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IN THIS ISSUE

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Pediatric rehab docs hope new board certification will attract more to field

Pediatric rehab patients currently being served by a dedicated few

In pediatrics, pharmaceuticals, and parenting, it has long been known that children are not just miniature adults. In the field of rehabilitation, that knowledge has been a little slower coming into practice.

There are at most 150 physicians practicing pediatric rehabilitation in the United States, says **Dennis Matthews**, MD, professor and chairman of the department of rehabilitation medicine at the University of Colorado School of Medicine. Matthews also is medical director and chairman of rehabilitation medicine at The Children's Hospital in Denver and holds the first endowed chair for pediatric rehabilitation in the country.

Most of those physicians are stretched to the limit, finding many more patients who need their care than they possibly can see in a timely fashion. It is not unusual around the country for patients with chronic issues to have to wait as long as six months to get an appointment. It can take months, if not a couple of years, to fill open positions for pediatric rehabilitation specialists. There just aren't enough doctors to go around.

In California, the situation is particularly dire. There only are 10 physicians dedicated to pediatric rehab in the entire state, says **Robert Haining**, MD, division chief of physical medicine and rehabilitation at Children's Hospital and Research Center at Oakland. Haining has been trying to fill two physiatrist positions for two years.

With insurance and reimbursement problems, coupled with the high cost of living, California just can't compete in the small pediatric rehab physician pool, he explains. At the same time, the number of potential patients continues to increase with strides in such areas as neonatal intensive care. "Kids with cerebral palsy get saved in the nursery because we don't let them die like we used to," Haining says. "Then they have to find a place to hang out, and that's generally in the rehab world. We have very limited facilities statewide."

When those kids are seen in rehab, they usually are much sicker than their adult counterparts. "We take kids straight out of the ICU [intensive care unit] because there is no nursing home to put them in," Haining says. "That means we have kids with IVs, central lines, on ventilators on a rehabilitation floor whom you would not generally have on an adult floor."

Rehab physicians need the extra training to work with kids. But many choose to stick with adults rather than go through the extra pediatric fellowship and potentially make as much as 40% less money in pediatric rehab, he adds.

Experts in the field hope to see that situation improve now that physicians can become board-certified in pediatric rehabilitation. Last November, the American Board of Physical Medicine and Rehabilitation (ABPMR) based in Rochester, MN, offered the first pediatric rehabilitation subspecialty exam. Forty-four physicians passed the exam.

"We hope the exam will give more credibility to the field," says **Maureen Nelson**, MD, director of pediatric rehabilitation services at the Charlotte (NC) Institute of Rehabilitation. "It should bring more awareness to people who have never heard of pediatric rehabilitation. We hope that means we can have a big impact on even more kids."

Nelson, chairwoman of the American Academy of Physical Medicine and Rehabilitation's special interest group on pediatric rehabilitation, says interest in the field has been growing steadily over the past decade. "When I started going to the pediatric rehab meetings, there would be maybe 30 people. Now we'll have 150 to 200," she says.

The special interest group is working to provide quality continuing education and write guidelines that would help make rehab care specific to children and consistent across the country. The group also is working to increase exposure to the field in hopes of attracting more medical students.

"It is horrendous how long people have to wait to get in to see us," Nelson stresses. "Right now [in January], you can't get an appointment until June. That is not how it should be. Of course, with urgent issues, we find a way to make it happen but a lot of children have chronic issues, and they just have to wait."

Some basic treatment issues overlap, of course, between adults and children. But the main difference is children still are growing physically, cognitively, and emotionally. "The big difference in pediatric rehab is that we have training with children. One of the most important things I have in my pocket is bubbles, as opposed to an adult doctor. Bubbles are fun, but I can also tell a lot clinically by how the child responds," she says. "We are in tune to the developmental impact on the child, and how their problem will impact their growth both cognitively and physically."

One of the unusual aspects of Nelson's practice is a twice-monthly brachial plexus injury clinic where she and an occupational therapist see children from newborns to teens. "This happens in two out of 1,000 babies, and most people have never heard of it," she explains. "Besides the clinical care, this is a social opportunity for the kids and their parents. It's helpful for the parents to know they are not alone. It's good for parents of babies to see a family with a 3-year-old and get that mom's advice in the waiting room."

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In Denver, Matthews and three other physicians see 7,000 patients a year. "We're as busy as we want to be, but we're still probably only seeing a very small number of the patients who could really be helped by pediatric rehab medicine," he says.

