledgment, it must document its efforts and the reason for its inability to obtain the acknowledgment. The attempt must be made no later than the date of first service delivery, including service delivered electronically. A health care provider whose first treatment encounter with a patient is over the telephone may satisfy the notice requirement by mailing it to the individual no later than the day following the telephone conversation, he says.

HHS recommends that the notice include a tear sheet or other document that requests an acknowledgment be mailed back to the provider. If the individual chooses not to mail the acknowledgment back, the provider has made the necessary effort. If the health care provider's initial contact with the patient is simply to schedule an appointment, the notice and acknowledgment requirements may be satisfied when the patient arrives for the appointment.

### *Providers waiting until the last minute*

Most of the final HIPAA rule was the same as the revisions proposed in March 2002, but health care providers apparently are not getting started on compliance until the last minute, says **Jack A. Rovner**, JD, partner and co-chair of the Chicago Health Law Practice Group with the law firm of Michael Best & Friedrich in Chicago. He works closely with risk managers and others responsible for complying with HIPAA, and he says he is dismayed at what he has seen so far.

"What I see them doing and what they should be doing are not necessarily the same thing," he says. "If you haven't started drafting your policies and procedures, that's what you should be working on right now. The secret to compliance is having a set of policies and procedures that actually reflect your business processes, and implementing privacy requirements that address your actual business. I don't see a lot of that happening yet."

Many health care providers have been working on HIPAA compliance for months, Rovner says, but they often get bogged down in analyses and retrospective assessment of how they have handled privacy issues in the past. That kind of analysis has a place in planning for HIPAA compliance, but many providers devote far too much time to it, he says.

"People have avoided focusing on the hard work of drafting policies and procedures, and instead they're spending time on gap assessments — saying, 'This is what we used to do and this is what we need to do,'" he says. "You feel like you're doing something, but if you do too much of that you'll find yourself without policies and procedures on April 14."

Rovner recommends avoiding too much of a focus on what you did with private health information last year. That's not so important, he says. The more important question is what you will do with it next year. He points out that health care organizations already protect private health information and always have to some extent, so it's not like HIPAA requires a wholesale reworking of your system. The biggest challenge, he says, will be to effect a cultural change that prompts your employees to think more about protecting a patient's privacy, to make that attitude second nature.

One major headache from the proposed HIPAA rule was eliminated in the end by changes that assure health care providers won't be prevented from carrying out normal, necessary transmissions of information. Previous versions led to fears that no information could be sent from one provider to another without the patient's specific permission, but the final rule allows a covered entity to disclose protected health information to any provider for the latter's treatment activities and to another covered entity or any provider for its payment activities. Rovner explains that the rule also allows a covered entity to disclose protected health information to another in order for the second organization to conduct quality control, competency control, or fraud control operations, as long as each has a relationship with the patient and the information pertains to that relationship.

Though HHS eased its position on some HIPAA issues, it took a hard line on marketing. The final HIPAA rule still prohibits providers from selling patient names to any marketers, such as pharmaceutical companies, without first getting the patient's specific authorization. That was exactly the situation that led to a class action lawsuit recently in Florida. The suit alleges that a Walgreen's pharmacy, a local hospital, three doctors, and drug manufacturer Eli Lilly misused patient records for a marketing campaign that mailed free samples of Prozac to people whose records indicated they might benefit from the drug. One recipient filed a lawsuit, saying he felt his privacy was invaded when Holy Cross Hospital in Fort Lauderdale, FL, and three doctors provided specific patient information for marketing of the drug.

To address a gray area that some providers had noted, HHS made clear that covered entities cannot use business associate agreements to get around HIPAA's requirements regarding marketing. The final rule explicitly prohibits pharmacies or other covered entities from selling personal medical information to a business that wants to market its products or services under a business associate agreement.

