Outcomes
Reimbursement
Personnel Management
Quality Improvement

Rehab Continuum Report™

The essential monthly management advisor for rehabilitation professionals

THOMSON
AMERICAN HEALTH CONSULTANTS™

IN THIS ISSUE

DECEMBER 2003
VOL. 12, NO. 12 • (pages 133-144)

Docs, therapists urged to provide rehab for multiple sclerosis patients

Rehab critical to quality of life

About 25 years ago when the idea of providing rehabilitation services for multiple sclerosis (MS) patients first surfaced, many providers didn't see the point. Given that MS is a lifelong, progressive disease with symptoms that vary wildly from patient to patient, could rehab even make a dent? Would it be worth the expense and the effort?

In the last five years, thanks in part to tremendous advances in the treatment of MS, physicians and therapists alike are answering those questions with a yes.

"We are much smarter about this now," says **Nancy J. Holland**, EdD, RN, MSCN, vice president of clinical programs for the National Multiple Sclerosis (MS) Society in New York City. "We know that the disease may continue to progress, but the point of rehabilitation is to help people function at their highest level, whatever their physical limitations are. It's become increasingly more recognized that rehabilitation is important in the treatment of MS."

The MS Society wants to see rehab considered one of the primary interventions for MS patients. To that end, it recently completed a training kit for occupational and physical therapists who want to work with MS patients. The kit, which provides six continuing education credits, was mailed out to local MS chapters around the country in October. The MS Society also has convened a task force to write a consensus statement on rehab for MS patients. The goals are to encourage physicians to refer MS patients to rehab providers and to help patients get insurance reimbursement for rehab services.

"Reimbursement for rehabilitation has always looked at gain, moving someone to a higher level of functioning," Holland says. "With MS, if you look at the curve of the disease going down, if the line of function stays level, then it is a gain. But it's a hard sell with the insurers."

Several MS treatment centers provide rehab, and a few general rehab programs are beginning to work with MS patients, says **Deborah Hertz**, MPH, director of medical programs for the MS Society. More physicians are referring MS patients to rehab, but it's not enough.

"We still need to get the word out that rehabilitation is a very important part of MS management," she says. "MS specialists are more in tune to the benefits of rehabilitation, but general physicians and even general neurologists are the ones we need to educate."

Besides the training kit, the society also provides videos, books, and articles that are specifically targeted at rehab professionals. Even simple interventions such as stretching, patient education, and gait training can make a big difference.

"Rehab can have a dramatic impact on the quality of life of people with MS," Holland says. "There are some other conditions where rehab is important, like stroke, where the person will naturally improve physiologically over time in most cases. With MS, there isn't always that physiologic improvement. The increase in function that the OT and PT can bring about can be very dramatic. Having someone who is walking one day and in a wheelchair the next is a tall order. The OT and PT can get a lot of satisfaction from helping someone adjust."

Many of the interventions therapists are accustomed to using for other types of patients also can be helpful for those with MS. "One of the problems, though, is that there aren't enough occupational and physical therapists who really have expertise in MS." There's no predictable course for the disease. "It's episodic," Holland says. "The condition keeps changing, so the need for rehabilitation is ongoing, and the program will change as the symptoms change."

Therapists need to be aware of problems specific to MS patients that will impact the rehab program, such as neurogenic bowel and bladder issues, problems with speech and swallowing, and disabling fatigue. Between 75% and 95% of MS patients have such fatigue, and half say it's their most troubling symptom, according to an expert opinion paper from the MS Society.

Physicians need to focus on coexisting medical conditions and medications, but rehab providers can step in to help patients manage weakness, spasticity, leg spasms, and bladder problems that could be contributing to the fatigue. Therapists also can teach activity modifications that will conserve energy.

These strategies are helpful even in the earliest stages of MS, Hertz says. "Rehabilitation is important at all stages of MS, not just as you progress in your disability. It's key even at the beginning.You don't have to have a severe disability to start rehabilitation." The problem is that newly diagnosed patients often don't want to think about rehab, so health care providers need to push them to consider the benefits, she explains. "Rehabilitation is going to help patients remain independent and keep their functions so they can continue being active parents, stay employed, and have good relationships. MS affects so many different aspects of an individual's life that the only way to really address all of them in a comprehensive way is through a rehabilitation program."

While the idea may make intuitive sense to therapists, there has been little in the way of clinical

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), $585. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $468 per year; 10 to 20 additional copies, $351 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 $98 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@thomson.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@thomson.com).
Managing Editor: **Alison Allen**, (404) 262-5431, (alison.allen@thomson.com).
Senior Production Editor: **Ann Duncan**.

