Outcomes
Reimbursement
Personnel Management
Quality Improvement

Rehab Continuum Report™

The essential monthly management advisor for rehabilitation professionals

THOMSON
AMERICAN HEALTH CONSULTANTS™

IN THIS ISSUE

AUGUST 2003
VOL. 12, NO. 8 • (pages 85-96)

Cancer survivor uses rehab to offer hope, healing to other patients

Fatigue is cancer patients' most debilitating symptom

If **Angelo Rizzo**, PT, had ever wondered whether he was on the right career path, those doubts were put to rest when he was diagnosed with chronic myeloid leukemia in 1999. A year before, Rizzo, president of Therapeutic Solutions in Atlanta, had begun a push to get oncologists to refer their patients to rehab for cancer-related fatigue (CRF). He had to put those plans on hold while he went through heavy chemotherapy, searched unsuccessfully for a bone marrow donor, and ultimately enrolled in a clinical trial that sent his leukemia into remission.

Rizzo, who also is vice president of the oncology section of the American Physical Therapy Association in Alexandria, VA, says the timing was no coincidence. "I feel like God had a plan for me," he says. "Putting me in that leukemia situation really gave me an opportunity to share with patients what I was experiencing first-hand. Every day, I feel I'm a better therapist because of what I've gone through personally with my leukemia."

During his six months of chemotherapy, Rizzo found he was unable to work more than two hours a day because of fatigue. "After about a month, I said I need to be practicing what I'm preaching here, and I started myself on the fatigue rehab program," he says. "I saw an amazing difference in a six-week period. It gave me an amazing passion to promote this."

Rizzo is constantly working to convince oncologists to set up formal rehab programs for their patients at one of the seven Therapeutic Solutions locations in the Atlanta area. It took four years to convince one oncology practice to do so, but as the physicians began to see the improvements patients were making, they started recommending it to more patients. Rizzo estimates, however, that the practice is still only referring about 25% of its patients who could be helped by the program.

Many physicians either don't realize the benefits of rehab for CRF or

underestimate the amount of fatigue their patients experience, Rizzo says. But studies from the Rockledge, PA-based National Comprehensive Cancer Network (NCCN), made up of the country's top cancer centers, have found that about 90% of all patients undergoing chemotherapy and radiation experience significant fatigue that physically impairs their functioning.

It's not hard to figure out why: chemotherapy, radiation, and surgery can all be debilitating. "The tumor is growing, so that expends energy. Then you are deconditioned because you're feeling weak and not exercising. Your nutrition is less than normal," Rizzo says. "Chemotherapy has an impact on so many organs and healthy tissues that are responsible for giving the body energy, so that's compromised."

Add to that pain, sleep problems, and emotional distress, and you have a recipe for physicians and patients who already have too much on their plates. "Doctors have so much to do with the more life-threatening issues that they're not all that concerned with the quality-of-life issues," Rizzo says. "And patients are so fatigued that they aren't even willing to get involved. The thought of going somewhere to expend more energy is out of the question. It's too exhausting even to make one more appointment."

But that one more appointment could make all the difference. The NCCN reports that when patients were asked what their No. 1 most debilitating symptom was, they said fatigue. Physicians who answered the same question said pain was the most debilitating symptom experienced by cancer patients. In the survey, 60% of patients said they mentioned their fatigue at every visit. Only 6% of doctors said it was addressed every time.

Improvement seen at first visit

Rizzo says patients see an immediate improvement, usually before their first rehab visit is over. "We teach them simple modifications to the ways they sit and stand and breathe and walk that immediately begin to add more energy," he says.

Therapeutic Solutions surveyed the first 200 patients in its cancer program and found overwhelming improvements. Patients were asked to rate their fatigue on a scale of 0 to 10 both pre- and post-treatment. Sixty percent of the patients had more than a 90% improvement in their fatigue level. Sixty-five percent had more than a 90% improvement in their functional activity level.

Research from the NCCN shows that exercise is the No. 1 most effective non-pharmacologic intervention for CRF. In its treatment guidelines (which can be found at www.nccn.org), the organization encourages physicians to be proactive about fatigue with early detection and intervention protocols. Before patients start the first day of chemotherapy, they should be told to alert their nurse or physician at the first sign of fatigue. Then the physician should be ready with a referral to rehab.

NCCN released a set of guidelines in May directed at patients experiencing fatigue. "Feelings of fatigue should not be dismissed but discussed," says **Rodger J. Winn**, MD, chairman of the NCCN's Guidelines Steering Committee and a researcher at the University of Texas M.D. Anderson Cancer Center. "When patients

Rehab Continuum Report™ (ISSN# 1094-558X) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Rehab Continuum Report**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m. -6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $575. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $460 per year; 10 to 20 additional copies, $345 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $96 each.(GST registration number R128870672.)