Handy says the business associate agreements need the attention of risk managers. HIPAA permits a covered entity to disclose protected health information to a business associate who performs a function or activity on behalf of the covered entity that involves the creation, use, or disclosure of protected health information, so long as

## Major Changes in HIPAA Privacy Rule

The final privacy rule required by the Health Insurance Portability and Accountability Act was published Aug. 14, 2002, in the *Federal Register*. The deadline for compliance is April 14, 2003 (April 14, 2004, for small health plans).

Here are the areas with major changes:

• **Privacy notice.** The rule omits the requirement for written consent from patients before disclosing patient information among providers. Instead, patients should be asked to sign or otherwise acknowledge that they have received information about their privacy rights and the providers' information practices.

• **Initial use and disclosure.** The final rule allows incidental uses or disclosure of patient information. For example, patient charts may be kept at bedside, and providers can talk to patients in semiprivate rooms or confer at nurse's stations without fearing that they violate the rule if a passerby overhears them.

• **Marketing.** The final rule says providers must obtain a patient's specific authorization before sending them marketing materials.

Copies of the Federal Register can be found at www.access.gpo.gov/su_docs/fedreg/frcont02.html. Click on "Wednesday, Aug. 14," and look under the "Health and Human Services Department." Or, you can view the *Federal Register* at many libraries. To order by mail, the cost is $10. Specify the date (Aug. 14, 2002), and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or MasterCard number and expiration date. Send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Credit card orders can be placed by telephone: (202) 512-1800, or by fax: (202) 512-2250.

the covered entity enters into a contract with the business associate containing specific privacy safeguards, Handy explains. The April 2003 compliance date may not provide enough time for large hospitals to reopen and renegotiate business associate agreements unless they start working immediately, he says.

### *'Minimum necessary' rule still applies*

The final rule takes the same approach to the "minimum necessary" concept as the version proposed in March. Handy explains that the concept of minimum necessary means covered entities and their business associates should not use or disclose protected health information beyond what is reasonably necessary for the purpose of the use or disclosure. But HHS allows for some exceptions. For example, minimum necessary does not apply to a covered entity's use or disclosure of protected information to another health care provider for treatment purposes. However, it does apply to uses or disclosures for payment and health care operations.

The final rule exempts from minimum necessary restrictions all uses or disclosures for which the covered entity receives an authorization from the individual to whom the health information pertains or the individual's authorized representative. HHS emphasizes that any authorization must include a description of the information covered "in a specific and meaningful fashion."

Like Rovner, Handy cautions that there is significant work to be done before April 2003. They both advise reading the HIPAA rule carefully, including the preamble, to determine what changes may be necessary in your policies and procedures. HHS' explanations in the preamble probably "create or enhance legal duties that covered entities need to identify and keep in mind for risk management purposes," Handy says. (To see the entire HIPAA rule at the HHS web site, go to www.hhs.gov/ocr/hipaa/.)

However you approach HIPAA compliance, Rovner says you must avoid being paralyzed by the fear that HIPAA will turn your world upside down. That fear is not justified, he says.

"I don't think people have taken a rational approach to HIPAA, and that's why we're not very far along in compliance," he says. "There's too much hysteria. It's complicated and requires work, but it's not what everyone has made it out to be. It is not the end of health care as we know it." ■

## Don't assume 'if we offer it, they will come'

*Good group facilitation/interesting topics key*

It is sometimes difficult to know why some support groups flounder and others thrive, yet there are several tactics organizers can use to help ensure that their group will be successful. The first may seem obvious, but it is vital that those who may benefit from the support group learn about the meetings so they can attend.

Organizers often turn to local advertising outlets such as the newspaper, and that is a good place to start, says **Barb Roseborough**, MSN, RN, CCE, education specialist at Saint Vincent Health Center in Erie, PA. "People who are interested in attending or have specific concerns that might prompt them to try a support group have a place to look for that information, and that is helpful," she explains.

However, many people who would benefit from a support group might not be motivated to look for a group on their own initiative, so it is important to reach the target population in some other way as well, says **Rose Konsel**, RN, BSN, CWOCN, coordinator of the Erie Ostomy Support Group.

