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The essential monthly management advisor for rehabilitation professionals

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AMERICAN HEALTH CONSULTANTS™

## IN THIS ISSUE



FEBRUARY 2004
VOL. 13, NO. 2 • (pages 13-24)

# Therapy cap moratorium, 75% rule addressed in Medicare drug bill

*Rehab providers are relieved, but know therapy cap issue isn't dead*

If all your news of the Medicare prescription drug bill that President Bush signed into law on Dec. 8 has come from local newspapers, news magazines, or network newscasts, you may have missed two golden nuggets in the law that address major rehab issues.

Buried in the voluminous bill underneath high-profile issues such as the drug benefit are a two-year moratorium on the outpatient therapy cap and language that directs delayed implementation and further analysis of the 75% rule.

"I have not seen anything in the press about the therapy cap, but certainly getting rid of the cap is a benefit to our patients and to the clinicians," says **David Perry**, PT, a member of the American Physical Therapy Association's (APTA) federal government affairs committee. He is the owner of Perry Therapeutics in Grosse Pointe Woods, MI.

"The physical therapy profession and the patients we serve came out very much winners with this legislation, [though] the legislation has its flaws," he says. "The headlines in the newspaper all talk about the prescription drug package, which was probably the weakest gain, and from some people's perspective, may even be a loser for seniors. But that was the legislation we needed to tag along with to get the benefits for physical therapy."

The law applies a two-year moratorium on the therapy cap, which had been set at $1,590 for physical and speech therapy services combined, with another limit of $1,590 on occupational therapy services. The cap was on from Sept. 1, 2003, until the law was signed on Dec. 8. Services rendered from Dec. 8 through the end of 2005 will not be subject to the cap.

The law also requires that a study be done by March 2004 on therapy cap alternatives and outpatient therapy utilization. By October, a study by the comptroller general of the U.S. General Accounting Office (GAO)

on conditions appropriate for cap exemptions must be completed. Also included is a required Medicare Payment Advisory Commission (MedPAC) study on allowing Medicare fee-for-services beneficiaries direct access to outpatient physical therapy.

Yet another benefit is that the law prevents a scheduled 4.5% cut in Medicare payments to physical therapists and other providers from taking effect in 2004, replacing it with a 1.5% increase for 2004 and 2005.

"The cap issue was first pushed as an independent bill. Direct access is being pushed as an independent bill, but they weren't going to fly through Congress," Perry says. "That's just the reality of the system, so this was the vehicle we were fortunate enough to have legislative support to tag along with."

**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.

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The APTA had hoped for a pilot project on the direct access issue, but was happy enough to get the MedPAC study, Perry says. "The bill was introduced earlier this year that would provide for direct access under Medicare in those states where direct access is allowed by the state practice act. That bill is still out there, but the reality of that bill passing as a stand-alone bill is probably still a few years away," he says. "The study mandated in the new law provides the profession and the associations an opportunity to work with CMS [Centers for Medicare & Medicaid Services] to have input into it. It's another step in the right direction."

The APTA has taken the stand that providing greater access to physical therapy will ease the burden on the health care system.

"There are certain conditions where it's very clear that the patient requires the services of a physical therapist," Perry says. "You've got the time factor and the expense of going to a physician first, when what you really needed to do is get in quickly to see your physical therapist.

The more quickly you can get in with the physical therapist in certain conditions and the more quickly that treatment can be initiated, the more quickly the patient can recover. In the more acute phase, the impact can be greater and you will need fewer visits," he explains.

Physical therapists are trained to recognize what is within their scope and what isn't, Perry says, so they know when to refer a patient back to a physician.

Despite the benefits of the Medicare law, he acknowledges that it could be a short-lived victory. "The law is still there from the original Balanced Budget Act of 1997 that instituted the cap. What passed was instructing CMS not to implement the cap for two years, so the issue still exists," Perry says. "At the end of that two years, if the law has not been changed, the law theoretically would go back into effect. Work still needs to be done to provide a change in the law or an alternative mechanism to save money."

That is precisely the issue that bothers many physical therapists and has engendered heated discussions within the profession in the weeks since the law was signed. **Peter van Well**, PT, a physical therapist in Redford, MI, says he is happy about the physical therapy relief in the law but worries at what cost that relief comes.

"Medicare in the end is not a blank check. It has limited funds, and in the end, someone will have to sacrifice," van Well says. "I understand

that many are saying, 'As long as it is not us.' But in the end, we will be affected. To me, it is an ultimate reality."