Editor: **Ellen Dockham**, (336) 778-0371, (edockham@aol.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Managing Editor: **Alison Allen**, (404) 262-5431, (alison.allen@ahcpub.com).
Production Editor: **Brent Winter**.

THOMSON
AMERICAN HEALTH CONSULTANTS

Editorial Questions
Questions or comments?
Call **Alison Allen**, (404) 262-5431.

Need More Information?

- **Angelo Rizzo**, PT, president, Therapeutic Solutions, 1901 Montreal Road, Suite 132, Tucker, GA 30084. E-mail: arizzo8109@aol.com.
- **National Comprehensive Cancer Network**, 50 Huntingdon Pike, Suite 200, Rockledge, PA 19046. Telephone: (215) 728-4788. E-mail: information@nccn.org.

and physicians work together, they are often able to find the source of the fatigue. With that knowledge, the health care team is able to provide suggestions to lessen the fatigue."

Rizzo says from his personal experience that it was amazing how much the rehab program helped. Patients usually come three days a week for one month, and the therapist teaches them a home program to follow. The program starts with an assessment of such issues as functional changes, strength, endurance, mobility, breathing, and gait. Then the therapist makes an individual plan to improve areas of weakness. "The therapy program is not all that different from the program for other patients, but therapists do need to understand the cardiac, respiratory, and bone risk factors," Rizzo says. "We can show patients energy conservation techniques, like how to change an inefficient gait. We help them prioritize and see what activities or chores are truly essential and which could be delegated. That gives them the energy they need to do the more important things."

Besides making life easier physically, fatigue rehab also can dramatically improve patients' emotional state, Rizzo says. Patients in his survey reported an improved sense of control over their lives. "They are hooked up to machines so much of the time and they lose so much control. They have physical limitations and are dependent on caregivers," he says. "Patients who have fatigue have much higher incidences of depression, anxiety, and pain. We can teach them how to get more independence and give them a sense of hope and a positive outlook. That can make a tremendous amount of difference in the healing process."

And it doesn't hurt to have a physical therapist who is living proof that cancer doesn't have to be a death sentence. "I'm still in major remission, and I think it just reinforces to them that hopefully their situation is only temporary," Rizzo says. ■

The Road to PPS Success

Team conferences lower hospital's length of stay

Technology, paper forms increase efficiency

A green monster may not be the first thing you would like to see when you get to work in the morning. But for one rehab hospital, the green monster has been a key to successful implementation of the inpatient prospective payment system (PPS).

At National Rehabilitation Hospital (NRH) in Washington, DC, a bright green pen-and-paper form has taken up residence in each patient room to help team members document the initial functional independence measure score required under PPS. The green form is hard to miss, but if someone neglects to record a score in the required first three days, the hospital's PPS coordinator will make sure it gets done.

"Before PPS, we used to rate the patient as to level of function. With PPS, you have to rate what the burden of care is," says **Rosemary Welch**, RN, MSA, CNA, vice president for patient care services. "It's very important for all team members to do the ratings. If the patient had one incontinent event in the middle of the night, the day nurse wouldn't know about it. That one event creates a whole list of actions nursing must do — look at medications, clean up, notify the physician. We would have missed that had we only been rating them the old way, which was usually on the day shift. It has made us more aware of what happens to the patients. Obviously, the patients get better care the more we know about them."

NRH also has changed to daily team conferences and has added a nurse coordinator with no patient load to ensure communication and follow-up with nursing staff.

It's working. In the first two months of using the system, NRH's average length of stay (LOS) dropped two days to 18 days, the lowest in the hospital's 17-year history. NRH has maintained that LOS for more than a year. The hospital, which had budgeted for a first-year $1 million loss due to PPS, ended up in the black. But more important, patients are benefiting from a more cohesive, efficient approach to care.

Cathy Ellis, PT, director of physical therapy, occupational therapy, vocational rehab, and therapeutic recreation, says while PPS has its problems,

the new system has resulted in positive changes at NRH. "It has improved our team functioning. The real positive thing has been the way we approached PPS from the perspective of process improvement," she says. "The entire team was included in the process, from staff level up to VPs. Our medical director was integrally involved. We didn't fall into a situation of 'we hate PPS.' Instead, we improved our team function."

The NRH staff is most proud of the redesigned team conference system, which grew out of an intensive benchmarking process. "Each team member called several facilities they were familiar with, and we did conference calls and a site visit. We looked at best practices, examined data, and pulled in standards from the Commission on Accreditation of Rehabilitation Facilities and the Joint Commission on Accreditation of Healthcare Organizations," Ellis says. "Our goal was to create a patient-focused model of care that would actually improve the quality of patient care. We knew we wanted a model that was patient-focused, with a highly integrated team that would allow us to manage our patient care tightly day to day."