For example, the Erie Ostomy Support Group reaches new ostomy patients by placing a flyer about the group in their discharge education packet. The flyer describes the support group and lists the dates and times it meets. It also lists the topics to be covered at future meetings.

Many of the support group leaders at Ridgecrest (CA) Regional Hospital place flyers in the waiting room at the hospital as well as in local clinics and physician offices, says **Kristin Henden**, CHES, education director at the hospital.

A hard sell is not necessary. "Simply provide information and invite patients," advises **Rita R. Miller**, RN, RRT, coordinator of patient education at Indiana University Hospital in Indianapolis. However, the appeal of a support group seems to depend upon the individual, she says.

"We see similarities in specific generations of people. For example, baby boomers are by far the most interested group. The newest generation to come of age never wants to participate," says Miller.

There almost seems to be a "support group personality," says Roseborough. Many who

attend seem to enjoy the interaction and sharing of information. Yet some who attend are very quiet and seem to just want to listen. They only speak if a skilled facilitator is able to draw them out, she says.

### *Help people belong*

To keep people coming back, groups need to be kept interesting but also all-inclusive. Group leaders must go out of their way to welcome new participants and perhaps, over time, ask a few of the people who attend regularly to become greeters, says Roseborough.

Creating a social environment by offering coffee or tea or some sort of refreshments seems to break the ice, she says. But it is important to strike a balance. Most people who attend sup port groups are not looking for a social club. It is important that groups not be a waste of time. Group leaders who are trained in facilitation and come prepared to help create an interesting discussion are vital to a group's success, says Roseborough.

"It is always good for a facilitator to have a couple of discussion topics or a newspaper article they have read that will spark interest," she says. Leaders who understand group dynamics will be able to generate discussion that makes the group beneficial to those who participate.

Other factors that keep group attendance between 15 and 25 participants include well-organized and well-run meetings that start and end on time. The monthly meetings are from 6:30-7:30 p.m. on Thursday evenings, and people don't have to do much more than show up. "People want to have minimal involvement. They don't want to be involved in leadership or have anything that is required of them," says Konsel.

Being allowed to bring a spouse or significant other seems to improve attendance as well, she says. Henden agrees. Prostate cancer survivors are encouraged to bring their wives to the support group meetings at Ridgecrest Regional Hospital, and that seems to be one factor that keeps attendance high. ■

### Need More Information?


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## Keeping up with changing work force is essential

*Language, literacy gaps may affect training*

As hospitals hire growing numbers of foreign-born workers, health professionals are facing an unprecedented challenge to adapt health and safety training.

The proportion of Hispanic workers in the U.S. work force is expected to increase by more than one-third by 2008, and the number of Asian workers will rise by about 40%, according to the Bureau of Labor Statistics. Overall, about one in 10 Americans was born in a foreign country, according to a recent U.S. Census report.

While some workers are well-educated and highly proficient in English, low-wage foreign-born employees may struggle with literacy even in their native language. The bottom line: Employers must make sure employees understand their health and safety training — not just that they receive it, experts stress.

That may include providing written materials in the employees' native language, using an interpreter during training sessions, and considering cultural and literacy issues, says **Sherry Baron**, MD, MPH, medical officer and co-team leader of special populations at risk for the National Institute of Occupational Safety and Health (NIOSH) in the Cincinnati division office.

"No matter if the employees' first language is English or not, you must have training that they can understand," emphasizes **Sandra Elias**, RN, OHN, occupational health and workers' compensation consultant at St. Jude Heritage Occupational and Environmental

Health Services in Fullerton, CA.

New employees may be so agreeable that they nod politely when asked if they understand the information in a training session, but the consequences of that gentle evasion can be significant.

Piedmont Hospital in Atlanta hired a group of young men from Sudan who had been dubbed The Lost Boys because of their traumatic experiences after their villages had been destroyed. The men had high school educations, and some had even attended college. While they speak English, "some of them understand better than others," says **Joyce Geddie**, RN, former manager of the hospital's employee health clinic. Their native language was an unusual African dialect that was not available from translation services.