He points out that while physical therapists are concerned about access to care for their patients, they also are concerned about their ability to earn a living. "It is clear that the government believes we rehab professionals are, if not too expensive, at least very expensive; and likely in their opinion, there is not enough evidence that what they pay for is truly effective," van Well says. "And so they begin to restrict access and, thus, expense. Things happened to others for the past years, and we weren't crying foul then. Now it affects our pockets, and now it becomes a problem. I, too, am a PT; and I, too, wish to make an honest buck for my family; and I, too, want the cap to go. But another moratorium is just that: another moratorium. A year from now we'll have to go through this again."

**Paul Simonetti**, DPT, MTC, a physical therapist with Chestertown (MD) Orthopedics and Sports Medicine, agrees that the law is not a total victory. "Clearly, this is a victory, but it can only be viewed as a short-term, stopgap measure to a much larger issue. Let us not set up the ticker tape parades yet," he says. "Perhaps before the end of 2005, a new payment scheme may be created to replace the one currently being used. If not, we are faced with either a reinstatement of the cap or a new legislative battle to again provide relief from this piece of bad legislation."

## *Further analysis on 75% rule*

On the 75% rule issue, the language included in the legislation does not have the force of law but rather is a directive, says **Rochelle Archuleta**, senior associate director for policy development — post-acute care for the American Hospital Association in Washington, DC. It states the conferees' concern that the 75% rule would have "severe consequences" for access to inpatient rehabilitation hospital services and urges further analysis of which conditions are clinically appropriate for inclusion in the calculation of the 75% rule. It also directs the GAO to issue a report on the current list of conditions and to delay implementation of the rule until the report is finished.

"We are hopeful that the administration will follow the directives in the report," Archuleta says. "At this point, the fate of CMS' draft final rule rests in the secretary's [of Health and Human Services (HHS)] hands," she says. "CMS and HHS have been negotiating changes to the draft final rule. It's unclear what the final HHS position will be."

One option, Archuleta says, is for HHS to sign off on the draft final rule, which would then go to the Office of Management and Budget (OMB) for review prior to publication in the *Federal Register*. That option would be contrary to the recommendation in the drug bill conference language. Another option is for HHS to act on the "stop, study, revise" position in the prescription drug law. "We've heard they may forward the draft final to OMB and commission a study," Archuleta says.

Similar language can be found in the FY 2004 Omnibus Appropriations bill (H.R. 2673), which also is directive and not mandatory. It is similar to what is found in the Medicare conference report, but directs CMS to contract with the Institute of Medicine (IOM) to issue a report on the clinically appropriate standards for inclusion in an inpatient rehabilitation facility. It also suggests delaying implementation of the local medical review policies until the report is finished. **(See related story, *Rehab Continuum Report*, November 2003, p. 126.)**

"We are thrilled to have both," says **Carolyn Zollar**, JD, vice president for government relations at the American Medical Rehabilitation Providers Association.

"The language in the appropriations bill is more consonant with our advocacy efforts in that it urges an IOM study and mentions the local medical review policies, too," she adds. ■

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# Innovative research keeps rehab hospital on top

*Patients invited to team meetings*

Want to know what it takes to be one of the top rehab hospitals in the country? At the University of Washington (UW) in Seattle, the answer is outstanding quantity and quality of research, cutting-edge treatment, and administrative processes that focus on the patient. At UW, the patients even get to come to the weekly team conferences.

UW ranked third on the rehab section of *U.S. News & World Report's* annual list of the best hospitals in America in 2003. The rankings are determined by a survey of board-certified specialists in each category, who are asked to identify those hospitals that are leaders in their specialty without regard to location or cost.

It's not hard to see why UW is well known and highly regarded around the country. The rehabilitation medicine department receives more National Institutes of Health (NIH) funding than any other in the country and annually turns out around 100 peer-reviewed publications.

"The big thing is we have an outstanding reputation for our faculty and our staff, both for providing outstanding critical care and for our research efforts," says **Lawrence Robinson**, MD, professor and chairman of rehabilitation medicine at UW.

"When you look at the research work at the University of Washington, it's really quite amazing. What that level of research means is we're at that cutting edge where research meets clinical care. Patients who come here can expect the latest in clinical care that can be offered any place. Some patients are enrolled in new treatments they couldn't get anywhere else," he adds.