Matthews serves on the board of directors for the ABPMR and helped write the questions for the new pediatric rehab exam. To take the exam, the majority of a physician's practice has to be pediatric rehab medicine. Until 2007, physicians can qualify for the exam with a combination of completing a residency and demonstrating years of clinical experience. After 2007, physicians must successfully complete a residency and fellowship training in pediatric rehab medicine to take the exam.

"We think this will increase the number of programs around the country, resulting in more fellowships," he adds. "What this will really do is develop a uniformity in training and improve the quality of education for the residents. The second thing it will do is continue to expand the field because it will provide a group of people interested in education, training, and research in pediatric rehab. We expect the knowledge of the field to increase exponentially."

Some children may be seen by adult rehab physicians or by a developmental and behavioral pediatrician, a neurodevelopmental specialist or a pediatric orthopedist. But for the total rehabilitation package, more kids need to be seen by pediatric rehabilitation specialists, Matthews says.

"We're most interested in function and reintegration of the kids into the community. We're interested in school re-entry, participation in activities, recreation, quality of life," he notes.

"We have particular expertise with children with developmental or early-acquired disability. If a baby or a child has a stroke, the whole issue is how do you separate out what is normal development vs. what is the effect of the brain injury, and how do you help facilitate recovery or compensation," Matthews continues.

Pediatric rehab specialists also work to incorporate parent, sibling, and school issues into the treatment process. Matthews' team is working now on a research project on school performance issues for kids with brain injuries.

"Physically, they restore," he says. "It's the learning, memory, and attention issues that are problematic. The attention, behavior, and cognitive issues can be difficult for teachers to deal with in the classroom." ■

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Student sees progress with Reeve's program

College PE department involved in rehab

In 1999, **Chrissy Parker** was a typical 14-year-old high school freshman riding home from school with a friend. Now, Parker is a college freshman whose name is frequently mentioned these days in the same sentence as Christopher Reeve.

That's because that ride home from school ended tragically: The car Parker was riding in was rear-ended, throwing her from the car and severing her spine. The incomplete spinal cord injury — she has a slight ability to move but little feeling in her legs — left her in a wheelchair. She went through rehabilitation in her hometown of Anderson, IN, but with the goal of adjusting to life in a wheelchair, not of walking again.

After completing her initial rehab program, she spent 2½ years thinking life in the wheelchair would be as good as it would get. Then her hairdresser saw an article about Christopher Reeve's amazing improvements after he was paralyzed in a 1995 horseback riding accident. Parker's family contacted the Rehabilitation Institute of St. Louis, where Reeve has demonstrated slow but progressive results since 2000.

Last spring, Parker began a rehabilitation process based on studies of Reeve's progress, which suggest regeneration of the nervous system is possible. In 2002, researchers at Washington

University School of Medicine in St. Louis published an article asserting that Reeve was the first documented case of partial recovery more than two years after traumatic spinal cord injury.[1]

"In light of science's perception of spinal cord injuries, it's remarkable to recover any sensation or movement whatsoever long after the injury has occurred, particularly in those most injured," the study's lead author, **John McDonald**, MD, PhD, said in a press release after the study's publication in 2002. McDonald is medical director of the Spinal Cord Injury Program at Washington University School of Medicine.

"It is impossible to determine the cause of recovery in a single patient case study. However, these results are likely due to Reeve's dedication to an activity-based approach to rehabilitation since his injury in 1995," McDonald said. "Our goal is to make recovery from spinal cord injuries a feasible option for most individuals. I believe rehabilitation is going to shift to being a home-based, lifelong process that almost anyone with determination and proper medical supervision can achieve."

Parker is a case in point. In St. Louis, she began an aggressive prescription exercise program using the LiteGait therapy device from Mobility Research — a Tempe, AR-based rehabilitation technology company. The LiteGait is a harness-type device that bears some of the patient's weight to allow walking therapy. She continued the program at Saint John's Health System in Anderson.

"When I first started out, I wasn't able to move my legs very much," Parker says. "Now I'm able to move them a lot more, and I have a lot more range of motion. I can tell my muscles are getting stronger. Before the LiteGait, my therapy was getting me to transition to my life in a wheelchair. Now the goal is to get me walking."

Parker enrolled at Ball State University in Muncie, IN, last August. She brought the LiteGait with her, and students in Ball State's adapted physical education program are helping with her therapy.

Ron Davis, PhD, coordinator of the adapted PE program and professor in the school of physical education, says he jumped at the chance to help when he got the call from Saint John's about continuing Parker's rehab program at Ball State.

"I saw it as a tremendous opportunity," Davis says. "Ball State students work with Chrissy, and they are getting a great experience. At the same time, this should help us learn more about servicing this type of spinal injury."