As new employees in environmental services, they received the standard orientation as well as specific training in bloodborne pathogens. They acted as if they understood everything, even nodding during the training session, Geddie says.

But when one employee was observed pushing down on the trash with a gloved hand, Geddie realized the training would have to be repeated, this time with feedback focused on determining whether the employees understood.

"You need to be prepared for all the extra [things] you need to do," she says. Piedmont also has a large Hispanic work force and has conducted some training in Spanish. The Material Data Safety Sheets also are available in Spanish, she says.

### *Web sites have Spanish versions*

As employers recognize the importance of training geared toward immigrant workers, more resources are becoming available.

The U.S. Occupational Safety and Health Administration (OSHA) announced efforts to improve safety for Hispanic workers and launched a Spanish-language Web site. Employees now can file OSHA complaints in Spanish.

The NIOSH division office in Morgantown, WV, just launched a Spanish-language web site with links to other health and safety information in Spanish. The web site includes about 25 NIOSH documents that have been translated into Spanish, as well as some documents from OSHA.

"It was really in response to a large demand from employers and from our own discussions with people in industry and labor. There was a big need for [material in the] Spanish language," says **Marie Haring Sweeney**, PhD, chief of the document development branch in the education and information division.

Meanwhile, employers sometimes hire translators for specific orientation materials. Elias is not bilingual, so she sometimes works with a translator as she conducts a session. Even if the employees seem to have good English skills, it may be helpful for them to have printed material in their native language, she says.

If you have workers who are employed by an outside contractor, such as food services or security personnel, you are not absolved from responsibility to make sure they were properly trained, Elias notes. "I'd ask for their training documentation and an outline of their training," she says. "I'd also watch and see what they're doing."

Language isn't the only barrier that can affect

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comprehension of training material. Sometimes cultural differences may affect how employees interpret policies.

"Trainers may take for granted information about disease or disease causation, but it may be very different in another culture," Baron says.

In one case, researchers observed that farm workers weren't washing their hands after working in the fields. After some discussion with workers, they learned that the workers mistakenly believed that they could get arthritis or other conditions from washing with cold water.

Low-wage earners who are recent immigrants also may have lower literacy levels, Baron says. Training methods should take that into account.

"Some training methods that may be more participatory, involving the use of lots of drawings and explanations and activities, probably work well for everybody, but [they work] particularly well for individuals who come from backgrounds where they're not as attuned to reading documents," Baron points out.

It may seem like a new burden to provide foreign-language materials or training, but keep in mind that foreign workers usually represent a growing segment of the community served by the hospital, she says. "You'll be hiring people as part of an ever-increasing size of some ethnic community." ■



# High-reliability facilities thrive on info, proactivity

*See errors as opportunity for learning*

Information and analysis are the keys to becoming a high-reliability organization, says **Grena Porto**, RN, ARM, DFASHRM, senior director of clinical operations at VHA Inc. in Berwyn, PA, and past president of the American Society for Healthcare Risk Management. She lists these main components of a high-reliability organization:

- **Acknowledgment of risk:** Errors will always happen, and they are not shameful, so we can talk about them. Errors are opportunities for learning. Those who make errors can help us to learn from them. The focus must be on detection and recovery.
- **Auditing of risk:** Effective risk-auditing systems use simple standardized forms, multiple formats for reporting, no confusing or restrictive definitions, no complex terminology, minimal duplication, and anonymity. The auditing program also should focus on information, not data, so that it allows narratives, doesn't require the reporter to analyze the information, and provides feedback in a "lessons learned" format. There also should be immediate response to serious hazards.
- **Appropriate reward system:** Everyone must understand what safety is, and front-line operators must be empowered to act. Rewards must be timely and appropriate, and they must be publicized.
- **System quality standards:** All participants must know what quality is and everyone must be expected to maintain quality. The quality standards must be based on evidence.
- **Flexible management models:** Front-line workers are trained and empowered, and the one with the most expertise is in charge. Anyone can make a safety-motivated decision. The goal is management, not micromanagement. ■