Robinson supervises the work of about 50 faculty members who are split among the UW system hospitals: University of Washington Medical Center, Harborview Medical Center, and Children's Hospital and Regional Medical Center. The department also provides services at VA Puget Sound Health Care System and Overlake Hospital Medical Center in Bellevue. Half of the faculty are physicians; the other half are PhD-level psychologists and therapists.

"We have a little different model than some institutions in that our researchers are pretty much all clinicians, too," he says. "In some places, those functions are separated; and it takes a little more effort to make sure that translation between research and clinical care occurs. Here we have overlap since the researchers are the clinicians."

UW researchers are working on a number of interesting developments in rehab care:

**1. Psychological treatment of pain**.

UW researchers have found that patients' attitudes strongly influence their experience of pain. It has long been puzzling why patients with similar injuries report such wide differences in how much pain they feel and how much it inhibits their daily function.

"One of the things we've found is it depends on how much people catastrophize about their pain," Robinson explains. "If someone has an injury that's painful and they say, 'What am I going to do, and how am I going to survive this?' they don't do as well as someone with the same type of injury and the same type of pain who says, 'I'm just going to figure out a way to get through this.'"

UW is starting a new treatment called "decatastrophizing" in which patients are given the tools they need to better take their situation in stride. "We're hoping to see that it will improve their function," he says.

**2. Treatment for burn pain.**

UW has an NIH research grant for a project that examines the ability of virtual reality and hypnosis to improve pain during procedures such as dressing changes. "With virtual reality, you basically enter another world. The glasses give you such a three-dimensional picture and cover enough of your field of vision that you feel like you're someplace else," Robinson adds.

"We're looking at ways for burn patients to go in this place called 'snow world' where it's a cool, snowy area that you can maneuver around in. You get a sense of deep relaxation. It looks like it's very effective in reducing pain during some of the procedures," he explains.

**3. Prevention of phantom limb pain.**

Robinson is the principal investigator of a trial on using epidural anesthesia during amputation to prevent phantom limb pain. "We put a catheter into the spine region and give anesthetics during the amputation and for several days after to try to prevent phantom limb pain from occurring even a year or two down the road," he says. "We don't really know if it works yet, but it might; and there's some evidence in the literature that makes us optimistic about it."

Robinson also works on patients with voice

disorders. "Some people have vocal cords that are too tight. We've worked with surgeons to put fine wires into the muscles that control the vocal cords," he says. "We have people do a bunch of vocal tasks, and we can tell which muscle is the problem. Then we put BOTOX in the offending muscle, and they usually get some improvement."

UW is the only hospital in the country that has earned model systems grants from the National Institute for Disability and Rehabilitation Research in all four areas offered: spinal cord injury, traumatic brain injury, multiple sclerosis, and burns.

**Diana Cardenas**, MD, MHA, professor and chief of service in the department of rehabilitation medicine, is the principal investigator of the Model Spinal Cord Injury System.

"As researchers, we attempt to bring the latest findings to our patient care," she says. "We are able to provide rehab for spinal cord injury patients on ventilators and utilize computers widely for all our patients."

The model systems grants have research, education, and clinical care components. The grant provides a patient/family advisory board that gives input on rehab services. UW also offers a monthly spinal cord forum for patients and families where neurologists, physiatrists, and other experts speak on a related topic.

"It's a really nice educational session that really brings it above the level of a support group," says Robinson.

The UW Medical Center was the first hospital in the country to be certified as a Magnet hospital by the American Nurses Credentialing Center. The Magnet program identifies institutions that provide top-quality nursing care for patients. **Sandy Painter**, RN, nurse manager for inpatient rehab, says all of her staff are registered nurses.

"We have developed the primary nurse and nursing panel representative role to facilitate continuity of care for the patients," she says. "The nurses are assigned to a team and are responsible for the patients assigned to that team."

UW's weekly team conferences are unique in that patients and families are invited to attend, Painter adds.

"This has helped to involve the patient and family in working toward their goals. Everyone on the team hears the same information at panels. This has improved the patients' and families' communication with the team," she says.

Robinson says staff, at first, were concerned that involving patients and families would complicate the meeting process. What they have found, however, is that care becomes more efficient when patients help make the goals.

"It doesn't take that much longer," he says. "Patients are prepped ahead of time that we only have so many minutes per session. It also saves us time in terms of other meetings with the patient to go over the stuff that we just went over in the team meeting."