Previously, team conferences were held twice weekly for one to one-and-a-half hours. Each patient would get a formal conference once a week. But the meetings were not particularly efficient, and team members were concerned about fragmentation and confusion over such issues as discharge dates, Ellis says. Now, the teams meet daily for half an hour, with two to four patients scheduled for formal conferencing on a rolling basis. The case manager runs the meeting, which begins with a five- to ten-minute discussion on big issues such as pain management or discharge plans and moves on to the formal conferencing.

One logistical hurdle was setting a time for the meetings that could accommodate the schedules of physicians, nurses, therapists, case managers, social workers, and psychologists. The hospital settled on meetings at 8:30, 9, and 9:30 a.m. and another at 1 p.m. for its various teams.

Because nurses busy delivering patient care often missed the team conferences under the old system, NRH appointed a nurse coordinator with no patient load to attend the meetings. "She serves as the liaison between the team and the nursing staff," Welch says. "Nurses often felt they were out of the loop on the team conferences, but it is so important to have their input. We also get improved action because now there is somebody to actually follow through. The nurse coordinator doesn't have a patient load, so if there's some piece of equipment that needs a rush order or a different dressing needed, she has the ability and the time to get it. It relieves stress for the nurses."

Ellis notes that the nurse coordinator provides cohesiveness to a staff of constantly rotating nurses. "The coordinator position is full-time permanent, and she is at the team conference every day," Ellis says. "She communicates regularly with front-line staff nurses who are delivering most of the care to the patient."

The team's case manager runs the meeting, and it falls to that person to prepare reports on the patients ahead of time. The advance preparation, while time-consuming for the case manager, makes the meeting much more fruitful, Ellis says. The hospital has alleviated some of the burden on the case managers by making their conference report also serve as their weekly progress note for therapy. Because the reporting has already been done, conference time can be used for productive discussion on how to address any issues. "We put the report up on a screen at the front of the room," Ellis says. "Everyone can see the report, whether the patient's goals are being met or not met, any barriers to achieving their goals, and adjustments to the treatment plan."

Paul Rao, PhD, vice president for clinical services at NRH, says another component of the hospital's PPS success has been the change to eRehabData, the web-based outcomes system offered by the American Medical Rehabilitation Providers Association. During team conferences, case managers can modify the report on-line and can even interject benchmark data simultaneously.

Another benefit is that physicians have easy access to the data. "We now have physicians every morning looking at how their program is doing. That was never the case before," Rao says. "They used to have to wait three months for the data. Web access has allowed every physician and every manager to see how their patients are doing compared to the nation, how we did over the last three quarters, how we did today. It's a huge change in terms of how our physicians have been analyzing data and managing results." ■

Need More Information?

☎ **Rosemary Welch**, RN, MSA, CNA, National Rehabilitation Hospital, 102 Irving St., N.W., Washington, DC 20010. Telephone: (202) 877-1000.

Rehab's solution to 75% rule could be costly

Transfer rule may affect facilities

Health care consultant **Fran Fowler** says the rehab field is making a huge mistake. Two huge mistakes, actually, which could wind up costing the industry millions of dollars and forcing hospitals to close acute rehab units. One of them has to do with the 75% rule; the other relates to an overlooked proposal by the Centers for Medicare & Medicaid Services (CMS) for acute care hospitals that has the potential to reshape the future of rehab, she says.

Fowler, the president of Fowler Health Affiliates in Atlanta, agrees with the loud and clear message the rehab field has sent to CMS in recent months regarding the 75% rule. "I think you should get paid regardless of the diagnosis; you shouldn't be held to a 75% rule," Fowler says. "But rehab is making a serious mistake. They will get what they want, but the pot of money is not going to grow to pay for it."

The rehab field presented a united front at the town hall meeting CMS held in May to discuss the 75% rule for payment as an inpatient rehab facility. The industry's overwhelmingly preferred solution to the problem is for CMS to to determine compliance with the rule by using the 21 rehabilitation impairment categories (RICs) from the prospective payment system, instead of using the original "HCFA-10" categories. CMS did not appear likely to favor that solution, so the rehab field is backing legislation co-sponsored by U.S. Rep. Frank LoBiondo (R-NJ) that would require it.

"If the legislation is passed, what no one in the industry has recognized is that there is a pool of money CMS has under a Republican Congress, and they're not going to give more money for rehab," Fowler says. "The folks at CMS are going to have to take the pool of money and divide it over more people and more CMGs [case mix groups]. They're going to have to reduce the payment on every CMG. This is a congressional edict. They don't have any more money."

Fowler points out that LoBiondo's bill does not ask for an increase in money to pay for the additional RICs. "The amount of money paid per RIC will drop dramatically, because they've only got a total number of dollars to spend," she says. "No one ever looks at what the government constraints are. CMS will not have a choice."