A graduate student and two undergraduates help Parker with her exercise program three days a week for 90 minutes. "We start out and stretch the major muscle groups in the legs," she says. "I get into the LiteGait. They buckle me into this machine, and it will raise and lower you. It suspends me in the air so I can walk on the ground. I'm not able to put weight on my legs, so it holds me up. I walk on the ground and also on the treadmill."

Davis says after a short walk down the hall, Parker walks at 1.3 miles per hour on a treadmill for about 10 minutes. But according to the research, that's not fast enough to get the desired results.

"That's where the students come in. The heart and soul of the therapy is that we have to move the treadmill to 2.5 miles an hour," Davis explains. "She doesn't have the ability to do that on her own. Each student takes a leg and patterns the step to keep up with 2.5 miles an hour.

"The literature supports the idea that at a particular walking speed, reflex characteristics are indeed activated or somehow brought into the pattern that is going to help with this re-education of the muscles. The literature appears to support the speed. They were not seeing it at a lower speed. 2.5 or faster is where you get the results."

Parker has enough recovery in her hips and buttocks to get some movement in her legs, but walks with a lot of hip abduction and adduction instead of the regular flex and extension, Davis says. "The theory behind this approach is we're trying to use the reeducation of the muscles to help her regain some ability to walk. The goal is to get her walking with braces eventually," he explains. "We're trying to get as much recovery and function as we can so that can happen."

So far the improvements are anecdotal. Parker reports feeling more movement, and her parents were amazed at her progress when they visited Ball State after about two months of the program.

"They were astonished. Very anecdotally, they could see some changes," Davis says. "At the end of the routine, she does standing leg exercises during cool down. I watched her move the other day, and she had greater movement. That's what's

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driving us to quantify the movement to get some real numbers on what's happening."

He is planning some research with the university's biomechanics lab to do electrical measurements of Parker's muscle activity. Davis intends to start systematic videotaping and periodic bone scans to measure her progress.

This program is a new twist on his normal goal of teaching students interested in physical education and exercise science how to exercise people with disabilities. "We are not claiming to be therapists," Davis points out. "We are providing a prescription exercise program. Rehab was done; they were finished with her. I'm interested in the transition from outpatient therapy — where do they go and what can they do? Adapted PE can step in. Many folks still need that prompt, that guidance. That's what we can contribute."

Davis and his students also are contributing to a potentially amazing recovery. "She wouldn't be walking without this. The only thing we could have done was gotten her in the pool and try to use the water as a medium to get her to do range and strength work," he adds. "This is obviously a different way to go."

Reference

1. McDonald J, Becker D, Sadowsky C, et al. Late recovery following spinal cord injury. *J Neurosurg* 2002; 97:252-265. ■

Rehab unit is hands-down winner in war on germs

Chocolate bars, pizza parties are sweet rewards

Rehab usually isn't considered the most glamorous unit in the hospital. Emergency department, intensive care unit (ICU), obstetrics — they get all the press.

But the rehab unit at the University of Utah Hospital in Salt Lake City isn't going to take it anymore. Last year, they declared war on the rest of the hospital, and won — hands down — or hands clean, as the case may be.

In the hospital's "War on Germs," the rehab unit continues to smoke the medical-surgical units in the quarterly competition to see which unit can get the most staff to wash their hands each time they enter a patient room. Rehab has won each of the three quarterly competitions held so far.

The hospital's infection control committee decided about three years ago that it needed to increase hand hygiene, says **Barbara Mooney**, RN, BSN, CIC, coordinator of hospital epidemiology. International data show hand washing in hospitals worldwide happens only about 30% of the time. Utah set a 60% threshold and now is fighting toward a goal of 80% to 90%. While Mooney will not share the exact numbers reached, she says the hospital has tripled its hand-hygiene compliance numbers so far.

At about the same time the hospital was looking at ways to increase compliance, the university developed a hand sanitizer called GelSan; it has a 64% alcohol base that kills a variety of organisms while preventing chapped hands.

The hospital started with a one-year project comparing the use of GelSan in certain units to other units that used soap and water. "We showed an increase in hand hygiene and an improvement in the transmission of organisms, so we went housewide with the GelSan," Mooney says.

Besides just plain forgetting to wash, one of the reasons hospital staff avoid hand washing is it hurts their hands to scrub them with soap and water so many times a day. GelSan moisturizes hands and prevents chapping. Also, getting a squirt from the dispenser as they enter the patient's room takes less time than scrubbing at the sink, she adds.