With ever-shorter lengths of stay, the rehab department decided that the weekly conference was not enough. So teams began the daily huddle, a 45-minute session that hits the high points on what patients need that day.

Cardenas says the keys to rehab success at UW are its core values, which include:

- compassion and service to the patient above all else;
- encouraging individual ability and creativity in staff, patients and students;
- excellence in reputation and being part of something special. ■

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# Falls clinic gets patients back on their feet

*PT, doc team up to cut fall risk*

If you took a young athlete and put him on bed rest, he would lose between 2% and 4% of his muscle strength each day. Imagine what happens when an elderly person remains sedentary for long periods due to a fear of falling.

"For older people, that compounds because they

just don't move as much anymore," says **Richard Brunader**, MD, a geriatrician with the University of California (UC), Davis Health System, and associate professor of family and community medicine at UC Davis Medical Center.

"Their joints become stiff; their muscles become weaker; the systems in place to keep the blood pressure up when standing weakens. The very act of cutting back increases the risk of falling," he points out.

But cut back they do. Between 20% and 25% of elderly patients who have fallen have a severe fear of falling that often rules their lives. "People realize they can injure themselves. It's often a fear of nursing home placement. If the family becomes concerned, they might say 'Dad, you need to slow down. You shouldn't be doing this stuff anymore,'" Brunader says.

"Most falls happen, not with a person on a ladder, but in ordinary everyday activities like walking around the house, getting into the shower, going out to the back yard," he says. "Because of that, people really cut back. As you cut back, further deconditioning occurs."

To help break this vicious cycle in elderly patients, Brunader recently started a Geriatric Falls Evaluation and Management Clinic at UC Davis Medical Center. Brunader and **Janet Retke**, PT, a physical therapy supervisor with the hospital's outpatient therapy clinic, see patients every Wednesday from 8:30 a.m. to noon.

The goal is to look for patients older than 65 who have had a fall that required medical attention or who have had more than two falls in six months. Other candidates for the clinic are patients who have a high likelihood of fall injury due to underlying conditions such as osteoporosis, arthritis, hypertension, and dizziness.

The medical literature shows that about one-third of people older than 65 fall every year, and that a multifactorial assessment intervention can reduce those falls from 20% to 50%.

"It's a widespread problem," Brunader says. "It's something that is not easily addressed in a regular office visit."

At the initial visit, Brunader reviews potential causes for falling and injury, including medications, circulatory problems, vision, balance, depression, dementia, and osteoporosis. "If you approach it as 'I'm going to look at why the person fell,' you're not going to find it," he says. "Most people fall for multiple reasons. It might have been one final thing, but there's a host of imbalances as one ages. It's a genetic part of aging, the deterioration of organ systems. Your nervous system slows down; your receptors slow down; but there's also disease: arthritis, hypertension, diabetes. The other part is deconditioning. You have arthritis in your knee, so you don't move as much and your muscles begin to atrophy."

Brunader performs a physical exam, complete with fall history, orthostatic vital signs, and depression screen. One of his early findings from this clinic is that more patients are depressed — and more intensely depressed — than the geriatric population he normally sees. He cautions that he has not seen enough patients yet to have numbers he can bank on, but the early sample shows that 70% to 80% are significantly depressed.

"When they are depressed, they lack the motivation to help themselves," he says. "If you are depressed, it accentuates your pain, it hinders your ability to work with us. If you're not improving, that makes you more depressed."

## Care team sets course

The other component of the clinic — and the thing that sets it apart from other clinics for elderly patients — is the fact that the physical therapist and the clinician work together and see the patients at the same visit. Retke gives patients a series of tests, including a balance-gait assessment, a modified clinical test of sensory integration and balance, and a dynamic gait index.

At the second visit, the care team discusses medical management and recommendations for physical therapy, ongoing exercise routines, or perhaps participation in a community-based exercise program. Brunader says he is exploring ways to make home visits to assess environmental hazards financially feasible. Patients will return for follow-up appointments at six months and one year or more often as necessary.

He says he feels a sense of urgency to help this population. If a patient is hospitalized with a hip fracture, there is a 50% one-year mortality rate.

"The population is aging. The fastest-growing segment of the population in the United States today is those [older than] 85, and those are the people who fall," Brunader says. "Anything that can be reasonably done to better their lives that is cost-effective is going to be very valuable. There is a large number of patients coming down the road that we're going to have to address this with."