THOMSON
AMERICAN HEALTH CONSULTANTS

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

evidence to support MS rehab. A study published in the September issue of the *Journal of Neurology, Neurosurgery and Psychiatry* is one of the first to find a comprehensive rehab program improves patient outcomes. British investigator **Jenny Craig**, MD, and colleagues at the Walton Centre for Neurology and Neurosurgery in Liverpool, England, studied the combined effects of rehab and intravenous steroid treatment.[1]

"There is evidence to support both the use of intravenous methylprednisolone in MS relapse and physiotherapy in the management of MS, but no studies have investigated the combination of steroids and rehabilitation together," the authors wrote. "The experimental hypothesis was that steroid therapy for MS patients in relapse combined with focused multidisciplinary team care was more beneficial than steroid therapy alone."

Forty patients experiencing an MS relapse were given the standard treatment of steroids. Half also received multidisciplinary treatment including patient education, physical therapy, bladder management, and mobility aids.

After three months, the rehab patients had a much greater reduction in disability and were better able to walk and perform other motor tasks. Scores on the 60-point Guy's Neurological Disability Scale improved by a mean of 8 points in the active treatment group and by 1.75 points in the control group.

"The findings suggest that introducing a problem-focused, team-integrated approach to the steroid management of MS relapse in the acute setting, including access to appropriate levels of therapy, is of benefit to patients in terms of motor function, disability, and aspects of health-related quality of life," the authors wrote.

A comprehensive approach

One rehab hospital that is getting in the MS game is The Institute for Rehabilitation and Research (TIRR) in Houston. **(See related article, p. 136.)** A year ago, a neurologist referred an MS patient to TIRR, and the hospital's community reentry program decided to take the patient on, says **Ellen Levin**, PhD, clinical director of the TIRR Challenge Program. The patient needed a cane to walk and was suffering from mood and memory problems. But after a comprehensive approach including physical therapy, occupational therapy, cognitive therapy, and individual and group psychological work, she improved considerably.

"She became much more independent, she felt better emotionally and physically, and her endurance improved," Levin says. "It was a very successful experience for her, and it led me to believe that quite a number of people out there with MS could benefit from our program."

Because MS often strikes women in their childbearing years, there are additional family problems that must be addressed. "It doesn't receive as much attention as it should," Levin says. "A lot of young kids have the responsibility of acting as caregivers for moms with MS, and that has a profound psychological effect on them."

Levin's staff includes social workers, psychologists, and counselors who can help with such issues. That first patient TIRR saw had been forced to retire 20 years earlier than she had planned. "If she had been seen earlier in our program, I think she could have stayed employed longer," she says. "She was very career-oriented, and she had no preparation for losing her job. This type of situation compounds the psychological problems that come with MS."

TIRR could help a patient keep their job by working with the employer to institute modifications such as voice-activated computer equipment. "Companies are often amenable to talk about ways to accommodate employees. If we can't help them with assistive technologies or strategies to combat cognitive problems, we can possibly help them find another job that would be easier to manage," Levin says.

TIRR staff members set out to educate themselves about MS and to plan an appropriate rehab program. Patients in the Challenge Program start off with treatment that lasts five hours a day, four days a week. As they begin to re-integrate into their roles in the community, the treatment time is reduced. But Levin isn't sure that's the best approach for MS patients. She's considering adapting the program for MS patients who are

Need More Information?

- **Deborah Hertz**, National Director of Medical Programs, or **Nancy Holland**, Vice President of Clinical Programs, National Multiple Sclerosis Society, 733 Third Ave., Sixth Floor, New York, NY 10017-3288. Telephone: (800) 344-4867.
- **Ellen Levin**, Clinical Director, TIRR Challenge Program, 2455 S. Braeswood Blvd., Houston, TX 77030. Telephone: (713) 383-5608.

already functioning at some level in the community, perhaps to a one- or two-day commitment.

"We're learning as we go. Not all patients can be served by this type of program," she says. "We're still trying to figure out which patients can and how to alter our offerings to best serve them. With MS, you have a very diverse population. With each patient, it's almost a whole new disease."

One of the hallmarks of the Challenge Program is dealing with cognitive impairment, which affects as many as half of MS patients. Problems include slowed information processing; impaired attention and concentration; impaired short-term memory; and reduced abilities in problem solving, planning, and sequencing. Physicians and even the patients sometimes fail to recognize the deficits.

"A lot of MS patients are functioning, but not very well," Levin says. "Many are just getting by. Because a lot of the problems are cognitive and are not visible sometimes, there are a lot of attempts to hide them. It takes a lot of energy to hide a problem like that. We can help them accept what's happening and teach them how to cope in spite of it."

An MS diagnosis brings with it a huge existential crisis, Levin says. "These patients need more than medications; they need to learn how to live in spite of this chronic illness."

Reference

1. Craig J, et al. A randomized controlled trial comparing rehabilitation against standard therapy in multiple sclerosis patients receiving intravenous steroid treatment. *J Neurol Neurosurg Psychiatry* 2003; 74:1,225-1,230. ■

Research, leadership put Houston hospital on top

Shorter meetings don't hurt

If you look closely at two lists from *U.S. News & World Report*'s annual health care survey, you'll see an overlap. The Institute for Rehabilitation and Research (TIRR) in Houston makes its 14th appearance on the list of the best rehab hospitals in America. TIRR grabbed the No. 2 ranking for the third year in a row.