The hospital uses three observers who work about 10 hours each per month to spy on the units and record whether staff are washing at each patient room. The program has logged 40,000 observations in the computer system. For the first year, the hospital also took stool samples from patients on admission and at discharge to test for the spread of organisms. "Now we're looking at the ebb and flow of organisms throughout the hospital. We've not had the same blips of organisms that we had before," Mooney says.

But the real reason the hand-hygiene program is working, says **Sunny Vance-Lauritzen**, MS, SLP, CCC, director of the neuro/rehab service line, is food. When staff members are observed using the GelSan or washing their hands, they're given a chocolate bar with a wrapper that reads "Caught in the Act." The wrappers can be turned in for a monthly drawing for a $100 gift certificate. And the unit that wins the quarterly competitions gets a pizza party.

"Every time they win the war on germs, they get to choose their reward and recognition. For rehab nurses, food always works," Vance-Lauritzen says.

"As a CARF surveyor, I've never seen anything like that out there. For rehab to win every quarter is remarkable."

It's particularly easy to forget to wash between patients on the rehab unit, because there still are some four-patient rooms there, adds **Keri Burton**, RN, BSN, nurse manager for the rehab unit.

"It's imperative to wash between patients, not just rooms," she says. "This has been a real eye-opener for the staff. We didn't realize how often we could share germs between patients. It is really cumbersome to go to the sink between all four patients in the room."

The GelSan dispenser makes that easier, Burton explains, and the hand-hygiene reminder signs all over the unit make it hard to forget. "The patients' families are washing, too; and the patients will remind you now if you forget to GelSan."

The unit numbers are divided into percentages for nurses, physicians, and other staff, such as therapists. "Our weakness has been in the physician area, so our staff give them a hard time," she continues. "They say, 'You're bringing our score down.' I show the scores to the medical director so they'll see they are our low score. But it's become a game for the whole staff. Everyone, even the therapists, are trying to make sure I catch them so they can get a chocolate bar."

Vance-Lauritzen says the program, besides engendering the obvious benefits of improved hygiene and infection control, has had another result in rehab: It's created a real team spirit.

"It's been great for the nurses. Rehab isn't always as glamorous as working in an ICU," she points out. "Our rehab nurses take a lot of pride in what they do. It's just one more bee in their bonnet. It made them feel good about themselves as a specialty in the hospital.

"As the day goes through, we're in and out of patient rooms; and I think we forget how important hand washing is. I don't think we always in a therapy arena think about washing our hands. It's as important on a rehab unit as it is in an ICU, because we have people on respirators; we have wounds. It's every bit as important, but we just didn't think about it on that level." ■

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Fire chiefs back alcohol hand rubs

May lead to national code changes

Saying the risk of infection outweighs the risk of fire, a national fire marshals' association has come out in support of the use of alcohol hand rubs in the health care facilities.

The Centers for Disease Control and Prevention (CDC) now recommends the routine use of alcohol-based hand rubs by health care workers, but the historic transition from soap and water has run afoul of fire codes because the products are flammable.

"We have taken the information given us by the CDC and [looked at] the lack of fire incidents that have been recorded," says **Bob Shewbrooks**, president of the Hospital Fire Marshals' Association (HFMA) in Philaphelphia. "It seems a wise thing to do. The [CDC] didn't hide the fact the less than 50% of physicians and nurses wash their hands."

The executive committee of HFMA recently voted unanimously to support the installation of alcohol-based hand-washing gels in corridors. HFMA compared the fire risk vs. the risk of infection and concluded the likelihood of a fire was minimal by comparison to the risk of spreading a life-threatening infection.

Indeed, the likelihood of alcohol hand-hygiene products contributing to a fire appears to be exceedingly remote, a recent study found.[1] Not one of 798 surveyed facilities using the hand-hygiene products reported that "a fire attributed to [or involving]" an alcohol-based hand-rub dispenser had ever occurred.

Although a few facilities had been using alcohol-based hand rubs since the 1980s, 87% of respondents started using them routinely after January 2000. The initial date of use of alcohol-based hand rubs was available for 766 (96%) of the facilities.

These facilities had accrued an estimated

combined total of 1,430 hospital years of use of an alcohol-based hand rub.

In addition, the American Society of Healthcare Engineering reported that dispensers of gels not exceeding 1 liter could be installed safely in corridors as long as they were spaced intermittently and not in carpeted areas. Thus, HFMA recommended that national fire code officials revise the rules to allow installation of the hand-hygiene products. The association recommended that facilities using the gels have automatic sprinklers.