One benefit of the thorough exam and the approximately 1½ hours each patient spends with the care team at the initial visit is the detection of

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previously unknown disorders. "I'll end up finding related diseases such as vascular disease or undetected diabetes or cardiac causes or a stroke they were unaware of," Brunader stresses. "Some of these things may not show up in a regular office visit. They are gradually progressive, and maybe nobody noticed Mom seemed different until after the fall. The fall is a symptom but also a marker for underlying conditions."

Retke helps Brunader determine the best course of rehab action for each patient. If it's appropriate, Retke will set up one-on-one therapy with her or with a physical therapist close to the patient's home. She and Brunader also have been traveling to community exercise locations such as the YMCA to observe and assess their ability to work with elderly patients. That way they can recommend a program for patients who don't need or qualify for individual therapy.

Elderly patients and their families may resist the idea of exercise. But Retke emphasizes the benefits of exercise, even if all the patient can manage is simple tasks such as stretches, short walks, or chair aerobics. "The results can be dramatic," Retke says. "I've seen patients who can get to the point where they can walk without being considered a fall risk. They can live a more active and independent lifestyle, to be able to go out and about instead of being restricted to the home."

The exercise has another benefit: increasing patients' self-confidence. "Their anxiety around the possibility of falling decreases their normal body movement and perpetuates the problem," she adds. "If you show them what they can do, they reinforce it themselves by being successful at doing it." ■

# Taking a toll: Back pain sidelines nurses daily

*Debilitating injuries could be prevented*

*[Editor's note: Every day, 150 health care workers suffer musculoskeletal disorders (MSDs) that cause them to lose time from work. Countless more end their shifts with aching backs, shoulders, or necks. In hospitals, overexertion in lifting is the most common cause of lost workday injuries. Here is the story of a nurse who suffered a debilitating injury — and the steps she says could be taken to prevent others from a similar fate.]*

**Anne Hudson** of Coos Bay, OR, was walking across her kitchen when she suddenly felt a surge of incapacitating pain. She could barely move. Ten years of lifting patients without mechanical aids had led to cumulative trauma injury to two lumbar disks.

As she stood immobilized in her kitchen, Hudson didn't know about the condition of her back. She kept thinking the pain would go away and she would be able to return to work on her weekend shift that Saturday.

Her most immediate concern was finding temporary relief from pain. "I couldn't sit; I couldn't lie down; I couldn't get in a car to go to the doctor," says Hudson who is now 54.

"I didn't recognize my pain as severe muscle spasms in response to spinal injury. All I knew was that I had pain like I had never experienced before. A deep severe ache and intense burning settled into my lower back, and I had pain and burning into my lower legs and sometimes into my feet."

The pain lessened at times, enabling Hudson to at least lie down and rest. But she was in no condition to return to the hospital that Saturday, where she worked as a floor nurse in the medical/surgical, telemetry, and intermediate care units. Hudson began back therapy with the same mantra in her head: "This will pass, and I will be better." She couldn't imagine life without nursing, without caring for patients.

But her career as a floor nurse already was over. While Hudson visited physical therapists, orthopedic doctors, and neurologists, and tried anti-inflammatories, heat and cold treatments, and pain medications, she faced a struggle over workers' compensation. At first, she was allowed to work in limited-duty jobs that used her nursing skills. That avenue shut down when workers' compensation denied her claim.

Hudson convinced one of her physicians to give her a work release, as long as she wore a

back brace. That lasted three weeks — until she helped care for and reposition a 400-pound patient. She realized she could no longer handle the lifting and transfer tasks.

A workers' compensation judge and the workers' compensation board ruled that Hudson's injury was work-related. The hospital continued to appeal. Meanwhile, Hudson was allowed only two 90-day periods of light duty. There were no permanent accommodations for a floor nurse who could lift no more than 20 pounds.

Today, Hudson works for the county health department, a job she enjoys but one that pays significantly less. Workers' compensation payments, which brought her income up to two-thirds of her wage at injury, stopped at claim closure. Still, Hudson is very grateful to be working as a public health nurse. "Many back-injured nurses never work as nurses again. Either they are too severely injured to work or they are unable to find an employer willing to accept an injured nurse."

A chiropractor helped ease her pain, and a neurosurgeon fused two of the disks, giving her relief from some of the most intense pain. But not a day goes by without a deep aching in her back.

Hudson can no longer work in the garden. Doing laundry or grocery shopping brings pangs of pain. She rarely enjoys a night of sound sleep.