Fowler says the industry should have asked CMS to recognize the RIC for hips and knees and to form an advisory committee to see how CMS could achieve equitable payment for all the RICs. Instead of using a 75% rule, Fowler suggests hospitals should validate the rule that requires rehab patients to have three hours of therapy, five days a week.

"All CMS has to do is have people document that patients have received those hours, regardless of their DRG [diagnosis-related group]," she says. "If people had to do that, you would get away from the rehab providers who don't provide three hours of therapy a day. There are a number of them, sometimes because of scheduling problems or patients refusing therapy. The people who really can't tolerate or won't cooperate with the three-hour therapy get moved to the right level of care.

"CMS is saying the only way to distinguish rehab from acute care is the 75% rule. But the two differences really are the hours of nursing care and hours of therapy," Fowler explains. "It's called acute rehab because these people have tremendous rehab needs that can't be met anywhere else. If they can measure it that way for skilled, I don't know why they can't do it for acute. No one has ever measured it."

Fowler fears that if the legislation passes, more hospitals will decide to open rehab units. "But when they change the payment, you will see everyone's mouths drop open," she says. "I agree the 75% rule is ridiculous, but the industry's solution is not the answer. No one will be able to make money in rehab, and hospitals will end up losing acute rehab. That's where the industry can shoot itself in the foot."

Another potential problem for rehab that has been overlooked in the hue and cry over the 75% rule is a proposed rule published in the June 9 *Federal Register* that would add 19 DRG codes, several of which apply to rehab, to the transfer rule for acute care hospitals. The transfer rule penalizes acute care hospitals if they discharge patients under these DRGs to post-acute care earlier than the desired length of stay. Hospitals receive only a per diem amount if those patients are discharged early.

"If hospitals keep these patients for the full length of stay, some won't go to rehab," Fowler says. "Others will go to rehab more functional, and that means rehab will get less dollars. Or you will see an increase in the volume for skilled care.

It has a negative impact on acute rehab and a positive impact on skilled care rehab."

Most people in the rehab industry have not paid attention to this information because, on the surface, it applies to acute care. "They only read the rules that apply to rehab; they haven't read this one," Fowler says. "They won't feel it initially. They will feel it as they look out one or two years."

The problem CMS is trying to address with the transfer rule is summed up in this example from Fowler: A hospital might be paid $10,000 by CMS for a case with a 10-day length of stay. But if the hospital gets the patient well and discharges him or her in five days, then the hospital's cost is only $5,000. If the patient is discharged to post-acute care, CMS might incur an additional cost of, say, $9,000 for that level of care.

"CMS just spent $19,000 on somebody, and you made $5,000 on that. You get to keep the rest of the money. But Medicare says, 'No you don't, not if you're pushing them out early and shoving them into acute rehab,'" Fowler says. "It's legitimate, what they're thinking. There are people out there who could game the system. CMS thinks people really plan these events, but I don't think it happens that way."

Fowler says the federal government needs to look at the whole continuum of care before forcing patients to stay longer in an acute setting. "Because so many of the beds are filled, more and more acute care hospitals are going to have to build more facilities to accommodate the demand for Medicare patients," she says. "If we could flow patients through the continuum to open up more beds so we don't have to spend that money, have not we done the better thing for the community?"

For patients who need comprehensive rehab, acute care is the worst place to be, Fowler says. "They are not staffed and put together to manage a rehab model of care. What you're going to do is have more fragmented care, and the people who would really get the functional gains from acute rehab are not going to get them."

Nosocomial infections also are a problem. "That's the biggest gamble. I'd rather pay somebody else to do the rehab and not have to deal with the infections," she says. "You can do your darndest to protect people, but they are in a less-than-optimal physical condition, and those bugs just love living in the hospital. It is not in the best interest of anyone to be in acute care one moment longer than they have to be."

Need More Information?

☎ **Fran Fowler**, President, Fowler Health Affiliates, 2000 RiverEdge Parkway, Atlanta, GA 30038. Telephone: (770) 261-6363. E-mail: ffowler@fowler-consulting.com.

Fowler's advice for acute rehab staff is to stay on top of what happens with the transfer rule. She advises learning the length of stay that Medicare wants for your patients when they are in acute care, and make sure your hospital is meeting those criteria. She also suggests meeting with the hospital's finance department to determine the financial implications of moving patients from acute care to rehab earlier. "If you bring someone to rehab, is there somebody else waiting for that acute bed that you could put in there? Convince the hospital it makes sense to give you patients early if they can make up revenue by filling that bed. That will help ensure your population base." ■

Get a handle on denials, increase reimbursements

Central clearinghouse for all rejections is a must

In these times of dwindling health care reimbursement, there's no phrase more significant to managers — and their bosses — than "denial management."

