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IN THIS ISSUE

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Changing demographics translate into changes in how care info is given

Rehab community could set standard for dealing with diverse population

You can hardly pick up a newspaper or watch a television newscast these days without seeing something about the thorny issue of managing cultural diversity. It's easy enough to agree in principle that all people should be treated equally regardless of their background, but it's much more difficult to figure out how to translate that to your everyday practice. But figure it out you must.

Census data show that the face of America is changing: Within the next 50 years, Caucasians will be in the minority. According to the 2000 census, 26 million individuals in the United States speak Spanish and almost 7 million individuals speak an Asian or Pacific Island language at home.

Title VI of the 1964 Civil Rights Act requires health care organizations that receive federal funds to provide equal access to treatment for patients with limited English proficiency (LEP).

It's not enough to call in a staff person who took Spanish in high school to try to communicate with a Spanish-speaking patient. It's also not acceptable to rely on friends or family members of a patient to translate. You must have a plan, and if you don't, you could set yourself up to become one of the increasing numbers of health care organizations being reviewed by the Office for Civil Rights.

"The whole thrust of the legal responsibility is to ensure people have meaningful access to health care," says **Robinsue Frohboese**, the principal deputy director of the Office for Civil Rights in Washington, DC. "Communication is the very essence of the doctor/patient relationship in terms of everything from taking responsibility for your own health care to communicating ailments and problems to follow-up care."

People tend to underestimate the importance of hiring qualified interpreters, says **Bonnie Breit**, MHSA, OTR, president of BRB Consulting Inc. in Media, PA. Breit teaches seminars on managing cultural diversity

and has written a book on the topic, *Communication Helps All People*.

"If you don't have somebody who knows what they're doing, they may change the question. They may not give you the answer, or they may not give you all the details because they don't understand the significance," she says.

"They may not have the language skills to go from English to the target language or back to English. They may have a hidden agenda, especially if you're dealing with a psychiatric situation. You don't know that the mother has a million dollars and if she dies, the family member doing the interpreting gets it," Breit adds.

Providers can contract with a telephonic language bank or an agency that provides interpreters or they can hire bilingual staff. "I don't think organizations want to not be doing this," she explains. "I think there is a general lack of awareness."

The Office for Civil Rights is developing a new guidance document that will help providers meet their Title VI requirements. The document should be released some time this fall. Frohboese says the document will give specific examples and solutions for problems providers might face.

"Our guidance stresses that one has to be reasonable in terms of which documents to translate and when to bring in an interpreter," Frohboese says.

"It is all a balancing act. It's looking at the populations you serve, looking at the make-up and composition of those populations and the extent to which particular language groups are represented. And it's looking at the need for translated documents and interpreters and looking at the resources that are available," she adds.

The Office for Civil Rights attempts to achieve voluntary compliance with Title VI requirements, Frohboese says. The office initiates compliance reviews and has the legal power to bring action against a provider or withhold federal funds. But in its 30-year history, only a handful of cases have not resulted in voluntary compliance, she says.

Even in the absence of fines or withheld federal funds, the voluntary compliance route can be a huge headache. Just ask Maine Medical Center in Portland, which in May completed a five-year process of implementing a series of requirements to ensure equal access for deaf and hearing-impaired patients.

The hospital signed a consent decree in 1998 following a lawsuit alleging the hospital's failure to provide auxiliary aids and services for deaf or hard-of-hearing patients as required by the Americans With Disabilities Act (ADA).

Maine Medical Center also signed a voluntary compliance agreement with the Office for Civil Rights in 2000 to ensure that LEP patients have access to interpreters and other language assistance.

The result has been the creation of a plan for accommodating patients that has become a model for hospitals nationwide, says **Suzanne Gardiner**, MS, the ADA access coordinator for Maine Medical Center.

Gardiner's job was created to fulfill one of the requirements of the consent decree. The other requirements included:

• Making a qualified sign language interpreter available at no expense to patients during pre-scheduled visits or within one hour of the

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request at other times.

• Providing telephones in deaf patients' rooms that have amplified sound or a TTY (telecommunications typewriter) with a printer.

• Training all hospital personnel about the communication needs of deaf patients.

• Creating a new hospital policy stating that people who are deaf or hearing-impaired will fully and equally enjoy all of the hospital's services, benefits, and facilities.