"What we are hoping is that the National Fire Protection Association — the one that has the life safety code — will put an exemption in to make this a permissible thing," Shewbrooks says. "The life safety code itself is probably two years away [from periodic review]. They could always add an interim addendum until the new code comes out. I don't know, but I feel that may happen because there is so many people in favor of this."

In lieu of that national change, the HFMA action remains a "vote of support" for groups seeking fire code exemptions at the local level, he says. "I just got off the phone with someone with the Philadelphia Fire Department, and what we are going to do [there] is ask for a variance from the city to permit this to be done. Hopefully, we will be successful."

Reference

1. Boyce JM, Pearson ML. Low frequency of fires from alcohol-based hand-rub dispensers in health care facilities. *Infect Control Hosp Epidemiol* 2003; 24:618-619. ■

Electric hospital beds pose risk, FDA warns

Precautions reduce fire hazard

In a "Dear Colleague" letter aimed at hospital leaders, the Food and Drug Administration (FDA) warns that some electrically powered hospital beds may pose a risk of fire. The letter notes the FDA has received 95 reports of fires involving electrically powered hospital beds since 1993.

To prevent incidents of this kind, the FDA offers safety tips that apply to both electrically powered and manual health care beds and to adjustable medical beds. The advice may be particularly useful for older-model beds, notes **David W. Feigal Jr.**, MD, MPH, director of the FDA's Center for Devices and Radiological Health in Rockville, MD.

In the warning letter, he explains that the Safe Medical Devices Act of 1990 requires hospitals and other user facilities to report deaths and serious injuries associated with the use of medical devices.

According to Feigal, the FDA's safety tips assume that normal behavioral policies such as prohibitions against smoking and lighting candles already are in place. The fire risks posed by oxygen administration to a patient in bed are not addressed in this list of safety tips.

To address the fire concerns specific to electrically operated beds, the FDA offers this advice:

• Connect the bed's power cord directly into a wall-mounted outlet.

Make sure the wall-mounted outlet will accommodate a heavy-duty or hospital-grade plug and the outlet is in good working order. The plug of the power cord should have two blades and ground pin that fit tightly into the wall outlet. Power-cord plugs that have the ground pin removed should never be used.

• Do not connect the bed's power cord to an extension cord or to a multiple-outlet strip.

Whenever possible, avoid using extension cords or multiple-outlet strips in patient rooms for any medical electrical equipment since they are highly vulnerable to physical damage that can cause fires. If extension cords or multiple-outlet strips cannot be avoided, use only heavy-duty or hospital-grade connectors that are approved by the facility's engineering department. Extension cords and multiple-outlet strips should be installed only by properly trained electrical maintenance personnel.

• Inspect bed's power cord for damage.

The bed's power cord, as well as power cords from other medical electrical equipment, can sustain damage from crushing, pinching, shearing, cutting, or cleaning solutions. Bed movement, deterioration from use or aging, or human or equipment traffic also can damage them.

• Do not cover bed's power cord or any power cord with a rug or carpet.

Rugs or carpets can prevent normal air flow, which can lead to greater heat buildup. Covered power cords also are more prone to being walked on or having furniture placed directly on them. The bed maintenance staff should place the cord in a low- or no-traffic area.

• Ensure appropriate staff inspect all parts of bed frame, motor and hardware, mattress, and the floor beneath and near the bed for buildup of dust and lint.

• Test the bed to ensure it moves freely to its

full limit in both directions. In many facilities, wall-mounted outlets are located directly behind the hospital bed.

Check to be sure that the vertical motion of the bed does not interfere with the bed's power cord or plug. In addition, the bed's hand-control cable and all other power cords should not be threaded through mechanical parts of the bed or bed rails where normal bed movement may damage or cut the cable.

• Test the bed's hand and panel control, including patient lockout features, to ensure the bed is working properly.

• Inspect the covering of the bed's control panel and the patient control panel to ensure the covering is not cracked or damaged.

Cracked or damaged covers can allow liquids or other conductive material to penetrate to the switches.

• Check patient bed occupancy monitors and all other equipment in patient's room with plug-in power supplies for indications of overheating or physical damage.

Make sure power supplies are plugged into a wall socket where they cannot be contacted by bedclothes, bedding, etc.

• Report to bed maintenance personnel any unusual sounds, burning odors, or movement deviations observed in controls, motors, or that limits switch functions.

• Ensure all manufacturers' recalls, urgent safety notices, etc., are followed.

(Editor's note: For additional information, go to: www.fda.gov/cdrh/safety/bedfires.html.) ■

Killer practitioners: Can you stop them?

