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Providers are concerned about the future of long-term care hospitals

MedPAC study, House bill seek to redefine LTCH role

Concern over the 75% rule, new local medical review policies, and the on-again, off-again outpatient therapy cap certainly have kept rehab advocates busy over the last year. Now another area of concern is emerging: the future of long-term care hospitals (LTCHs).

LTCHs were the latest segment of the rehab continuum to go under a prospective payment system (PPS), which began for cost reporting periods after Oct. 1, 2002. The LTCH version has proven to be a windfall for some hospitals, but some specialty providers are losing money and fear for the future.

"If you can pick and choose who comes into your LTCH and control the length of stay, you can make money," says **Gary Ulicny**, CEO of Shepherd Center in Atlanta, which specializes in spinal cord and traumatic brain injuries. "But organizations like ours that serve a well-defined population can't pick and choose who comes in. We can't control those patients, and we're getting killed. We'll lose $350,000 this year alone on the new PPS, and we haven't even fully phased it in yet."

It's not just the rehab field feeling the heat; it's a hot topic for the Centers for Medicare & Medicaid Services (CMS) and Congress as well. In February, Rep. **Pete Stark** (D-CA), senior Democrat of the House Ways and Means Health Subcommittee, introduced a bill that would place a moratorium on the growth of LTCH beds.

"With the dramatic growth of long-term care hospitals, Congress ought to take a hard look at whether this growth corresponds to actual need," Stark said in a press release. "At issue is whether these facilities are merely cash cows for their corporate investors or if they are truly adding value to the care provided to our seniors and people with disabilities."

The bill is a response to recent government reports that LTCHs have become the most costly post-acute setting for CMS. Medicare expenditures to these facilities have grown from $398 million in 1993 to an anticipated

$2.3 billion in 2005. In that same time frame, the number of LTCHs has jumped from 109 to more than 300.

"If you look at the dramatic growth that's occurred in the long-term care hospital sector, it's being driven by big for-profit companies raking in huge profits," Stark said. "These are not mom-and-pop, nickel-and-dime operations. Their margins swamp those of acute hospitals and skilled nursing facilities, all the while drawing sizable dollars from Medicare."

Stark's bill would place a hold on LTCH growth until specific public policy questions are addressed. It also would require the secretary of Health and Human Services to submit a report to Congress specifying rationale and evidence before terminating the moratorium.

The Medicare Payment Advisory Commission (MedPAC) is studying long-term care hospitals now and released a draft recommendation in March to redefine the role of LTCHs under Medicare. MedPAC commissioners were expected to vote on the recommendations to Congress in April. MedPAC calls for narrowing the types of patients admitted to LTCHs and creating a clinically based definition of LTCHs. Other LTCH requirements would be considered, including:

- mandatory admissions criteria;
- standard patient assessment tool;
- daily physician assessment/intervention of patients;
- minimum licensed nurse staffing of six to 10 hours per patient day;
- 24-hour staffing of therapy services;
- classification of a high percentage of patients into broad (and as yet undefined) LTCH categories.

The new criteria would distinguish LTCHs from other levels of care and also ensure patients admitted to LTCHs would be best served there and could not be treated in a less costly setting.

Crucial questions raised

MedPAC raised questions about this issue in a June 2003 report to Congress (available at http://w3.votenet.com/newmedpac/publications/congressional_reports/June03_Ch5.pdf). The report pointed out that LTCHs are unevenly distributed throughout the country. For example, Louisiana, Massachusetts, and Texas together have more than 35% of LTCHs but only 10% of Medicare beneficiaries. Since some states, such as Alaska, New Hampshire, and Montana, have no LTCHs at all, is this level of care even needed?

"What CMS concludes is you can do without LTCHs," says **Marsha Lommel**, president and CEO of Madonna Rehabilitation Hospital in Lincoln, NE. "But those states have these patients, too. Some of them are living in acute care hospitals."

Lommel is chairing a new task force for the American Medical Rehabilitation Providers Association on post-acute inpatient care. She and the 25 members of the task force are researching these issues in the hopes of helping CMS and Congress sort through what she calls "a mess."