Now look at the list of America's best physicians, and you'll find no fewer than five doctors associated with TIRR.

"That says a lot about this organization," says **John Kajander**, CEO and president of TIRR Systems, which includes the hospital, 21 outpatient locations and TIRR Foundation, a philanthropic organization that supports hospital operations, education, and research.

TIRR, located in the Texas Medical Center, enjoys an extraordinary set of partnerships for research and patient care with area institutions including Baylor College of Medicine, the University of Texas (UT) Medical School at Houston, the UT Medical Branch at Galveston, and Texas A&M University Institute of Biosciences and Technology.

TIRR and all four of those schools participate in Mission Connect, a $10 million project that seeks to improve function of patients with spinal cord and brain injury by affecting the biology of the injured nervous system. Teams made up of investigators from the different institutions are working on projects such as:

- preventing or breaking down formation of scar tissue at the site of spinal cord injury to encourage natural regrowth of damaged nerve cells;
- understanding what proteins are needed to accelerate neuron production and improve cell repair;
- testing in sheep to determine if surgical connection of nerves in the chest wall to damaged bladder nerves could improve bladder function in patients with spinal cord injuries;
- stimulating memory function after brain injury;
- investigating how to make stem cells become the exact kind of nerve cell needed at the site of brain or spinal cord injury.

TIRR also participates in a unique physical medicine and rehabilitation alliance with Baylor and the UT Medical Center that provides physicians for TIRR and $40 million worth of research on spinal cord and traumatic brain injury, making it one of the largest research and education programs in the nation.

"The model we use for research is collaboration," Kajander says. "We really believe that by bringing these partners together that we can accomplish far more. We think it makes a material difference for patients, and we think that's one of the reasons we continue to receive recognition in *U.S. News & World Report*."

The collaboration model also is what TIRR uses to run its operations and provide quality patient care. The management team includes the chairpeople from the departments of physical medicine and rehabilitation at both Baylor and the UT Medical School.

Those physician chairpeople are not employed

Need More Information?

- **Jean Herzog**, Executive Vice President and Chief Operating Officer, The Institute for Rehabilitation and Research, 1333 Moursund St., Houston, TX 77030. Telephone: (713) 797-5278. E-mail: herzoj@tirr.tmc.edu.
- **John Kajander**, CEO and President, TIRR Systems, 5100 Travis St., Houston, Texas 77002-9746. Telephone: (713) 942-6176. E-mail: Kajanj@TIRR.TMC.EDU.

by TIRR, but they have the opportunity to work on every major strategic decision the hospital makes.

The management team meets weekly to discuss strategic issues, and Kajander has made it a personal goal to keep the meetings on track and on time. "The management team approach is really an outgrowth of the clinical protocols we use for patient care," he says. "The physician truly sits down on a colleague basis with the therapists, social workers, case managers, and nurses to design a care plan for each patient. We have learned to use that teamwork concept that we do for every patient in our management decisions."

Kajander has worked to eliminate as many meetings as possible so staff can concentrate on patient care. "I had every person write down the number of meetings they attend," he said. "We cut out close to 1,000 hours of meetings per year. It's so important to get the caregivers more time with the patients. We found sometimes too many people were in the meetings."

The role model is the weekly management team meeting, which previously ran as long as three hours. Kajander has cut it to 90 minutes by limiting the discussion to strategic issues and allowing members to review the agenda beforehand and challenge items that would be better discussed elsewhere. "I'm hell-bent on 90 minutes," he said.

Jean Herzog, executive vice president and chief operating officer, says TIRR's approach to developing leadership has led to a culture that is open to both suggestions and criticism. "We've created a safe environment to suggest ideas from top management all the way through the organization," she says. "Any organization needs to create a culture that is open and encourages people to be creative and to look at better ways to do things."

TIRR doesn't just leave this strategy to chance. About 10 years ago, TIRR began this effort with a formal program called Transformational Leadership that looked at the principles of communication at all levels. The program has gone through several metamorphoses over the years, but continues to work through a train-the-trainers approach. "One component is how to develop a project so that you're looking at all components so you have a much greater chance of success," Herzog says.

"Make sure you have the right people involved, that you look at all aspects, that you examine everything thoroughly. There is a format for the development of projects, and we use that a great deal. Our preparation for [the prospective payment system] used those techniques," she says. ■

Could therapy cap wreak havoc on private practice?

Some patients already reaching $1,590

If you've been holding out hope that something would happen to stop the $1,590 cap on outpatient therapy for 2003, it's time to buckle down and put plans in place to help your patients who are likely to hit the cap before the end of December.