There are several key components that must be in place if a hospital is to achieve best practice in denial management, says **Joe Denney**, CHAM, director of revenue management at The Ohio State University (OSU) Medical Center in Columbus.

"The goal, of course, is not to receive any [denials] if possible," he notes.

At his organization, Denney notes, a distinction is made between "rejections" and "denials," which is key to understanding the process.

"In our lingo, whenever a claim goes out the door and something comes back from the payer saying it is seeking more information or saying, for example, 'I will deny the last day of this inpatient stay,' we call that a rejection."

Hospital staff work all rejections with the aim of turning them around if there is a reason to do so, he explains. "A lot of times a rejection has to do with documentation, as when it says that [access personnel] didn't precert or preauthorize."

That particular type of rejection is sent to the registration quality assurance manager, who looks in the system and may say, 'We did do the authorization and here's the authorization number.'" In that case, he adds, "we would write a quick appeal letter and get the money."

What his hospital considers "denials," Denney explains, is when a rejection has already been appealed and the payer has come back and said, "There is no way we're going to pay." At that point, he says, "we write it off to bad debt. So there's a real distinction between rejection and denial."

That distinction made, he says, the central component of successful denial management is establishing one area in the hospital where all rejections and denials will be received.

"Until we established that here, [rejections and denials from payers] went everywhere — to the director of utilization review [UR], the business office, even hospital administration or the chief operating officer. We found it extremely important to have one designated area and say, 'This is the address.'"

To clarify that requirement, Denney suggests making sure the necessary language is in managed care contracts. With Medicare, it's not an issue, because those communications are sent electronically.

Don't let one department sit on rejections

"We also did some internal communication, saying, 'If you get these [rejections or denials], forward to this person in the central business office, and that person will get in touch with the insurer.'"

This piece of the process is crucial, Denney points out. "Every [payer] has a deadline. Some say, 'If you don't appeal within 30 days, we're not going to pay no matter what.' If a rejection went to the director of UR, for example, and that department sat on it for a while, you could be past that line."

The next step, he says, is to have a very good grasp of what a rejection is about so it can be placed on a work list and sent to the appropriate area to be investigated and appealed.

At the focal point of the rejection/denial activity at OSU Medical Center, Denney notes, is the organization's central business office, where **Mark Tennant**, the rejection/denial manager, oversees the process.

In November 2001, Tennant explains, he was given the mission of developing a rejection process using the health system's existing staff and computer technology.

"The flow was to have the business office receive all rejections, whether correspondence, follow-up, or explanation of benefits," he says. These rejections, Tennant adds, would go to employees known as "rejection reps," who would review the information and put them in various categories, or electronic buckets, depending on the reason for the rejection. A service code assigned to each rejection sends it to one of the following buckets, he says:

- precert/authorization;
- medical necessity;
- medical documentation;
- peer review organization denials;
- Medicaid sterilization.

The latter, Tennant says, has to do with a consent form that Medicaid requires in order to process claims for a service requiring a "sterilization procedure," such as an abortion or a hysterectomy.

Gatekeepers resolve rejections

There are more than 50 open service codes — defined by the payer's reason for the rejection — within the five categories, he adds. So, for example, there are several reasons why a rejection might go into the precert/authorization bucket. "If authorization date was the problem, the [rep] would apply that [specific] service code."

One person is assigned the role of gatekeeper for each bucket, Tennant says. The gatekeeper for each bucket receives a daily revenue management work list listing all the rejections in the bucket. While the gatekeepers may delegate tasks to other employees, they are ultimately responsible for resolving those rejections.

"Their names are assigned to that work list, which is important for accountability," he notes. "The gatekeeper has 10 days to resolve the account. At that time, they put a 'close code' on it, which shows what the resolution was."

The resolution might be "authorization obtained," "no authorization obtained," "additional information sent," and so forth, Tennant says. "Once [the rejection] is closed, that account goes back into our regular business operation,

and the code triggers the next action."

What's unique about the process, he notes, is that everything that happens within the service code — a function of the hospital's patient accounting system — is a permanent stamp. "The 'open' and 'close' codes are tracked to the ultimate payment or adjustment to the account, why we opened it, and why we closed it."

As part of the denial management process, the hospital's information services department has developed an information warehouse for the rejection data, Tennant says. In place since September 2002, this data warehouse "is like a sub of the process," he explains. "The information is identified and dropped into the warehouse, which produces reports that show a breakout of the buckets."

Those reports show which payers the rejections are coming from and what the problems are, Tennant says. "We can look at the whole process to see if it's the payer having the issue or a practice we need to change."

Almost all departments participate

Administrators, directors, and managers throughout the hospital system receive biweekly summary reports on the five buckets, including the number of rejections and the related dollar amount for each one, he notes.