• Refraining from using relatives or friends of deaf patients as interpreters.

• Maintaining TTY telephone numbers and installing public TTY pay phones.

• Providing closed-caption televisions in patient rooms.

"I think people have a hard time wrapping their minds around thinking of deafness as a culture," Gardiner says. "People who are born deaf are really proud of their language, which is completely different from English. Within the deaf culture, there are even subgroups, such as people who were late-deafened or are hard of hearing."

Gardiner does monthly training sessions with new nurses to go over the hospital's policy and teach the protocol of what to do when a deaf patient comes in. Staff in each department know how to use TTY equipment and who to call to get an interpreter.

"We teach staff to talk directly to the patient instead of to the interpreter and to have eye contact with the patient," she says. "When you're waiting for the interpreter to come, don't ignore the patient because you're scared to communicate with them. Tap them on the shoulder, smile, write a note. Also, remember that an interpreter will interpret everything that is said in the room. If you get paged and you make a phone call, leave the room if you don't want the patient to hear what you say. Basically, just treat them like a person."

For LEP patients, Maine Medical Center's agreement with the Office for Civil Rights included data collection, training of interpreters, grievance procedures, use of telephonic language-assistance sources, effective monitoring for five years, and assessing whether signs and documents should be translated into additional languages.

Treatment based on needs

The rehab community has a special opportunity to help other providers deal with diversity, says Breit. "We could help organizations learn to accommodate without judgment because we do that so often with disability. Our job is to figure out ways to get people to function as independently as possible. We're used to looking for modifications and accommodations we can make in the community or the environment. By understanding language and cultural differences, we could find ways to make the world a much more accommodating place."

It's important to remember that diversity is not just about race or creed. It could mean age or gender as well, Breit says.

"From a rehab perspective, understanding culture is important because how one interacts with a patient matters. In home care, if you want your services to be followed, you have to follow certain guidelines," she adds. "If you go into many of the Asian communities and you don't take the time to do the formalities and the greetings with the elders in the household before you start working with the daughter, you may not be accepted. The likelihood that your treatment will be valued is going to be less. You need to go through certain cultural courtesies. Having that awareness will make your ability as a therapist more effective."

The difficulty lies in learning about different cultures without creating stereotypes, Breit says. It's important to know, for example, that African-American males have more lower extremity amputations than any other culture in the country because of diabetes and that Vietnamese women have more cervical cancer.

"None of us can change our race, but what we can change is how we approach the world and our expectations of others," she says. "In the rehab continuum, many clinicians are white females. There's nothing they can do to change that, but they need to understand that they come to the table with a different expectation than an African-American or Asian man might. Therapists can ask themselves: How do I build my treatment based on their needs?"

Breit advises that rehab providers:

• Develop a diversity plan.

• Become familiar with the law on this topic. This includes providing interpreter services so you can communicate effectively.

• Become aware of changing cultures in your community.

• Address stereotypes and learn about the cultural patterns of diseases.

• Try to hire a more diverse work force.

• Reach out to different cultures.

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Barbara Hansen, MS, OTR/L, clinical assistant professor and academic fieldwork coordinator in the occupational therapy department at Ithaca (NY) College, says that lack of awareness is precisely why it's important to include cultural information in the OT curriculum.

At Ithaca, cultural issues have been infused into the existing curriculum.

"In the OT code of ethics, we pledge to provide fair and equitable service to all people that we treat. It makes sense to treat all people as they should be treated," Hansen says.

"Cultural competency is something to strive for even though you probably never truly reach it. It starts with understanding yourself and knowing what your own culture is," she points out. "People start off thinking culture is ethnicity, but we try to broaden that scope so that you are an occupational therapist, or you are a freshman in college, or you are a student. Those are all cultures."

One exercise Hansen does with students is to ask them to close their eyes and picture a person based on four words. She starts with Vietnamese refugee, then adds single mother, then physician, then wheelchairbound.

"Your image really changes as you go through those words. It's a powerful exercise in looking at the total person," she says.

Hansen and her colleagues also include cultural issues in case studies that students perform. Students are divided into groups and given the same information about a patient's health problems. But each group is given different information about the patient's culture to see if that changes anything in the treatment plan the students create.