But for Hudson, there is another pain that is not physical. She has become an unwitting expert on the ergonomic hazards of manual patient handling and MSDs among nurses, and she now knows that a zero-lift policy and proper lifting equipment could have saved her career and her back.

She also stresses it is unethical for hospitals to deny permanent light duty to injured nurses after not providing safe patient lift equipment and policies to protect them from lifting injuries.

Hudson formed WING USA (Work-Injured Nurses' Group USA), an advocacy organization patterned after similar organizations in the United Kingdom and Australia. Hudson also has co-edited a book with health and safety expert William Charney, which includes the personal stories of injured nurses as well as technical information on ergonomics and safe patient handling.

Hudson is working on state initiatives for Zero Manual Lift for Healthcare legislation and promotes industry-specific ergonomic solutions that could spare other nurses from a similar fate.

"Their careers, their finances, their lives are being impacted by a preventable injury," she says. "It's devastating."

*[Editor's note: The book* — Back Injury Among Healthcare Workers: Causes, Solutions, and Impacts — *edited by William Charney and Anne Hudson, is available from CRC Press Catalog No. L1631. Price: $79.95. Phone: (800) 272-7737. Web: www.crcpress.com.]* ■

# Survey: Violence warning signs often go undetected

*Study shows need for more education, training*

Experts claim that workplace violence rarely strikes without warning, but according to a new study on the issue, the majority of the work force does not recognize those potential warning signs. This is one of many compelling findings from a recent study commissioned by the Atlanta-based American Association of Occupational Health Nurses (AAOHN), indicating the need for employee education and training on workplace violence.

"Our study found that nearly 20% of the entire work force claimed they have experienced an episode of workplace violence firsthand, yet the majority still do not know what to look for when it comes to determining potential offender characteristics," notes **Susan A. Randolph**, MSN, RN, COHN-S, FAAOHN, AAOHN president. "The fact that most people do not realize what some of the warning signs are is critical; if you know them, then you can look at your potential responses."

AAOHN's survey was designed to gauge employee knowledge around the issue of workplace violence and demonstrate the need for violence prevention education. To help ensure survey accuracy, experts from the FBI's National Center for Analysis and Violent Crime, who are currently developing a workplace violence monograph available to companies later this year, were consulted during the development of survey criteria.

Respondents to AAOHN's survey were asked about their personal experiences, concerns, perceptions, and overall awareness of the issue. Here are key findings from those questions:

• **Recognizing the warning signs.** The AAOHN survey found the vast majority of respondents did not recognize many of the key workplace violence warning signs, which have been identified by the FBI. In fact, when given a list of red-flag behaviors, less than 4% of respondents were able to identify

## Workplace violence prevention program recommendations

In response to findings such as the ones outlined in the survey by the Atlanta-based American Association of Occupational Health Nurses (AAOHN) and the overarching prevalence of workplace violence among the U.S. work force, the AAOHN and the FBI offer this guidance to help companies develop workplace prevention and education programs:

- ✔ Management should conduct a thorough organizational risk assessment and develop workplace violence prevention policies and programs that address potential risks in environmental design (security cameras, key card access), administrative controls, and behavioral strategies.
- ✔ Programs should clearly define the spectrum of workplace violence (ranging from harassment to homicide), delineate employee responsibilities for recognizing and reporting signs, and be shared with every employee. All programs should promote zero tolerance.
- ✔ Ask for and integrate employee ideas when developing and implementing a violence prevention program.
- ✔ Create a confidential and seamless reporting system. Encourage workers to report any and all concerns to a single representative, such as an occupational health and safety professional or human resource manager.
- ✔ Incorporate a variety of communications tools such as posters, newsletters, staff meetings, and new employee materials.
- ✔ When training employees, review common warning signs, behavioral traits, and how to recognize potential problems. Employees also should understand that each case is different and to not limit at-risk behavior to a standard profile.
- ✔ Involve *all* employees in workplace violence prevention programs. Training should be ongoing and mandatory for every employee.
- ✔ As an employee, actively participate in all education and awareness programs. If you do not have a violence prevention program at work, request information from your occupational health department, human resource department, or manager.
- ✔ As an employee, if you recognize that a colleague exhibits at-risk behavior, report any concerns to your human resources representative. ■

some of the most common warning signs usually seen in potential offenders. These warning signs include changes in mood, personal hardships, mental health issues (e.g., depression, anxiety), negative behavior (e.g., lying, bad attitude), verbal threats, and past history of violence.