Thorough screening is first step

When a Pennsylvania nurse reported seeing potentially fatal drugs stuffed inside a disposal container for used needles, suspicion centered on one nurse in the cardiac care unit. When confronted with questions about dozens of patient deaths, the nurse refused to answer and instead, quit his job.

Over the next few months, he worked at two other hospitals with no system in place to alert employers about his past. He later admitted killing more than 30 patients during his 16-year nursing career. This story has sent chills up the spines of managers everywhere. The question is: What can you do to stop this nightmare from occurring at your organization?

Your focus must shift from a reactive patient safety approach to a proactive stance, by implementing effective strategies to identify potentially harmful scenarios in your midst, says **Angie King**, BSN, CPHQ, quality management director at Tift Regional Medical Center in Tifton, GA.

Hospital administrators, risk managers, and lawyers have scrambled to lay blame, with some pointing fingers at the current nursing shortage for allowing incompetent or malevolent practitioners to slip through the cracks. "The need to protect patients from caregivers who might be killers is certainly real, but I do not believe the nursing shortage is relevant, nor is any particular environmental factor," says **Janet A. Brown**, RN, BSN, BA, CPHQ, FNAHQ, president of JB Quality Solutions Inc., a Pasadena, CA-based consulting firm. "We are dealing with persons who are aberrant to the norm."

Here are strategies recommended by experts:

• Improve communication with human resources (HR).

Harmful or malevolent employees are able to elude detection in large part because of failure to share concerns, King points out. "Too often, hospital departments are like silos. Human resources management should have a greater interaction."

As a manager, if you notice any type of pattern in patient deaths, especially patterns involving personnel, it's your duty to share this information with HR leaders, she says. "Likewise, HR should be informing managers, 'This is a troublesome employee, so be alert for any trends."

Don't be reluctant to freely exchange this kind of information, adds King, who also is a risk manager.

States do have different labor laws and levels of peer review protection, so be familiar with yours. "In some cases, if somebody is being looked at, they may have to be notified," she says.

• Put reasonable barriers in place during the hiring process.

Managers with patient safety responsibilities need to evaluate what barriers can be put in place to prevent the hiring of individuals with detectable psychological disturbances, Brown advises.

"These folks may be very competent and deliver care that is seen by their peers as genuine TLC, but still euthanize patients, because of their aberrant mental processing," she says. "Others truly may be

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malevolent in intent." Brown recommends a basic uniform psychological screening process at point of hire, at least for all employees with direct patient contact. "Of course, there also must be the criminal background checks."

In addition, there also needs to be a system that allows former employers to respond honestly to reference checks, if well-documented negative information is relevant to patient safety, she says. "Former employers tend not to relate negative information, even though it is relevant and significant, due to fears of legal repercussions, such as slander, libel, or breach of confidentiality."

Each organization should solicit its own attorney's interpretation of state statutes, Brown adds. "Perhaps more in-depth reference checks, using very specific questions with 'yes/no' options, might elicit enough information to provide the red flag."

• Implement a viable reporting system for suspicious behavior.

Brown points to her experience working with event reporting, beginning with California's Notification System in the 1980s, which allowed reporting to be anonymous if necessary with convenient locked drop boxes. This clearly is the most effective way to get the necessary information to begin investigation, she says. "If leaders encourage staff to express any patient safety concern, including suspicious behavior, and all concerns are investigated confidentially, then the system works."

• Find better ways to track and analyze all deaths over time.

The recent horror stories reveal the importance of reviewing all deaths, King advises. "Even a terminal patient can have an unexpected death, and patterns of mortality should be observed," she says. "Terminal patients may be actively dying or not. It depends on the individual patient, but they all have to be reviewed."

A terminal patient's death is not unexpected at first glance, but the goal is to detect any patterns, King explains. She recommends tracking the time of death, type of patient, medications, systems involved, notification, comorbidities, and whether the death was unexpected.

Even expected deaths should be categorized and tracked in a database over time as part of mortality review, Brown advises. To find a pattern linking deaths with caregivers, individuals providing direct care during a specified time period preceding all deaths must be included in the database, she says. ■

HIPAA privacy rule: Myths and facts

Expert responds to 13 persistent HIPAA myths

During testimony late last year before the Department of Health and Human Services' (HHS) National Committee on Vital and Health Statistics' Subcommittee on Privacy and Confidentiality, **Janlori Goldman**, director of the Health Privacy Project (HPP) in Washington, DC, presented 13 myths that persist about the Health Insurance Portability and Accountability Act's (HIPAA) privacy regulation and facts addressing those myths. (For more information, go to the HPP web site: www.healthprivacy.org.)