It has been extremely important to the success of the denial management initiative that almost all the departments in the hospital are involved, Tennant says. When he made the initial presentation on the process, he adds, "the right people were in the room to say, 'I can do this, I can help.' That's the plus of doing that."

In addition to putting language into the contract regarding where rejection correspondence should be sent, the managed care department comes into play in communicating with payers at the other end of the process, Tennant points out.

When managed care personnel meet periodically with payers — for some it's quarterly, for others every two months or once a month — they discuss and review denial management reports, he says.

"[The hospital representative] says something like, 'We've boiled it down to what we think the real issue is,'" Tennant says. "If it's a payer problem, [the hospital's position is] 'This is what we're seeing. Tell us why you're rejecting these claims.'"

The managed care department, as well as everybody in the revenue cycle, has direct access to the denial information, he notes.

The next step is to designate one individual on the payer's side and one individual from the hospital who correspond directly regarding rejections, Tennant adds. The hospital already has this relationship with two of its biggest payers, he says, and the goal is to increase that to five. ■

OSHA issues ergonomic rules for nursing homes

Proper lifting is central focus

The Occupational Safety and Health Administration (OSHA) recently issued the first in a series of industry-specific guidelines for the prevention of musculoskeletal disorders (MSDs) in the workplace. Its target: nursing homes.

The good news, however, is that the guidelines could help reduce workers' compensation expenses and other costs related to ergonomic injuries, and the guidance is equally applicable to other health care settings.

OSHA's *Guidelines for Nursing Homes* focuses on what the agency calls practical recommendations for employers to reduce the number and severity of workplace injuries by using methods found to be successful in the nursing home environment. OSHA administrator **John Henshaw** announced the guidelines by saying they were the result of a close collaboration with the long-term care industry.

The guidelines are divided into five sections: developing a process for protecting workers; identifying problems and implementing solutions for resident lifting and repositioning; identifying problems and implementing solutions for activities other than resident lifting and repositioning; training; and additional sources of information.

OSHA emphasizes that specific measures or guideline implementations may differ from site to site. Still, the agency recommends that all facilities minimize manual lifting of residents in all cases, and eliminate such lifting when feasible. Further, OSHA encourages employers to implement a basic ergonomic process that provides management support while involving workers, identifying problems and implementing solutions, addressing reports of injuries, providing

training, and evaluating ergonomics efforts.

"Nursing home workers are suffering too many ergonomics-related injuries," Henshaw said. "But the experiences of many nursing homes provide a basis for taking action now to better protect these workers. These guidelines reflect best practices for tackling ergonomic problems in this industry."

Industry leaders say guidelines are good

The ergonomic guidelines were endorsed by the American Health Care Association (AHCA) and the American Association of Homes and Services for the Aging (AAHSA), which issued statements saying the guidelines demonstrate an understanding of the complexities involved in applying ergonomics to the lifting, transferring, and repositioning of nursing home residents.

Praising OSHA for its inclusion of key stakeholders early in the process, AHCA president and CEO **Charles H. Roadman** II, MD, CNA, says the guidelines appear to acknowledge the indelible connection between patient handling tasks and clinical care by recommending use of the Minimum Data Set to assess resident handling tasks.

"Nursing home professionals are in the business of caring for the frail, elderly, and disabled. When we talk about ergonomic safety for our staff, we aren't talking about moving boxes. We are talking about moving real people," Roadman says. "We cannot ignore the clinical needs of our patients when discussing employee safety, and the OSHA guidelines recognize this."

Similar praise comes from **William L. Minnix Jr.**, DMin, president and CEO of AAHSA. He commends OSHA for making sure the guidelines take into account the groups' experience-based understanding of ergonomics in nursing homes.

"These final guidelines are far superior to the draft guidelines issued last summer, in large part because OSHA listened to what we had to say and worked with us," Minnix says. "As a result, these guidelines not only are stronger and will do a better job of protecting our direct care staff, but they are more realistic."

In April 2002, OSHA issued a comprehensive plan to reduce ergonomic injuries through a combination of industry-targeted guidelines, tough enforcement measures, workplace outreach, advanced research, and dedicated efforts to protect immigrant workers. Secretary of Labor **Elaine L. Chao** subsequently announced that the first industry-specific guidelines to reduce ergonomic-related injuries would be developed for nursing homes. Information for the guidelines came from numerous sources, including existing practices and programs, trade and professional associations, labor organizations, the medical community, individual firms, state OSHA programs, and available scientific information.