"Students often find they need more information from the patient. They learn that one particular diagnosis doesn't mean the same thing for every person," she says. "If our ultimate goal is to allow the person we're treating to have the most productive and meaningful life they can, then it behooves us to know what makes their life productive and meaningful rather than have them try to do what we think."

For example, one of the activities of daily living that an OT might work on with a patient is how to make a bed. "If they sleep on the floor at home, you're just wasting your time," Hansen says. "If you're going to work on meal preparation, make sure it's something they actually eat. You will run into problems if you think your way is the only way."

Hansen offers this advice to providers:

- Let clients tell you what is important to them.
- Adapt your treatment plan to best meet their needs.
- Do not make assumptions.
- Ask the right questions. If you're working with a child, be aware of the differing definitions of family. If the mother is single and has four other children, that alters how much you can ask for in a home program.
- If their values are different from yours, go with theirs as long as it will not be harmful to them. ■

Make diversity part of daily operations

Orientation, mentors make difference

At SSM Rehab in St. Louis, diversity has become part of the institutional culture. Staff have successfully built diversity into its ongoing operations rather than instituting one program that would meet federal and industry guidelines, says **Kurt Delabar**, director of human resources.

SSM Health Care (SSMHC), the not-for-profit health system of which SSM Rehab is a part, last year became the first health care organization in the country to be named a Malcolm Baldridge National Quality Award winner. Successfully

managing diversity among patients and employees is one of the elements involved in winning the award.

"Diversity is not a program," Delabar says. "It's part of what we do every day. Whether it's the diversity of focusing on marginalized patients or whether it's activities geared toward attracting and retaining employees with diverse backgrounds, it's just part of what we do. If it's part of what you do every day, that's how you will be successful."

One example of how SSM Rehab has incorporated diversity into its regular operations is its orientation program that gives new hires a comprehensive understanding of the organization. Instead of a quick, one-day event, the employees attend five days of orientation during their first month. Each new employee, from janitors to office workers, from therapists to physicians, gets hands-on training from all disciplines.

Gina Garippo, communications manager, says the orientation helps staff members understand what patients are going through, how they feel, and what they encounter when working through recovery at the facility. Employees try on special clothing that allows them to feel what it is like to be paralyzed on one side of their body or to try getting dressed after an amputation. They practice transferring from wheelchairs and tying shoes without the use of their hands.

"It really raises the sensitivity of our entire work force to who we're trying to treat," she says. "I hadn't thought in terms of what it might feel like to have lost a limb or to experience a stroke and not be able to use one side of my body. If the whole staff have been trained to have a heightened understanding, there's that sensitivity level that is different."

Annual training covers diversity

Cultural diversity is also a topic in the staff's annual training, where issues such as differing customs are addressed. Staff members learn to be sensitive to Middle Eastern patients who may not embrace modern Western medicine and to Asian patients who may feel direct eye contact is a sign of disrespect, Delabar says. Employees also have quick access to reference books on diversity issues at nurses' stations throughout the facility.

SSM Rehab has begun a nurse recruitment program in the Philippines, which serves to alleviate the nursing shortage and bring diversity to the work force.

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Research has shown that some countries, including the Philippines, have an abundance of registered nurses who undergo training similar to what is offered in the United States, Delabar says. SSM Rehab now has eight Filipino nurses on staff.

"Some of these nurses have left their families to come halfway around the world, and our staff have embraced them," he says. "It has been interesting to work on a daily basis with people from another culture."

SSM staff members have helped the nurses find housing and become more comfortable with their jobs and the community. "One nurse even spent the holidays with one of our senior-level managers, who wanted him to feel at home during the holidays without family," Garippo says.

SSM Rehab also participates in a diversity mentor program that identifies employees — predominantly minorities — as future leaders. They are paired with a mentor from senior leadership who meets with them regularly for a year to teach them about such areas as budgeting and staffing that they would need to know in order to become a manager.

"They work to develop those individuals professionally; and in a lot of cases, they are also developing personal relationships," Delabar says. "One of the things that is built into our strategic plan is a goal to increase the numbers of minorities and women in professional and management positions. This initiative helps move toward that goal."

Other activities include specific recruiting techniques to hire minorities and quarterly diversity forums for all employees.

"It has been the mission of SSM for over 100 years to focus on the marginalized," Delabar says. "We constantly find new ways to further that mission." ■

Cancer rehab improves function, quality of life

Programs help patients cope with side effects

The National Cancer Act of 1971 set cancer rehabilitation as a goal and provided money to develop training programs and research projects.