"The hard part for the hospitals and for the post-acute industry and for CMS is that these patients are not going away," Lommel continues.

"They can rewrite the rules and change all the payments for all these different levels of care, and it just shifts all the patients into different levels of

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care. If we close rehab tomorrow, where would all these patients go? They are not going home," she points out.

Madonna has dealt with the shifting ideas of which patients should go where by obtaining certification for all three levels of post-acute inpatient care: LTCH, acute rehab, and skilled nursing. So the new PPS has not hurt the hospital's bottom line.

But Lommel remains concerned that no one is looking at the big picture. "It's not just the new PPS for LTCHs that is causing the problem. The issue is all these rules the government has created. You can't fix these things separately. These patients have to go somewhere. What I want to see is a payment system that makes sense across the post-acute continuum."

Lommel says she doesn't oppose the Stark bill because she doesn't think the LTCH growth is particularly healthy. But she also doesn't think it's enough to just stop the growth; positive change must be made. Because for-profit companies have been able to set up LTCHs as "hospitals within hospitals," they are taking market share from traditional rehab providers without incurring the same regulations and outcomes standards, she says.

"What's happening to us is we're providing a comprehensive rehab program that is very intensive and costly, but an LTCH in an acute care hospital can take that same patient and not provide all of that and get the same amount of money," Lommel says. "People who have been in rehab a long time are losing market share to LTCHs who are taking traditional rehab patients. CMS continually says all of these levels are the same — they're interchangeable, yet they make all these different rules. They don't look at the whole thing at once, they just look at each piece individually, and they never get the full picture."

Lommel asserts it only makes sense to buy services from rehab hospitals. "First, it's cheaper; second, you document and are accountable for your outcomes; and third, you get the patient out of the hospital much faster," she notes. "When patients end up staying in a nursing home, they run out of money and become Medicaid patients and now the government ends up paying again. It makes no sense."

For Ulicny at Shepherd Center, it also makes no sense that the new PPS is forcing his hospital to send away many patients who need to return for short-term specialized care. "Because of the prohibitive rules on short length of stay, people who receive specialized care like baclofen pump patients or bladder augmentation surgeries, we've now had to send somewhere else," he adds. "Under the new rules, it jeopardizes your overall length of stay because they don't base it on all the patients; they just base it on Medicare. So to even qualify as an LTCH, those people can no longer receive those specialized services here."

Because most patients who experience spinal cord and traumatic brain injuries are young, Shepherd Center has only a small percentage of Medicare patients. The average patient age at Shepherd is 32. "We've had to go train other hospitals on how to provide those services. We would not meet the 28-day length of stay if we continued to take those people, so we've had to transfer them out. We can't take people with an anticipated length of stay of less than 10 days. Unfortunately there are no other hospitals that are really equipped, so we've had to go and train other people. Our physicians are now going over to another hospital to see their own patients."

Acute hospitals aren't necessarily equipped with lifts and other specialized equipment for people with such severe impairments. "We're scared that patients are going to go to the other hospitals and the hospitals are just going to freak out," Ulicny says. "We have been that provider for about 20 years in this community, and now you just simply say, 'You guys have to do it.' They've depended on us. Patients who really need highly specialized care are going to have to fend for themselves. It's really a service issue on our part."

He says Shepherd would be willing to take a loss on performing those procedures but cannot risk losing the LTCH designation. "We even told Medicare we would continue to serve these people if they didn't count them in our length of stay, but if they have Medicare, you have to bill Medicare. It came down to an issue of survival for us."

Some action needed

Ulicny supports the Stark bill. "For most people, this is a windfall. But hospitals that really serve specialty type patients are getting burned."

"That's what these hospitals are for: They're supposed to be for those people who don't fit into the average acute care hospital length of stay. I support Stark's bill 100% because I do think that a lot of these companies are using the system to their advantage," he adds.

Like Lommel, Ulicny says that the bigger issue is defining post-acute care. "We need to step back and say, 'What is this level of care and who is it really for?' Fixing the situation for us is not the issue. The issue is: How does an LTCH fit in the continuum of care for these patients, and what is that level of care really all about and who is it really designed for? We've dramatically moved away from what LTCHs were designed for. Why do you think there weren't a bunch of these prior to this new legislation?"