• **Defining workplace violence, men vs. women.** The FBI says workplace violence can be defined as any action that may threaten the safety of an employee, affect the employee's physical or psychological well-being, or cause damage to company property.

When respondents were given a list of examples and asked to flag what they perceived as actions of workplace violence, the majority of respondents were in agreement on what was and was not considered violence. However, when answers were analyzed by gender, there was a significant difference between what men and women considered to be workplace violence, especially when it came to such actions as stalking, threats and intimidation, and sexual harassment:

—**Stalking:** 73% of men compared to 94% of women agreed that stalking was a form of workplace violence.

— **Threats and intimidation:** 76% of men compared to to 90% of women agreed that threats and intimidation were examples of workplace violence.

— **Sexual harassment:** 83% of men compared to 97% of women agreed that sexual harassment is a form of workplace violence. *(Editor's note: The AAOHN survey primarily focused on employee-on-employee violence.)*

"It's important to put a program together at your worksite now so you will have a planned approach to dealing with violence, rather than waiting until you have an episode," Randolph advises. "With some of the work pressures employees face today, may of them are short-tempered and there are many different types of violent episodes possible at work."

To create such a plan, Randolph recommends putting together a multidisciplinary team including upper management, security, legal, human resources, health and safety, and employees. "Once you have determined what should be included in the policy, the next step is education," she observes. "Teach employees about the factors that contribute to workplace violence, as well as the early warning signs." **(For additional recommendations on workplace violence prevention, see box, above.)**

The AAOHN Workplace Violence Survey was conducted by International Communications

## Need More Information?

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Research in October 2003 and included 500 telephone interviews among full-time employees 18 and older. The margin of error for this study is plus or minus 4.4%. ■

# Privacy regs complicate patient communication

*Balancing confidentiality and safety is a challenge*

The privacy regulations enacted as part of the federal Health Insurance Portability and Accountability Act (HIPAA) have caused some unforeseen complications for hospitals trying to ensure patient safety and improve communication between providers and patients, say health care professionals and legal experts.

And as hospitals continue to develop new policies and procedures to comply, it's important that they carefully examine how their efforts will affect caregiver-patient relationships.

"Some of the good things about HIPAA, obviously, were the enacting of standards to ensure continuity of care and maintenance of insurance coverage while switching jobs and health plans," notes **Arnold Rosenbaum**, MD, a practicing surgeon and president of Seacrest DocSecurity, a HIPAA consulting firm in Middletown, RI.

"But some of the regulations are actually going to impede care in some ways by slowing things down. It is impairing simple communication where there really needs to be communication," he says.

Because HIPAA allows patients to request total or limited anonymity while in the hospital and to have a significant amount of control of over the dissemination of information about their health conditions, most hospitals have done things such as removing the patient names from large boards behind the nurses' stations and replacing names and other information on wristbands with bar codes to prevent unauthorized disclosures of information.

While these measures do improve the patient's confidentiality, they can complicate patient care, Rosenbaum says.

"Hospitals have, in good measure, replaced the patient boards with names in most nursing units with boards that have initials or some other identifier," he explains. "But it can become quite difficult to find your own patient. There are added difficulties to patients requesting anonymity, because just finding the patient becomes a significant effort for anyone who has to do it, whether it is a physician, nurse, or technician needing to draw blood. You then have more potential for treating the wrong patient, operating on the wrong patient, etc. You have now this dual purpose in preventing errors and mistakes and in maintaining privacy and confidentiality."

Provider communications with family members — already difficult waters to navigate — are even more complicated now because HIPAA requires that hospitals get written authorization before disclosing information to a third party.

If a patient has established ahead of time that his or her condition can be discussed with a spouse or a child, no problem. However, providers frequently find themselves in other situations, says **William J. Spratt Jr.**, JD, a former health care administrator who's now a health care attorney with the Miami law firm Kirkpatrick & Lockhart, and vice chair of the Florida Bar Association's Health Law Certification Committee.

"HIPAA has put some constraints and created some doubt as to what the health care providers can do when they are dealing with a patient who is either incapacitated or in an emergency medical condition," he explains. "They are limited in their disclosure. Basically, they have to make a determination of what is in the best interests of the patient and disclose only the personal health information that is directly related to that person's involvement."

So if an 85-year-old woman in Miami suffers a heart attack and is taken to the hospital, and the woman's son in New York calls to speak to the physician, barring any prior authorization from the woman, the physician only can confirm to the family member that the patient is receiving care at the hospital and basic information about the patient's current condition.