Soon after, the Bethesda, MD-based National Cancer Institute identified four objectives for rehabilitation of cancer patients: psychosocial support, optimization of physical functioning, vocational counseling, and optimization of social functioning.

Thirty years later, outpatient cancer rehab is an idea that has yet to take root in the day-to-day management of cancer across the country. Many of the nation's premier cancer centers offer some type of rehab or wellness programs; only a handful of programs exist in other locations. But some providers are beginning to blaze the cancer rehab trail, and their patients are seeing the benefits.

At Saint John's Health System in Anderson, IN, a three-year-old physical and occupational therapy-based program has improved patients' functional performance and satisfaction by an average of 37% in fewer than eight visits.

The Saint John's staff used the Canadian Occupational Performance Measure to allow patients to rate their functional performance on a 100-point scale upon entering and completing the program.

"Can you imagine how patients feel if they are themselves rating their function and satisfaction to be that much better in usually only three to four weeks? It has been very rewarding," says **Julie McCormack**, PT, who led the collaborative effort to start the program between the Saint John's outpatient cancer treatment center and the Carl D. Erskine Rehabilitation and Sports Medicine Center.

A core group of two physical therapists, two PT assistants, and an occupational therapist works with patients to decrease fatigue, nausea, and pain as well as to improve strength, endurance, general mobility, and quality of life, McCormack says.

In two to three visits per week for three to four weeks, patients work on low-level endurance training, general mobility training, activities of daily living, range-of-motion exercises and strengthening, she adds.

The education component includes information on energy conservation, task simplification, relaxation, and stress management.

"We found that there was a great patient need for these types of services," McCormack says. "We work in the same outpatient building as several of the oncology doctors as well as the radiation therapy department and the chemotherapy department. We were able to see the functional limitations of patients coming and going for treatments and easily recognize their need for care."

A rehab staff member regularly visits oncology patients who don't get referrals to rehab to teach them how to help themselves through home exercise. "I can't say enough about the ways we have been able to improve the quality of life of those we have treated," she says.

McCormack set out to benchmark with similar programs when setting up the one at Saint John's.

"We tried for a long time to see if we could figure out what programs are out there, and we just really weren't finding programs like what we wanted to do," she says. "There are a lot of programs that include rehab on an inpatient side right after surgery, but for outpatients including physical and occupational therapy, we just really weren't finding those."

So McCormack attended a continuing education course on cancer rehab and then jumped in. The program is individualized based on each patient's goals for improvement.

"On the performance measure, we are finding out what types of things the patient is having trouble doing. We gear treatment right toward those top five or so items," she says. "It's nice to know you're affecting things that are very important to the patient. A lot of other things in physical therapy don't correlate so well straight through to what the patient wants to do."

It takes an ongoing effort to communicate with the oncology department to encourage referrals and to break through patient resistance, McCormack says.

"Part of it is the cancer diagnosis can be so dreadful. There are a lot of cases that are terminal, but there are a lot that aren't. People don't think of: 'What am I going to do to get better and get back to everyday life?' They're already thinking what's going to happen," she says.

"But there's a lot of time in between. There's a lot of stuff going on for these patients, a lot of bad news. It almost gets to the point where they don't want to hear anything else, that they've had all

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the information they can take." Every patient who has attended the cancer rehab program has said it was well worth the effort, McCormack says.

"It's such a common sense thing that we need to help these people," she says. "This patient population is not being serviced like it could be."

Stanford University Medical Center started a cancer supportive care program in 1999 that has a nice twist: All services are free to patients, even if they are not being treated for their cancer at Stanford.

"Our belief is that adequate support and informed guidance is essential to the success of cancer treatment," says **Holly Gautier**, RN, director of the cancer supportive care program, part of Stanford's Center for Integrative Medicine.

"Cancer treatment is so expensive, even with insurance coverage. So many patients are not able to stay employed, and some of our patients wouldn't even be able to afford 10 more dollars a month. I fight very hard for this to be a free program," she points out.

Donations support about half the program's cost; the rest is funded by Stanford. Between 600 and 700 patients per month participate in the menu of classes and workshops offered at the center.