In its primary suggestion, OSHA recommends that manual lifting of residents be minimized in all cases and eliminated when feasible. It also recommends that employers develop a process for systematically addressing ergonomics issues in their facilities and incorporate this process into an overall safety and health program. OSHA says an effective process will perform the following tasks:

- **Provide management support.** Employers should develop clear goals, assign responsibilities to designated staff members, provide resources, and ensure responsibilities are fulfilled. A sustained effort is paramount.
- **Involve employees.** Encourage employees to submit suggestions or concerns; discuss workplace and work methods; participate in training and procedural designs; respond to surveys; and participate in task groups with ergonomics responsibilities.
- **Identify problems.** Establish systematic methods for identifying ergonomic concerns in the workplace, e.g., analyze information from OSHA injury and illness logs, workers' compensation claims, and insurance company reports.
- **Implement solutions.** Effective solutions usually involve workplace modifications that eliminate hazards. Changes can be made in the use of equipment, work practices, or both. (The guidelines include solution examples in Sections III and IV.)
- **Address reports of injuries.** Manage work-related MSDs in the same manner and under the same process as any other occupational injury or illness. Like many injuries and illnesses, employers and employees can benefit from early reporting of MSDs. These reports also can help the establishment identify problem areas and evaluate ergonomic efforts.
- **Provide training.** Provide ergonomics training to nursing assistants and other workers at risk of injury, charge nurses and supervisors, and designated program managers.
- **Evaluate ergonomics efforts.** Evaluation and follow-up are central to continuous improvement and long-term success. They help sustain the effort to reduce injuries and illnesses, track whether

ergonomic solutions are working, identify new problems, and show areas where future improvement is needed.

OSHA offers other resources

The guidelines list a number of protocols designed to help employers with resident assessment and the determination of appropriate methods for transferring and repositioning residents. Some examples include the Resident Assessment Instrument published by the Centers for Medicare & Medicaid Services. The instrument is available at www.cms.hhs.gov/medicaid/mds20/. OSHA also recommends the *Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement*, published by the Patient Safety Center, the Veterans Health Administration, and the Department of Defense. This information is available at www.patientsafetycenter.com.

OSHA notes that a number of work-related MSDs occur in activities other than resident lifting. Some activities a nursing home operator may want to review include bending, lifting food trays above shoulder level or below knee level, waste collection, pushing heavy carts, lifting and carrying while receiving and stocking supplies, and laundry removal from washing machines and dryers. ■

Popular applications can lead to security leaks

Is instant messaging compromising privacy?

A report issued by Palisades Systems in Ames, IA, and HIPAA Academy in Clive, IA, says health care organizations that allow peer-to-peer (P2P) and instant messenging applications to run on their computer networks risk compromising patient health information and causing violations of the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA).

"P2P applications open up a health care organization's network to the outside world," says HIPAA Academy compliance manager **Mark Glowacki**. "Applications like P2P and AOL Instant Messenger allow employees to communicate and share files covertly with outside parties. Because these applications can run without being detected by conventional security applications like firewalls, security violations are only discovered after the fact. With instant messaging, undocumented communications regarding a patient may occur without the health care organization's knowledge, leading to an unintentional breach of HIPAA's access requirements."

In addition to undetected file sharing, P2P and instant messenging can expose an organization to security threats targeted at these applications, such as worms, viruses, and spyware. Glowacki says several P2P applications include spyware as a standard part of the installation, which may allow for unauthorized collection and distribution of confidential information. Free instant messaging applications can allow a hacker to take over the user's computer through security vulnerabilities that are not sufficiently patched.

Police department passwords found

The report specifically references the file-sharing program KaZaA, saying that in September 2002, city government officials in Aspen, CO, received an e-mail indicating that someone had downloaded police department passwords and sensitive city information over KaZaA from its network. The user was searching for a movie and came across the entire contents of the network administrator's hard drive.

The report says that while some cases of sharing confidential information are malicious, most involve users who are not tech-savvy enough to restrict access to appropriate files.

The authors say instant messaging applications provide no control over the sharing of confidential materials. Employees who use such applications to transmit patient information can open an institution to critical information leaks that can be a breach of HIPAA security requirements. "It would be easy for employees to illegally share critical protected health information with outside parties, either unintentionally or maliciously, without the detection or knowledge of the health care organization," the report declares. In addition, hackers can leverage well-documented instant messenging security vulnerabilities to take over computers.

"No organization with P2P or uncontrolled instant messenging programs running on its network can be HIPAA-compliant," says Palisades Systems president **Doug Jacobson**. "The applications open up too many security holes, and companies discover them too late." ■

Interim rule on monetary penalties to be replaced

Final enforcement rule to take effect Sept. 16

The Department of Health and Human Services (HHS) says its interim final rule establishing rules of procedure for the imposition of civil monetary penalties on entities that violate standards adopted under the administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) will not be in effect after Sept. 16, 2003, because it will be replaced by a final enforcement rule.