1. **Myth:** One doctor's office cannot send the medical records of a patient to another doctor's office without the patient's consent.
   Fact: No consent is necessary for one doctor's office to transfer a patient's medical records to another doctor's office for treatment purposes.

2. **Myth:** The HIPAA privacy regulation prohibits or discourages doctor/patient e-mails.
   Fact: The privacy regulation allows providers to use alternative means of communication, such as e-mail, with appropriate safeguards.

3. **Myth:** A person cannot be listed in a hospital's directory without his or her consent, and the hospital is prohibited from sharing a patient's directory information with the public.
   Fact: The privacy rule permits hospitals to continue the practice of providing directory information to the public unless the patient has specifically chosen to opt out.

4. **Myth:** Members of the clergy no longer can find out whether members of their congregation or their religious affiliation are hospitalized unless they know the person by name.
   Fact: The regulation specifically provides that hospitals may continue the practice of disclosing directory information "to members of the clergy," unless the patient has objected to such disclosure.

5. **Myth:** A hospital is prohibited from sharing information with a patient's family without the patient's express consent.
   Fact: Under the privacy rule, a health care provider may "disclose to a family member, other relative, or close personal friend of the individual, or any other person identified by the individual," medical information directly relevant to such person's involvement with patient's care or payment related to patient's care.

6. **Myth:** A person's family members no longer can pick up prescriptions for a patient.
   Fact: Under the regulation, a family member or other individual may act on a patient's behalf to "pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information."

7. **Myth:** The privacy regulation mandates all sorts of new disclosures of patient information.
   Fact: HHS has said that disclosure is mandated in only two situations — to an individual patient upon request, or to the secretary of the HHS for use in oversight investigations.

8. **Myth:** The HIPAA privacy regulation imposes so many administrative requirements on covered entities that the costs of implementation are prohibitive.
   Fact: Officials at the White House project a net saving of $12 billion to the health care system over 10 years as a result of implementation of the standards. The cost of implementing privacy over 10 years is estimated at $17 billion and savings from putting transaction standards in place are estimated at $29 billion over 10 years. Additional long-term savings are expected as patients develop more faith in the health care system and thus are less likely to withhold vital information from their doctors and will seek care more readily.

9. **Myth:** Patients can sue health providers for not complying with the HIPAA privacy regulation.
   Fact: The regulation does not give people the right to sue. They must file a written complaint with the HHS Office for Civil Rights. Although the agency has authority to assess civil penalties, it has said that enforcement will be complaint-driven, and penalties will be imposed only for willful violations.

10. **Myth:** Patients' medical records can no longer be used for marketing.
    Fact: Use or disclosure of medical information is explicitly permitted for certain health-related marketing activities under the regulation.

11. **Myth:** If a patient refuses to sign an acknowledgement of receipt of a health care provider's notice of privacy practices, the provider can, or must, refuse to provide services.
    Fact: The regulation grants patients a "right to notice" of privacy practices for protected health information, and requires that providers make a "good-faith effort" to get patients to acknowledge that they have received the notice. But the law does not give providers either the right or the obligation to refuse to treat people who do not sign the acknowledgement, nor does it subject the provider to liability if a good-faith effort is made.

12. **Myth:** The regulation imposes many new restrictions on hospital fundraising efforts, making it almost impossible.
    Fact: According to the rule, a hospital may use, or disclose to its "business associate" or an institutionally related foundation, demographic information, and the dates of health care provided to an individual "for the purpose of raising funds for its own benefit, without an authorization" from the patient. Such use or disclosure is not permitted unless disclosed in the notice of privacy practices.

13. **Myth:** The press no longer can access vital public information from hospitals about accidents or crime victims.
    Fact: HIPAA allows hospitals to continue to make public, including to the news media, certain patient directory information, including the patient's location in the facility and condition in general terms, unless the patient has specifically opted out of having such information publicly available. ■

IOM says electronic files promote safety

Electronic records aid in error prevention

Are you lobbying for your organization to make a capital investment in information technology systems? A new report from the Washington, DC-based Institute of Medicine (IOM) may give you added ammunition.

According to the IOM report, *Patient Safety: Achieving a New Standard for Care,* information technology systems capable of collecting and sharing patient medical records can have a dramatic effect on quality. These systems should be part of a national network of health information that is accessible by all health care organizations and includes electronic patient records, secure platforms for the exchange of information among providers and patients, and data standards that make health information uniform and understandable to all, said the committee that wrote the report.

"Our goal is to create a new standard of care," says **Paul C. Tang**, MD, committee chair and chief medical information officer at Palo Alto (CA) Medical Foundation. In addition to learning from past incidents, there should be renewed emphasis on preventing them from occurring in the first place, he says. "When we talk about mistakes, we typically focus on errors of commission; but we also have a lot of errors of omission — things that if we were to do, we would have better outcomes or less infections."