Classes include gentle exercise, restorative yoga, stress management, coping with treatment side effects, healing imagery, nutrition, and medical qigong, which incorporates meditation, breathing, and gentle movements to promote healing. Chair massages are offered in the cancer treatment waiting rooms.

An oncology nurse offers fatigue consultations. "Fatigue is the No. 1 complaint of cancer patients. Cancer-related fatigue is not something that can be corrected by sleep, so it's somewhat of a Catch-22," Gautier says.

"We really encourage them to exercise, even if it's starting by walking to their mailbox. Many of these patients are too fatigued to take a shower, but they really need to move," she adds.

A patient evaluation found that 75% of those attending the yoga class had an increase in energy. Ninety-six percent saw some reduction in stress; 65% reported more restful sleep, and 59% had less pain.

"All of these classes are looking at improving the quality of life for individuals. Once they receive a cancer diagnosis, their lives are never the same," Gautier explains.

"Hopefully, we are exposing patients to new ways of coping with stress and anxiety and side effects and getting a great foundation to improve their quality of life," she says. ■

Teamwork reduces on-hold accounts

Effort targets reasons behind DNFB, OPEX lists

Philadelphia's Presbyterian Medical Center, part of the University of Pennsylvania Health System (UPHS), is reducing dramatically the number of accounts on hold in its discharge not final billed (DNFB) and outpatient exception (OPEX) queues — and freeing up the revenue they represent.

The project targets accounts in the DNFB and OPEX categories, which — for a variety of reasons — have not been billed to the patient or the patient's insurance company, says **Anthony M. Bruno**, MPA, MEd, director of patient access and business operations.

During a two-month period from March to May 2003, the number of DNFB accounts was reduced by 18%, representing a dollar amount of $3.8 million, while OPEX accounts were reduced by 2.3%, representing a dollar amount of $1.5 million, or 18.7%, he adds.

OPEX accounts more than 90 days old were reduced by 60.8%, Bruno notes, while the dollar amount of those accounts was reduced by 55%, or $1.4 million.

"We have been working to improve our revenue cycle management, and there are a lot of aspects — front to back — that my department and others must get involved in," he says. "One of the things we have been most concerned about

on the front end is management of the DNFB and OPEX reports. We wanted to create tools to help us address and monitor both of those pieces."

The challenge was that removing the hold on these accounts requires interventions by a number of departments and a cooperative, collaborative effort to resolve the problems that caused them to be placed on hold in the first place, Bruno says.

Several reasons to explain hold status

There are several reasons why accounts might be placed on hold status, explains **Raina Harrell**, manager of access and financial systems. "You can enter all the information and think you did everything you needed to do, and [the account] will look perfect; but for some reason, the bill doesn't go out the door."

That might be because there was an automatic bill hold, because the guarantor information was incorrect, because a diagnostic code was not entered, or for any of a number of other reasons, Harrell says. "But if you look only at the front end and the back end, [an account] may look correct."

In addition, Bruno says, gaining access to the specific accounts that make up the DNFB and OPEX reports was a complex task that required obtaining and cross-checking several reports created by the hospital's computer system, which is a product of Malvern, PA-based SMS (Shared Medical Systems). Once the reports were obtained, he says, they were difficult to read and time-consuming to review.

When they worked together at another health care system, Bruno notes, he and Harrell had experience in creating tools to simplify this process, but with the computer expertise of outside consultants, who helped download the reports from SMS and compile them in a web-based format that provided access to individual account information.

Without a budget for outside expertise, Bruno and Harrell drew on in-house resources, assembling a team that included participation from — in addition to Bruno's staff — the director of medical records, the medical assistance coordinator, and a financial analyst from administration. The team discussed and implemented the following measures:

- developed and created a DNFB and OPEX review and monitoring reports on Excel spreadsheets;
- ensured that the DNFB and OPEX spreadsheet reports provide easy access to specific account information that could be reviewed efficiently and in a timely manner;
- examined root causes of why accounts were on hold on the DNFB and OPEX reports;
- established benchmarks for the DNFB and OPEX by "hold" area of responsibility for accounts on the report;
- established strategies to reduce DNFB and OPEX accounts and dollars;
- created and established an approach that encouraged team members to work collaboratively to reduce those accounts and dollars.