HIPAA gives the secretary of HHS the authority to impose a penalty of not more than $100 for each violation of a provision of the administrative services section, up to a yearly maximum of $25,000 for all violations of an identical requirement or prohibition.

The law says the secretary cannot impose a civil monetary penalty if: (1) it is for any action that can be punished under the law's criminal penalty provisions; (2) it is established that the person liable for the penalty did not know a provision was being violated; (3) the failure to comply was due to a reasonable cause and not willful neglect; and (4) payment of the civil monetary penalty would be excessive relative to the compliance failure involved.

The department notice says its approach to enforcement is to seek and promote voluntary compliance with HIPAA provisions. The agency is offering technical assistance to promote voluntary compliance. Enforcement activities will be primarily complaint-driven and will consist of progressive steps that give an opportunity to demonstrate compliance or submit a corrective action plan. The interim final rule discusses all the procedures involved in imposition of civil monetary penalties.

To download the interim final rule, go to www.cms.gov/hipaa/hipaa2/enforcement/default.asp#penalties. ■

Alliances tackle health care worker shortage

Study says career ladders help

If businesses and communities worked with hospitals, there would be fewer serious shortages of health care workers, says a new study by the VHA Health Foundation and the U.S. Chamber of Commerce. According to the study, working together works wonders.

In St. Paul, MN, hospitals, community colleges, and a work force training program participating in the national study, called *Community-Wide Career Ladders for the Health Sector*, enrolled 363 participants by the end of 2002. Among the participants who completed training were 128 nursing assistants, 18 phlebotomists, and seven health unit coordinators. Eighty-four participants had been placed in participating hospitals, while others had offers and were waiting to start work.

"Through the Career Ladders initiative, workers are empowered with the skills they need to excel, employers get the structure and support they need from education and work force groups, and hospitals develop and sustain a viable employee base," says **Linda DeWolf**, vice president of the foundation.

Funded by the Annie E. Casey Foundation, *Community-Wide Career Ladders* is a VHA Health Foundation study of three cities and their efforts to design and develop local programs that target the unemployed and current health care workers by giving them opportunities to advance in the health care sector. The U.S. Chamber of Commerce's Center for Workforce Preparation worked in collaboration with VHA Health Foundation and local chambers of commerce to facilitate community partnerships among health care providers, work force development leaders, and educators. The study provided leadership and facilitation in three urban locations: Sacramento, CA, St. Paul, MN, and Washington, DC.

COMING IN FUTURE MONTHS

- Handling no-shows in your practice
- An interdisciplinary approach to cancer rehab
- Managing cultural diversity
- Getting a handle on outlier payments

"The initiative shows that successful collaboration simply means more workers for everyone," says **Beth B. Buehlmann**, executive director of the Center for Workforce Preparation. "Organizations in a single market can communicate a positive image of health care careers and broaden opportunities and incentives for health care education through relationships with colleges, corporations, and foundations."

The three participating cities developed a health care career ladder and a working infrastructure unique to their cities that would ensure the continuation of local community efforts. Additionally, project participants learned about collaborative dynamics and factors that determine a community's readiness to develop a health sector career ladder. This information will be used as a resource for other communities interested in developing career ladders in health care or other industries.

Other key findings of the initiative include the following:

- It is important for all health care organizations in a market to participate. They are likely to do so if there is an assurance that everyone is playing by the same rules.
- Health care organization leaders need to support the project publicly.
- Partners should be willing to experiment with a variety of approaches.
- A sense of urgency causes quick action.
- For their economic buy-in, employers need to see a clearly defined return, such as a specified number of qualified new employees and improved retention rates.

Each city's collaborative was at a different point in developing sector-specific work force recruitment and retention programs, and each was at a different level of collaboration, both with one another and with other sectors that have a stake in an educated, trained, and employed population.

In Sacramento, looming state-mandated nursing ratios, which the state will implement next year, add urgency to work-force shortages. Sacramento health care and education organizations already were experienced in collaborating to create healthy communities. However, human resource departments in the health care organizations were new to collaboration. New relationships were formed using existing organizational contexts.

With a health careers institute up and running, health care organizations in St. Paul were already collaborating to address the work force shortage problem. For St. Paul, the job was to evolve and fine-tune the program to meet the needs of the employer and the incumbent and potential employees. Participation in the Community-Wide Career Ladders project was an opportunity to reflect on what they had accomplished and engage all stakeholders in developing the next steps for long-term success.

Competing health care organizations and education and work force training agencies met for the first time when they sat down at the table for this project in Washington, DC. While the city offers a wealth of funding and technical assistance for work force development, there was no central access point. This site would start from the beginning to create collaboration and define its vision.

"The Community-Wide Career Ladders study proves a point," says DeWolf. "When hospitals and businesses in a community cease competing for workers and work together, there are three winners: the community, the employee, and the employer." ■