The last ray of hope for relief in 2003 vanished in October, when U.S. District Judge Emmet Sullivan ruled that the Centers for Medicare & Medicaid Services (CMS) could continue to enforce the cap. Despite Sullivan's sympathetic comments at earlier hearings in the case against CMS *(American Parkinson Disease Association, et al. v. Tommy G. Thompson,* No. 03-1378), he was unable to find any violation of the partial settlement agreement. The plaintiffs had argued in September that CMS had not adequately notified Medicare beneficiaries about the implementation of the cap.

Christina Metzler, director of federal affairs for the American Occupational Therapy Association (AOTA) in Bethesda, MD, says rehab providers were disappointed but not totally surprised by the ruling. "I think the judge is sympathetic on the substantive issues, but he didn't have any legal basis to stop the implementation of the cap," she says.

The AOTA and other rehab groups still are working for passage of the Medicare prescription drug bill that includes a one-year moratorium on the cap for 2004. **(See *Rehab Continuum Report,* November 2003, p. 126.)** "We are encouraging

our members to re-contact all of the bill supporters to remind them the cap is already in place and so their support is even more important right now," Metzler says. "And we want them to contact those who haven't signed on yet to encourage them to take a position."

Metzler says patients already are hitting the cap and that the potential loss of those patients' business could have a significant impact on therapists in private practice. Some may even be forced out of business, depending on their patient profile. "I suggest that you call your senators every time you have a patient who reaches the cap," she says. "This has been a political issue from the beginning, and it only can be solved through politics."

On its web site (www.aota.org), AOTA advises therapists to realize they will be the main sources of information for beneficiaries on the rules regarding the caps. They also should use a Notice of Exclusions from Medicare Benefits, not an Advance Beneficiary Notice, to inform patients of the $1,590 cap. Clients may continue treatment at an outpatient hospital department or stay as private pay patients. AOTA has developed a sample form for occupational therapy practices available on the web site.

Metzler says AOTA will be looking into the efficacy of the (800) MEDICARE number that patients can call to get up-to-date benefits information. Patients are responsible for tracking their utilization and for paying for any services more than the $1,590 limit. "Beneficiaries are not going to be able to track this themselves," she says. "Therapists, because of the type of people they are, will want to help them. It's going to come down to a lot of activity and monitoring by providers."

Tom Howell, PT, says if the cap becomes permanent, it could devastate his small private practice of two physical therapists at the Physical Therapy Clinic of Boise (Idaho). "It may prevent us from growing as a clinic because our long-range plans may have to eliminate the hope of treating many Medicare patients," he says. "All in all, this cap hurts our ability to compete in the market against the hospital outpatient department. The cap regulation is unfair and discriminatory against private practice PT clinics. It is a rationing of health care and a restraint of free trade."

Howell says that because it will take between 24 and 26 visits for patients to hit the cap, the clinic still will be able to treat a large portion of its Medicare clients this year. But starting in January, if patients hit the cap early and then have another problem later in the year, they may have to be referred elsewhere. "Chances are in the next calendar year, they won't come back," he says. "We thrive on repeat business, and family, friends, and community referrals. This cap would hurt that part of our business."

By mid-October, the practice already had a few patients nearing the cap, so a plan was put into place:

- At the initial visit, a Medicare beneficiary is informed verbally of the cap and of options under the cap. These options include being referred immediately to a hospital outpatient department.
- Patients are given a written handout spelling out their options. "We chose to make up our own handout because the one available from CMS was not as simple to follow," Howell says.
- Patients are asked at the first visit if they are receiving other therapy services or if they have had any therapy since Sept. 1 at another clinic. "We track the cap as best we can. We are using number of visits, since our population is not as diverse and we have a good idea of the average cost per visit," Howell says.
- At 17 visits, the available options are discussed again. The clinic will work with patients financially if they choose to stay and pay for it themselves.
- If beneficiaries choose to stay at the clinic, they are asked to sign a Notice of Exclusionary Medical Benefits form. At that point, those patients are treated as private pay clients.

The clinic has chosen to apply a private pay flat rate of $45 per treatment rather than the Medicare fee schedule rates, Howell says. The clinic bills an average of $93 per visit with an average of $60 to $65 in Medicare reimbursement. "We feel this private pay arrangement is at a level that a number of beneficiaries, if given the choice, will decide to stay. If we made our costs too high, very few would consider staying with us. Now we feel most will seriously consider staying with

Need More Information?

- **Tom Howell**, PT, Physical Therapy Clinic of Boise, 4167 W. Blue Creek Drive, Meridian, ID 83642. E-mail: ptclinic@mindspring.com.
- **Christina Metzler**, Director of Federal Affairs, American Occupational Therapy Association, 4720 Montgomery Lane, P.O. Box 31220, Bethesda, MD 20824-1220. Telephone: (301) 652-2682.

us and paying out of pocket."