Depending on the reason an account was being held, responsibility was allocated to a particular department, Harrell says. Bills holding for diagnostic information, for example, are the responsibility of medical records. Those with user holds — a manual bill hold put on an account because it is awaiting additional information — go to the business office.

The bill might be, for example, awaiting an authorization number from clinical resource management or from an insurance company, she explains. "The business office can use [the monitoring and review report] to ensure that it is getting timely feedback [on missing information]."

After learning about the report and its purpose, team members were asked to help set expectations for their departments, Harrell says.

"For example, we asked the business office for the average amount of time it should take to receive an authorization number so we could remove the user hold, and that amount of time became our benchmark," she explains.

"As we get better and the number of accounts is reduced," Harrell adds, "we will lower the benchmark."

The process also has helped identify information systems issues, Harrell notes. "Maybe we've done everything correctly, but [the bill] is sitting out there because the system is not right — like there are two insurances on the front end and only one passes to the back end, or guarantor information or mapping tables are not set up correctly. We wouldn't know it unless we use the tools to look and find those problems."

Key to the project, Bruno notes, has been the participation of Carrie Moore, financial analyst with hospital administration, who worked with Harrell to create the pivot tables. "We really tapped into her Excel and computer expertise."

Those tables, Harrell explains, are an Excel option that will summarize data in a spreadsheet.

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"They make it possible to report and summarize different information without having to sort the actual data. The user can click on the specific information in the pivot table in which they are interested, and only that data will drop into a new spreadsheet just for them."

"The biggest impact we've made," adds Moore, "is taking canned legacy reports from SMS and parsing them out to get at the actual information and make it more actionable for individuals. In the process, we developed a way to scrub a text file version of the canned reports and arrived at a way to see a summary and see the details."

The summary shows the number of accounts in each category, Bruno notes, and by clicking on that number, the user can see the accounts behind it.

All the departments involved — admissions, business office, medical records — now can focus on the accounts they need to work, he says. DNFB and OPEX reports are created and distributed each Monday to the work areas responsible for holds, Bruno adds, as well as to the Presbyterian Revenue Cycle Management team.

"Everyone is more aware of the accounts and more cognizant of what their responsibilities are," says Harrell. "They know what accounts are out there, how they got there, how they can remove them, and what [each department's] role is." ■

Patient safety policy: Efforts can backfire

Too many details can be trouble

As hospitals continue their efforts to comply with the National Patient Safety Goals issued by the Joint Commission on Accreditation of Healthcare Organizations, some risk management and quality assurance experts are issuing a strong warning: Don't go overboard with your efforts to write new policies and procedures because they can create unnecessary liability risks.

The problem occurs when well-meaning hospital leaders develop overly detailed and prescriptive policies and procedures to ensure compliance with the safety goals, says **Geri Amori**, PhD, ARM, FASHRM, president of Communicating HealthCare, a risk management consulting firm in Shelby, VT, and past president of the American Society for Healthcare Risk Management (ASHRM).

Some health care organizations are painting themselves into a corner with these new policies and procedures, she says.

"You create a policy and procedure that nobody can keep up with," she says. "Then you go to court and the attorney says, 'You have a policy and procedure. Why didn't you follow it?' Either you have to make an excuse for not following it or you have to say you didn't know about it. Neither one sounds good in court."

That's not to say that policies and procedures won't be necessary in your efforts to meet the patient safety goals. It might even be appropriate to develop entirely new policies and procedures. But Amori says you must be careful not to make them so strict that they don't apply to all situations and your staff can't follow them. Policies and procedures should be based on reality, not an ideal, she says.

"I think what's happening is we're getting these new goals but we don't know how to deal with them, so we create more policies and procedures because that's what we know how to do," she says. "All we're really doing is creating more liability."

System analysis necessary for safety goals

The Joint Commission announced the first set of National Patient Safety Goals a year ago and they are in effect through the calendar year.

In January 2004, the next set of goals take effect. The goals are intended to help accredited organizations address specific areas of concern regarding patient safety.

Each goal includes no more than two evidence- or expert-based recommendations. To ensure a greater focus on priority safe practices, no more than six goals are established for any given year. Each year, the goals and associated recommendations are reevaluated; some may continue while others will be replaced because of emerging new

priorities. New goals and recommendations are announced in July and become effective Jan. 1 of the following year. (For the 2003 and 2004 goals, see the JCAHO web site at www.jcaho.org.)