A 1999 IOM report estimated that up to 98,000 deaths occur every year in U.S. hospitals as a result of medical errors.

The goal is to shift the emphasis of patient safety programs from a strategy of reporting infections or injuries after they occur, to one of prevention aimed at providing safe, effective care in the first place, Tang explains. "That is where we believe electronic health record systems play a role. We're interested in having people make the right decisions the first time. So you can think of infection control as infection prevention instead of infection reporting."

Need More Information?

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Since every patient has contact with a number of providers, the lack of ability to communicate data between among those caregivers and their computer systems is a major impediment to patient safety, he emphasizes. "One of the main reasons we don't communicate well is because there is no standard way of connecting systems and transmitting data," he says. "In order to improve overall quality, we think you need these electronic systems."

Currently, infection control reporting requires staff to make the effort to send a report to the quality manager, Tang says. "Imagine a world where instead of asking people to fill out a separate report, the data system was able to produce a quality report as a by-product of the care process. Basically, when the computer detects a post-op infection, they can send a message automatically to the quality manager." You also get more accurate data, Tang adds. "Instead of infections being reported only when someone remembers to take the time, you will have much closer to 100% of the infections reported."

One of the major obstacles to implementing electronic systems is financial, he acknowledges. "It does take a lot of money, but if you spend this money, it not only helps you with quality, it also helps you save money. The same system that will help quality, reporting, and patient safety will also help cost."

While working at Chicago-based Northwestern Memorial Hospital, Tang recalls Joint Commission on Accreditation of Healthcare Organizations surveyors being very impressed by the facility's electronic record system. "And in a very short time, you won't be able to keep up with the regulations on paper — it will be too much," he says.

There's a definite trend in organizations switching to electronic records, Tang notes. "The benefits are becoming clearer. It's almost becoming a necessity for doing business in this industry. It's like

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banking — you can continue to courier money, but it's just a whole lot easier to do electronically."

[Editor's note: A copy of the Institute of Medicine report can be ordered at the National Academies Press web site: www.nap.edu. Click on "Medicine/Public Health," "Patient Safety: Achieving a New Standard for Care." Or contact National Academies Press, 500 Fifth St. N.W., Lockbox 285, Washington, DC 20055. Phone: (202) 334-3313 or (800) 624-6242. E-mail: zjones@nas.edu.] ■

AHA releases guidelines on fair billing and collection

Government asked to clarify Medicare regulations

The American Hospital Association (AHA) in Chicago has announced it would provide guidelines for hospitals on billing and collection practices to ensure that poor patients and patients who lack health insurance are treated in a "fair-and-balanced" manner.

"Providing the patients and communities we serve with quality health care is our top priority," AHA president **Dick Davidson** said in a statement accompanying the release of the guidance.

"Hospitals see every day the stark reality that not all patients have insurance to help cover the cost of their care. In the absence of health care coverage for all, we are working on a number of ways to assist these patients and to ensure that hospitals are there when their communities need them," he added

The new AHA guidelines stipulate that hospitals should:

- help patients with payment for their hospital care by helping them qualify for existing coverage options, and communicate more effectively about available payment programs;
- ensure that hospital policies are applied accurately and consistently;
- make care more affordable for patients with limited means;
- implement fair and balanced billing and collection practices.

As part of this effort at improving hospital billing practices, however, the AHA also urged the federal government to clarify Medicare regulations that many hospitals perceive as a barrier to providing discounted services to indigent patients.

Medicare regulations require hospitals and other providers to maintain a uniform list of established charges for each product and service provided. Medicare bases its payments to hospitals on these rates, but it, and other third-party payers, typically negotiates discounts for goods and services provided to their members.

However, Medicare regulations and most third-party payer contracts stipulate that charging different rates for the same services is fraudulent.

So while covered patients pay for goods and services at a discount of the established charge, many providers have interpreted the regulations to mean that uninsured patients must be charged the full amount.

In a Dec. 16 letter to Health and Human Services Secretary Tommy Thompson, Davidson urged that Medicare regulations be re-examined.

"Hospitals believe that patients of limited means should not have to pay full charges simply because they have no coverage," he wrote. "But federal Medicare regulations, as written today, constitute a string of barriers that discourage hospitals from reducing charges or forgiving debt for these patients without potentially running afoul of the law."

(Editor's note: For copies of the letter and the new AHA guidelines for hospitals, go to: www.aha.org.) ■