Because Idaho is a rural state, Howell fears that many patients will choose to end therapy rather than travel to a distant hospital. In Boise, where there are some more convenient hospital choices, patients so far have indicated they would rather not leave. "The cap is most unfair to beneficiaries who have been seen off and on for many years by the same therapist," he says. "Now they are put in the unenviable situation of having to consider seeing another PT who they don't know and don't yet trust." ■

Data quality review one of best around

Every outpatient registration is checked

Not only do the verification and quality services personnel at North Carolina Baptist Hospital in Winston-Salem, NC, perform one of the most thorough registration quality checks around, they've been doing it for 12 years.

When **Keith Weatherman,** CAM, assumed his position there as associate director of patient finance, he was pleasantly surprised to discover the data quality review process was "the best I'd ever heard of.

"It seems like there is still finger-pointing [at registration] going on at other places I hear about, but here the front end is pretty well covered," he adds. "We just don't hear the fussing from the back end that happens at other hospitals."

Weatherman credits **Darlene Caudle**, manager of the verification and quality services department, and supervisor **Teresa Colvert**, who does all the departmental training and directly oversees the quality review staff. Both have been with the department since it was created.

"At the time," Caudle explains, "I was working in the collections department, cleaning up errors that occurred at registration and all the way through. I suggested it would be good to have a department to review registrations and get those errors corrected before the account was billed."

At first, the department included two groups of employees — the quality review group (for outpatient registrations) and the verification group, which verified insurance and benefits for inpatients, outpatient surgery, and the 24-hour observation unit, Colvert adds. "It was Darlene, myself, and 17 employees." Several years later, a preadmission function was added, along with 10 new employees and a second shift, she notes. "[Preadmission counselors] would call patients who were scheduled for admission, outpatient surgery, or a procedure in our day hospital. They would make calls until 9 p.m."

A few years later, Colvert says, a precertification group, made up of nurses formerly with the hospital's utilization review department, joined the mix. "Now we have nurses who get pre-certs started with patients who are going to be admitted or have outpatient procedures, she adds. "So we've gone from 19 people to about 42 people."

Colvert has trained all new employees since department's inception, she says, with some help from the quality review group. The reviewers show new employees how to use the Blue Cross Blue Shield network, known as Blue E, and the Medicaid common working file to verify eligibility.

Sometimes, she says, the new hires sit with quality reviewers so they can better appreciate the importance of registration accuracy.

Review provides a good tool

Conversations with access colleagues at other hospitals indicate that "a lot are talking about, but not many are doing," the kind of extensive quality review that Caudle and Colvert oversee, Weatherman notes. "It's a good tool to show where employees stand and where they might need more training."

Unlike many facilities where random quality checks are conducted, quality reviewers at Baptist Hospital check every outpatient registration.

Inpatient registrations do not go through the same process, Caudle says, because that information is verified in advance by financial counselors.

The basis of the quality review is the registration report, which is a single sheet of paper for every registration done the day before, Colvert adds. "The front side has the demographics and the physician information, and the back side has the insurance information."

On a daily basis, Caudle explains, the quality review process works as follows:

1. Sheets are gathered from all outpatient registration areas, including the emergency department, outpatient clinics, and private outpatient areas (tests and other diagnostic procedures).

2. One of the reviewers — typically the same person — divides the sheets among those on duty that day. "Everyone pitches in and helps, so

that everyone stays together. The team atmosphere keeps the whole group moving along," Caudle adds.

3. Reviewers examine each work sheet, which is "a picture of the registration as it is in the computer," looking closely at 19 key data elements, including name, telephone number, next of kin, accident screen, and insurance information. "We look closely at family and referring physicians because we're very interested in tracking that at our facility," Caudle notes.

4. Errors are highlighted in yellow or pink. "Yellow [indicates] a critical area that would cause a problem with reimbursement," she says, "such as an ID number, policyholder, or insurance address."

Errors highlighted in pink are considered less serious, Caudle adds, and either are sent directly to the individual registrar for correction, or in some cases, to the registration manager, who distributes them to the registrars in that area.

Because of reimbursement concerns, reviewers correct the more critical errors to ensure a clean claim is sent to payers, she says. "The bill goes out in five days, regardless of what we do."

During the highlighting process, Colvert adds, quality reviewers call insurance companies as necessary, and use the electronic tools such as Blue E and the common working file to check the data.

"Before they send the highlighted sheets back [to the registrars], they access a weekly Excel spreadsheet, which has a separate file for each department we review," she notes. "Within each file, there are separate folders for each [registrar] in that department."

Each day, reviewers pull up the folders of all the registrars whose work they have checked and load the resulting figures, or scores, into the spreadsheet, Colvert says. "They compute a maximum potential for that [registrar] — the possible number of data elements they could have gotten correct in that work, and then subtract the errors to come up with the number achieved."

On a weekly basis, the computer calculates a demographic achievement rate, an insurance achievement rate, and an overall achievement rate for each registrar, she adds.