All JCAHO-accredited health care organizations will be surveyed for implementation of the recommendations, or acceptable alternatives, as appropriate to the services the organization provides. Alternatives must be at least as effective as the published recommendations in achieving the goals. Hospitals have a strong motivation to comply — failure by an organization to implement any of the applicable recommendations (or an acceptable alternative) will result in a special Type I recommendation — and that is spurring some of the policy and procedure overkill Amori says will create new liability.

Developing a proper response to the patient safety goals should involve far more than just writing or revising a policy, Amori says. First, she says you should look at the processes that the goal assesses in your own institution. Then you need to look at the broad reasons why your system works the way it does regarding that goal.

"You're really doing a failure-mode analysis and sort of a root-cause analysis to determine why it's working that way in your system," she says. "Is there something in your policies and your system that is creating a system where you are not monitoring high-risk medications or that allows you to misidentify patients, or whatever the goal is? Once you have the data showing what's going on in your organization, only then do you go about developing policies and procedures to improve the situation."

If you put too much focus on writing the policy and procedures, you may not be paying enough attention to the actual process improvement, she says. When you have created a better process, then you might want to document that through a new policy and procedure.

"We've said that for a million years in risk management," Amori says. "Policies and procedures don't change behavior. They should memorialize the type of behavior we think is important. Change the behavior first, and write a policy and procedure that reflects that change."

Meeting JCAHO goals may not be enough

That advice is seconded by **Marie Pears,** RHIA, CPHQ, quality coordinator at Meadville (PA) Medical Center. She says her hospitals has struggled with its efforts to comply with the patient safety goals, at first developing some policies and procedures that went overboard.

For the 2003 goal regarding identification of patients, for instance, Meadville at first started developing a policy that required proper identification for any kind of encounter with a patient, but then Pears and others realized that wasn't what JCAHO intended. But they still had to figure out how to meet that goal.

"We did have policies and procedures for patient identification in place already, but we didn't have two patient identifiers, so we went to work on that," she says.

"In this case, we almost went overboard because we said that whatever you do with the patient you have to use those two patient identifiers," Pears explains.

"But in some cases, that's not necessary. We wrote the policy saying that at first, then we went back and rewrote it. That's an example of how you can go overboard with your policies and procedures," she adds.

Do thorough investigations

That experience with patient identification confirmed the value of the team approach Meadville uses for meeting the patient safety goals. Pears put together an overall team made up of key department leaders to address the goals, then that group broke up into smaller teams to look at individual goals. After allowing some time for the smaller teams to work, everyone regrouped to discuss their findings and recommendations.

Some teams determined that the hospital was already meeting that goal and no further action was needed. (In that case, Pears says, she still was careful to document the team's analysis and recommendations.)

To keep up with all the teams' work and ensure that the goals would be met on time, Pears used a matrix that listed each goal, who was working on it, the team's recommendations, and when any actions should completed.

Each team investigated what Meadville should do to comply with the goal, mainly by asking these questions: What is the patient safety goal? What problems have we had that pertains to this patient safety goal? Do we have data available on this topic? Do the data show we've had a problem in this area? Do we already have a policy and procedure in place? Are we already in compliance with what the goal says? Is that enough or

do we want to do better? How far beyond compliance do we want to go?

The goals give you areas to focus on that might not otherwise capture your attention, she says.

Even if it seems you are already meeting the safety goal, according to Pears, you should still study each one carefully. Use the patient safety goals as a reason to carefully assess your own policies and procedures for loopholes and weaknesses.

You won't have to develop a new policy and procedure for every goal, she says, but you will want to take a look at each policy and procedure addressing the goals.

Some might be fine; some might need improvement; and some goals may need completely new policies and procedures.

Err on the side of generalizations

Whether you're refining or developing them from scratch, Pears offers this advice: "You certainly can go overboard with policies and procedures. You need to keep them simple. The more complicated a policy and procedure gets, the harder it is for people to comply and that gives you more chance for error. You could be creating a problem just by the way you're writing the policy and procedure."

Amori says that, in general, you should avoid writing a highly detailed policy and procedure.

When in doubt, err on the side of being too general, she says.

"It can be extremely detailed if there is a complex process that only can happen one way, but my guess is 99.9% of our processes aren't that way," Amori says.