"But they cannot talk about it," Spratt explains. "They can't say, 'Mom had a heart attack and we've taken a look at it, and it appears to have

subsided; she has some weakness of the upper wall.' They cannot go into that level of detail."

Such efforts to protect the patient may do more harm than good, Rosenbaum says. "Open communication — communication with both family and other individuals — frequently is very important in patient care."

Now, physicians and nurses may feel a dual responsibility — provide information to worried family members about a patient who may need their support, and at the same time, protect their hospital and comply with the privacy protections mandated by federal law. With no clear guidance, hospital personnel can go too far with compliance efforts and restrict the flow of information even further than necessary, he adds.

"This issue has not been adequately clarified in the hospitals where I have worked," Rosenbaum says. "There may be a specific form relating to who can be spoken with and who cannot be spoken with, but that is very difficult to work with in the heat of the moment."

In their efforts to comply with the privacy regulations, some facilities have gone overboard and restrict information even when they don't have to and when the patient wants his or her health information transmitted elsewhere, Spratt notes.

HIPAA allows the free flow of information among covered entities for the purposes of treatment, payment, and health care operations, without prior patient authorization. But some facilities, under the gun to develop compliance plans, have blanket policies that require patient authorization in all instances.

Spratt finds that he frequently has to correct misunderstandings among hospitals and physicians and other providers about the purpose and intent of HIPAA.

"The purpose of HIPAA is not to interfere with the regular ongoing exchange of health care information that is relevant to the common treatment of patients," he notes.

"It is really intended more to protect that information from disclosure outside the scope of the treating people and put some limitations on exchange of information between health care providers and insurers so that insurers can't assemble huge databases on patients that may be used for improper purposes — denying coverage of determining pre-existing conditions, things like that," Spratt adds.

HIPAA was enacted because the health care industry was so far behind most other industries in terms of automation and use of electronic data and electronic medical records because of myriad state regulations and an overdependence on paper systems.

"HIPAA was invented to set the stage for facilitating the electronic exchange of information in order to increase efficiency and reduce health care costs by eliminating duplicative testing and things of that sort and to make the information more available to treating physicians and providers so that there may be a reduction in errors because information was not available," Spratt explains.

At the same time, he notes, the federal government was concerned that facilitating the efficient exchange of information would enable the establishment of huge databases of medical information about individuals and that this had a huge potential for abuse.

"This is a recurrent theme in federal regulations," he says. "Any time there is an initiative to aggregate substantial amounts of personal data, this element of Congress raises up and says, 'No, that's not what this country is about.'"

So, though the intention of the privacy regulations was to prevent Big Brother from knowing everything about everyone's medical condition, the real-world impact is that a worried sister might not be able to obtain information about her

## Need More Information?


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sick sibling hospitalized across the country.

Further complicating matters, HIPAA allows health care providers to provide information to people without prior authorization if they are allowed to do so under state laws, but only under the specific provisions under those laws.

The only recourse hospitals have is to ensure they understand HIPAA and its interaction with the laws in their state, and they develop policies that accurately guide their staff interactions with patients, says **Linda Ross**, JD, a health law attorney with the law firm of Honigman Miller in Detroit.

"There are already differing laws in differing states that deal with things like confidentiality and patient records and disclosures and subpoenas, etc.," she explains. "Rather than have HIPAA just trump everything, the lawmakers created a system where if the state law is contrary to — but more stringent than — federal law, the state law remains in place."



In Michigan, the health law section of the state bar spent months in committee going over the different provisions in HIPAA and any related statutes in their state to determine which requirements held.

"We created this tool for the state that is available and a guideline that goes through our analysis and decides what requirements hospitals and other entities in the state must do to comply," Ross continues.

As people become more educated about and comfortable with HIPAA, much of the confusion and conflicts will die down, she notes. But for now, hospitals must look at everything they do for how the privacy regulations may have an effect.

They must not only develop policies that require personnel to obey the law, but also ensure the policies don't encourage staff to become so rigid in protecting information that they harm patient relationships or impede patient care.

"Especially things like patient rights — patients have a right to access their records, request amendments, and say, 'Talk to my husband, but not to my son,' or 'Call me on my cell phone, but don't call me at home,'" Ross says.

"The result is that hospitals need to implement behavioral changes, cultural changes, and administrative changes with how they deal with patient information," she adds. ■