From the spreadsheets, Colvert says, she creates her part of the report, an achievement summary that is given to all registration managers. "It includes all the [registrars] in their department, and shows the number of registrations reviewed for that person that week, the total maximum potential for that week, the number achieved, and the achievement rate. [Figures] also are totaled for the entire department."

Managers get a packet containing the departmental report and individual reports, which are distributed to the registrars, she adds. In most of the affected departments, Colvert says, the quality review results are used in employees' annual evaluations.

Registrars who maintain an accuracy rate of 99% over a six-week period receive a special benefit, Caudle notes. Their work is given a cursory look, but no longer is reviewed like that of their peers.

"Every quarter or so we pull [a sheet] to make sure they maintain [the quality level]," she says. "If they don't maintain it, we take away the exemption; but most work hard to maintain." These registrars also are recognized for the achievement by the managers in their departments, Caudle adds.

To help ensure consistency, she says, "every 90 days or so, we take the same [registration] sheet and give it to each quality reviewer. Then we look at the sheets to make sure they're verifying in the same way."

If registrars disagree with a mark made by the reviewer, they can take their complaint to a manager and, if the issue is not resolved there, send the sheet back, Caudle explains. "Usually Teresa and I look at those sheets and, if it's appropriate, we adjust the person's score. Either way, we always give feedback.

"If we see that particular [registrars] are having problems keeping their scores up, we ask the manager to send the person back for some additional training." Less often, Caudle, Colvert, or the financial counselor/training assistant will work one on one with registrars in the individual departments, Caudle adds. ■

Need More Information?

- **Darlene Caudle**, Manager, Verification and Quality Services Department, Carolina Baptist Hospital, Winston-Salem, NC. Telephone: (336) 716-0720.
- **Teresa Colvert**, Supervisor, Verification and Quality Services Department, Carolina Baptist Hospital, Winston-Salem, NC. Telephone: (336) 716-0721.
- **Keith Weatherman**, CAM, Associate Director, Patient Finance, Carolina Baptist Hospital, Winston-Salem, NC. Telephone: (336) 713-474. E-mail: kweather@wfubmc.edu.

Make HIPAA fun, make lessons memorable

HIPAA education outside the box

What do a stuffed hippopotamus and a very cool hippie have in common? Both are tools used by hospitals to reinforce patient privacy regulations stipulated by the Health Insurance Portability and Accountability Act (HIPAA).

"We knew we had to think out of the box to find a way to make the dry topic of HIPAA regulations into something that makes sense and keeps employees' attention," says **Kathleen Graham**, JD, LLM, HIPAA privacy officer and director of corporate compliance and privacy for Children's Hospital in Birmingham, AL.

In order to educate all staff members in the hospital, HIPAA educational sessions were conducted as part of departmental staff meetings, as separate inservice educational sessions, within new employee orientation sessions, and through computerized lessons available to all employees, she points out.

The multidisciplinary team responsible for HIPAA education at Children's knew that it would take more than one or two educational sessions to really get employees to think about privacy on a day-to-day basis, Graham adds.

"We started educating our department heads and managers about four to five years ago, then introduced the education for all employees in the months preceding introduction of the privacy rule," says **Pam Atkins**, CPHIMS, HIPAA security officer and divisional director of information technology. Now the hospital is incorporating tips related to the security rule into the information.

Betsy Karr, RN, divisional director of surgical/anesthesia services, says, "Because we are a pediatric hospital, we can have fun when communicating with each other without being silly."

While the original HIPAA educational session involved one day of inservice for different groups of staff, the education continued with events that reinforced the teaching, she explains.

The fun included a scavenger hunt that consisted of hippo fliers posted around the hospital. Each flier contained one HIPAA-related question that the employee was to answer and return to the marketing department for prizes that included movie passes and hippo Beanie Babies, explains Graham.

"Of the more than 50 fliers we hid, we only received one wrong answer," she adds.

Other fun activities enabled employees to win hippos that ranged in size from Beanie Babies to a 4-foot-tall stuffed animal. These included *Family Feud*-type games in meetings that focused on

HIPAA quizzes test basics

Employees at Children's Hospital in Birmingham, AL, enjoy quick e-mail quizzes that test their knowledge of Health Insurance Portability and Accountability Act (HIPAA) requirements and give them a chance to win hippos.

"While the idea for the e-mail quizzes came from a consultant, we created our own content based upon employee suggestions," explains **Kathleen Graham**, JD, LLM, HIPAA privacy officer and director of corporate compliance and privacy for Children's Hospital in Birmingham, AL. Some of the quiz questions included:

Question: Baby Bubba is the son of famous country music singer Big Bubba. Baby Bubba is visiting Children's Health System for a checkup. The media has been attempting to contact you to ask questions about the Bubbas. One local TV station, promoter of the Big Bubba fan club, even wants to stop by to see Baby Bubba. What should you do?