"In most cases, you're probably better off not spelling out the step-by-step details of what a nurse should do in a certain situation, unless it's absolutely a situation where you know that's the best way and the nurse knows where the policy and procedure is, and it happens with enough frequency that people are going to know to look there," Pears explains.

"Otherwise, you're giving a plaintiff's attorney lots of ammunition, and you're going to have lots of frustrated staff," she adds. ■

NEWS BRIEFS

Lawsuit helps push back therapy cap to Sept. 1

The Centers for Medicare & Medicaid Services (CMS) announced in a July 3 program memorandum that it would postpone implementation of the $1,590 cap on outpatient therapy services from July 1 to Sept. 1.

The delay was granted after a lawsuit was filed in June against CMS in the District of Columbia District Court. *(American Parkinson Disease Association, et al. v. Tommy G. Thompson*, No. 03-1378.)

Rehab advocates met with CMS in May to express concerns about adequate time for notifying beneficiaries of the change in benefits.

Starting in October, the Medicare Summary Notice will inform beneficiaries on a monthly basis about their progress toward the cap.

For 2003, the cap only will apply to services rendered between Sept. 1 and Dec. 31.

The rehab coalition, which includes the American Occupational Therapy Association, the American Physical Therapy Association, the National Association for the Support of Long Term Care, and the American Medical Rehabilitation Providers Association, still is pushing for repeal of the cap.

Legislation introduced in the U.S. House of Representatives, the Prescription Drug and Medicare Modernization Act of 2003, contained a provision for a one-year moratorium on the cap to take effect in January 2004. But the Senate version of the bill did not include the moratorium.

Rehab leaders still are urging providers to contact their representatives and senators to urge them to cosponsor legislation that would repeal the cap entirely. ▼

COMING IN FUTURE MONTHS

- Handling no-shows in your practice
- New technology for rehab
- Trends in pediatric rehab
- In-house vs. outsourced billing

Insurance policy to cover violations of HIPAA rules

A San Francisco insurer is offering health care providers what it says may be a first in underwriting — a professional liability insurance policy specifically geared toward electronic-based and web-enabled transactions for health care operations. The policy might be especially useful in insuring against violations of the Health Insurance Portability and Accountability Act (HIPAA), the company says.

The insurance is offered by Healthcare First, a unit of the brokerage services division of Arthur J. Gallagher & Co. of Itasca, IL. Healthcare First president **David Wynstra** says that the insurance product was developed in response to the way many health care systems have become more dependent on electronic-based transactions via the Internet to carry out business basic functions.

"As a result, those organizations are now assessing their information technology risks and liability exposures," he says. "This corporate liability coverage will continue to indemnify electronic-based transactions that health care organizations use to manage, process, and disseminate information. Moreover, the coverage now helps indemnify corporate policyholders from damages resulting from HIPAA events, such as unauthorized disclosures of protected health information [PHI] arising out of computer security violations."

Wynstra says the intent of the policy is to cover organizations for inadvertent HIPAA violations and the policy would not cover any fraudulent activities. Health care providers would benefit in situations in which an unauthorized disclosure is made that results in damage to an individual or organization, and that party decides to sue for damages.

Though that may sound appealing to managers worried about violating the new HIPAA provisions, Wynstra notes that the coverage will not cover fines levied by the government for HIPAA violations. That is consistent with other forms of insurance that commonly cover civil liabilities but cannot pay fines imposed by government agencies or law enforcement.

The eHealth/Internet Liability Policy will be underwritten by Mt. Hawley Insurance Co., a subsidiary of RLI Corp. and will provide premium discounts to health care providers accredited by URAC, an accrediting body in Washington, DC. The policy covers more than just HIPAA violations, says **Michael Lamprecht**, national practice leader of e-Insurance with Arthur J. Gallagher & Co.

The policy provides worldwide cyber liability coverage for exposures such as privacy infringement arising out of computer security breaches and contingent bodily injury arising from web site content, he says. The policy provides coverage for media perils such as copyright and trademark infringement, libel, slander, defamation, and product disparagement.

Wynstra notes that the underwriter will expect your organization to take all appropriate precautions regarding HIPAA, including the implementation of policies and procedures.

"There's a rather rigorous underwriting program," he says. "Certainly, a security audit is necessary. We expect to see that the insured has taken all necessary steps to comply with HIPAA." ■