Answer: Stop, think, and clarify the HIPAA consequences. Famous people and their children have HIPAA rights. Talk to Big Bubba to let him know what is happening. Please follow Children's policy and call Media Relations for assistance.

Question: You go to church with the Bubbas. Many people at your church saw patient Baby Bubba and Children's in the news last week. They are asking you questions at the service about Baby Bubba because they know you work at Children's. They would like to pray for the Bubbas, who aren't there that day. How do you respond?

Answer: Tell them that they need to talk with the Bubbas to find out any information. HIPAA applies in the church setting. Sharing confidential patient information — even prayers — can be a breach of confidentiality. Although these people are genuinely concerned and their intent is good, they have no "need to know" confidential patient information because of Baby Bubba's privacy rights.

Question: What should you do if you are talking with a patient/parent in a semiprivate patient area?

Answer: Pull privacy curtains, lower your voice, and be discreet.

Question: What should you do if you are in an elevator and others are discussing a patient?

Answer: Politely remind them to respect patient privacy. ■

HIPAA questions, e-mail quizzes that went to all employees, a HIPAA holiday choir that sang a song that praised HIPAA rules, and a HIPAA safari theme for educational sessions. **(See example of quiz questions, p. 141.)**

"We encourage employees to be on the lookout for HIPAA violations and report them immediately to the compliance department," Graham says. "In fact, we call a HIPAA concern a HIPAAspotamus."

Cartoon hippie spreads word

While Children's Hospital in Birmingham relied upon a hippopotamus to carry their HIPAA message, the staff at Lee Memorial Health System in Cape Coral, FL, learned about HIPAA regulations from Chip, the hippie.

"Chip is a cartoon character that carries our 'hip on HIPAA' theme throughout our publications, inservices, videos, and meetings," says **Brad Pollins**, executive director of learning and performance systems.

A multidisciplinary team designed an educational program that would create a cultural transformation in the way staff think about privacy, Pollins says.

"The team developed a combination of videos, handbooks, and educational classes to share the information, but we needed something to tie everything together and make it memorable for employees," he adds.

The cartoon character, Chip the hippie, appeared on posters and in a cartoon strip that appeared in the employee newsletter, Pollins says. "We also found an employee who dresses as Chip for meetings and special employee events."

The HIPAA education program kept the hippie theme going with e-mail quizzes and contests that awarded lava lamps and tie-dyed T-shirts as prizes, he adds.

Pollins' staff also created a HIPAA site on the hospital's internal network that employees can access to find answers to HIPAA questions or concerns they may have, he says. The HIPAA pad, as the site is named, enables employees to submit questions or concerns to the compliance department, he explains. "Chip answers the questions with a note that starts out "Hey man," then responds to the employee's note," he says.

Employees at Children's Hospital also can use e-mail to report concerns or make suggestions to improve compliance with privacy regulations, says Karr. "Within the surgery areas, staff members suggested locations of whiteboards that would protect privacy, and our post-anesthesia care unit requested curtains for the cubicles," she explains.

An important part of the program at Children's is the clear identification of who to call if you have questions, says Karr.

"Because we are dealing with pediatric surgery patients, we have a larger group of family members who want information and are concerned. It's nice to have a compliance officer that can be easily reached when we have a question," she says. ■

Need More Information?

- **Kathleen Graham**, JD, LLM, HIPAA Privacy Officer, Director of Compliance and Privacy, Children's Hospital of Alabama, 1600 Seventh Ave. S., Birmingham, AL 35233. Telephone: (205) 939-9271. E-mail: kathleen.graham@chsys.org.
- **Brad Pollins**, Executive Director of Leaning and Performance Services, Lee Memorial Hospital, 636 Del Prado Blvd., Cape Coral, FL 33990. Telephone: (239) 772-6734. E-mail: brad.pollins@leememorial.org.

Beyond slogans: How to build a culture of safety

Red rules, raising risk awareness are keys

Safety culture (n): 1. A set of values and beliefs that results in fewer employee injuries and medical errors. 2. What all hospitals want but too few have.

In employee health, "safety culture" is the Holy Grail. If you have a strong one, employees are more likely to comply with rules and use equipment designed to protect them and their patients. But what is a safety culture? How do you get one?

Those are questions **Craig Clapper**, PE, CQM, MBA, partner and chief operating officer of Performance Improvement International in San Clemente, CA, has studied — not just in health care, but in the work of business effectiveness gurus such as Jim Collins, author of *Built to Last*, and efforts of the nuclear power industry, where accidents could be catastrophic. He has adapted techniques that can be put in place in hospitals to make "safety first" more than just a slogan.

"People aren't really articulating what this thing called safety culture is," he says. "We're just complaining that we don't have it."

In fact, everyone has a safety culture, Clapper says. Some are strong; many are weak. "In health care, the culture is one of workaround and shortcuts," he explains. By starting with basic values, establishing a few absolute rules, and establishing behavior-based expectations, hospitals can create an atmosphere that places a higher premium on safety, he says.

Case in point: Sentara Norfolk (VA) General Hospital launched a safety initiative, which included commitment from top leadership, a Safety Coaches program, and a four-hour hospitalwide training program — Behaviors for Error Prevention. Clapper has helped the hospital assess its current safety climate and establish a performance improvement plan.

"This isn't just a project to improve patient safety. This is an initiative to improve overall safety of everyone who works, visits or is treated at our hospital," says **Carole Stockmeier**, MHA, director for cancer services and one of the coordinators of the safety initiative.

"We're not just going to go for a behavioral change. We're trying to make a change to our whole foundation and create a culture in which safety is what we're all about," says **Cindy Parker**, director of operational support and one of the coordinators of the safety initiative. "This isn't flavor of the month. It's there in everything we do."

Here are a few key aspects of the Norfolk General safety initiative:

• **The vision thing.** It might sound trite, but every successful program starts with a slogan. At Norfolk General, the hospital stated, "Patient safety starts with me."

The idea is to link all aspects of safety — for patients, employees, and visitors — and to personalize it. Everyone shares the responsibility.

Senior administrators endorsed the program and agreed to provide resources for consultants, training, and ongoing performance improvement.

"Changing culture is a very long process," says Stockmeier. "It requires that you stick to it and that you don't allow other things to divert your attention from the task you have at hand."

The vision and the mission give a sense of purpose to your program, Clapper says. "To change culture, you probably do have to start out with a poster. You have to define and demonstrate the new expectation that we want everyone to believe in. Companies that do well with safety culture have amazingly simple mission statements."

Of course, the vision is just the beginning. Leaders then need to follow up with a set of behaviors and expectations, "describing what behaviors are consistent with that overall statement of purpose," says Clapper.

• **Red rules.** Sometimes, there is no compromise for safety. You want the staff to follow the rule in all cases. Clapper calls that a red rule.

"It gives you the ability to convey [a strong] expectation or conviction," he says.

For example, Norfolk General has a red rule that requires surgeons to identify the surgical site and confirm it with the surgical team before taking hold of the scalpel. No exceptions.

Zero lift is an example of an employee health-related red rule. A hospital might set up a policy that requires the use of a lifting device with any fully dependent patient. Norfolk General is in the process of identifying additional red rules.

"Some red rules will be the same across all departments. Others will be specific to departments," Stockmeier says.

"You want them to be few in number and you want them to be significant. It's a few key words that focus an employee in on remembering a specific action or behavior," she adds.

Stockmeier estimates that the hospital will settle on a maximum of three to five red rules per department.

Managers will designate the red rules, and senior leadership will sign off on them. Then employees will receive information about the rules and expectations. "We are going to be reminding managers that we have a code-of-conduct policy," she says. "That code-of-conduct policy covers failure to comply with performance expectations."

COMING IN FUTURE MONTHS

- The role of depression in your patients' recovery
- More best practices from America's top rehab hospitals
- Innovative technology that could change the way you do rehab
- Trend in pediatric rehab
- Should you outsource your billing?

• **The three-factor formula.** There are three factors that work together to determine how likely employees are to comply with safety practices, says Clapper. Consider the perceived burden or effort as the numerator. In the denominator is the risk awareness and the culture of compliance.

"Whenever the [perceived] burden is high, noncompliance is high," he says. "Whenever risk awareness is low, noncompliance is high. Whenever your culture or your shared value on safety is low, then compliance is low. It's very situationally specific."

For example, at one hospital, workers smelled smoke coming from a cable tunnel. They went to investigate a fire. "The work rule is that we verify that the atmosphere contains enough oxygen and doesn't have explosive gas until we enter. Our little gas meter is actually stored at another facility. The time and effort to get it gives you the burden. So they chose just to go in," Clapper says.

Five employees had to be treated for symptoms of headaches and dizziness for not using the proper protective equipment while handling the fire.

"The people who go to driving school are not taught about how to drive better. Their risk awareness is raised about the importance of driving better," he says.

"The other thing I'd work on is the culture of compliance — half of it comes from leaders, the other half comes from peers. You have to define it, then work on the knowledge and skills, and then work on accountability."

• **Continual feedback.** Accountability for safety can be built into performance evaluations. But continual feedback is critical, as well — and it should be delivered in a dose of five times as much positive feedback as negative, Clapper says.

Nurse managers should conduct safety rounds and catch employees doing something right — using alcohol-based hand rubs for hand hygiene, for example, or activating safety devices. A simple look of approval or thumbs up is all that is needed.

"You take all the rah-rah out of it," he says. "You might sympathize with them, saying 'I know this is inconvenient for us, but it's important.' Health care workers are motivated by knowledge and excellence." ■

Rehab Continuum Report
2003 Index

Need back issues? Call our order department at (800) 688-2421; inside Georgia (404) 262-7436.