Denny O'Malley, president and CEO of Craig Rehabilitation Hospital in Englewood, CO, says the reimbursement changes may harm the quality of care.

"There is a concern that the quality of rehabilitative services may not be the same, because we tend to have more comprehensive services in places like ours," he notes.

"If patients instead are going to these other licensed facilities that are getting into this because it actually represents an increased reimbursement, it may give them an incentive to take more patients than they used to take," O'Malley explains.

He says he understands the federal government's desire to create an efficient, sensible reimbursement policy. "But it is absolutely astounding to me that whenever a policy changes that the policy-makers are not aware of just how the field will respond to that. There is going to be created a new kind of way to give care because people are going to try to find a way to make a buck."

O'Malley also finds much of the policy-making shortsighted. If patients are denied access to appropriate care, they may end up back in acute care with costly complications.

"Some of the things they do end up biting them in the backside, and I think there's the potential for that in this issue," he says. ■

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Group sees potential for telerehabilitation

Task force works on new applications, outcomes

When **Steve Dawson**, PT, was first approached with the idea of teletherapy four years ago, he had to laugh. Providing therapy services over a videophone to a patient in a remote location went against the very grain of his profession.

"I said, 'There's a reason it's called *physical* therapy. You have to be able to touch the patient,'" says Dawson, clinical development specialist for Integris Jim Thorpe Rehabilitation Network in Oklahoma City.

But in rural Oklahoma, there was a great need for therapy services for patients who were unable to travel long distances to reach clinicians. So Dawson gave it a try, and after the first teletherapy session, he was hooked. "You are in a virtual world with the patient," he says. "It's like you can feel what they're doing and see what's going to happen. You can educate, consult, mentor, and treat over the videophone."

Dawson is so hooked on the idea that he not only treats patients that way, but he also recently became the co-chairman of a new special interest group on telerehabilitation for the American Telemedicine Association, based in Washington, DC.

The group has set the ambitious goal of shaping the future of telerehabilitation by exploring the potential uses of telemedicine devices in rehab, collecting outcomes data, and working for reimbursement for telerehabilitation services. Eventually, the group plans to write standards for the use of telerehabilitation.

It's a daunting task, but Dawson says he is up for the challenge. "I am totally convinced this will work. During a conference presentation, I did a live therapy session and everyone could see the patient could do more at the end of the session than when we started. There was a standing ovation in that room. They could see how we got there. It's very exciting."

The videophone can take still images and also can be hooked up to a VCR so therapists can have a record of the session for later analysis. The quality of the video images varies, but Dawson finds that the ability to see the patients is invaluable. "You can call somebody on a regular telephone and just hearing the information, you can fill out the FIM [functional independence measure] form,

so it's not a big stretch to watch somebody moving on a videophone and fill out some categories on the FIM form. It's better, of course, to be able to see. The intervention makes the difference," Dawson says.

The initial patient evaluation is always done in person, but the video sessions have proven effective for follow-up treatment. In a study of 10 patients at Integris who participated in teletherapy, all 10 showed significant improvement on their FIM scores. That's not enough data, of course, so Integris will begin a larger study to compare outcomes from traditional home health services with the telerehab program in June. The study will be done in conjunction with Blue Cross and Blue Shield of Oklahoma, the state's Medicare fiscal intermediary.

In about 20 states, including Oklahoma, legislation has allowed for tele-encounters with patients to be reimbursed on the same level as face-to-face sessions. But uniform reimbursement will be needed if telerehabilitation is to become more widespread, Dawson adds.

"As goes Medicare, so goes the world of reimbursement," he adds. "From a Medicare standpoint, they need to see that it's effective before they pay for it. Unless CMS [the Centers for Medicare & Medicaid] reimburses for telerehab, it won't be feasible for people to get involved."

Dawson says he sees the effectiveness of the technology in his daily practice. He mainly works with stroke patients; many live in rural areas and would not receive services from a physical therapist otherwise.

"I connect with the patients by videophone, and I ask them to do the same things I would ask in a face-to-face visit. These are mostly people who need assistance to move, so I direct the caregiver to help move their arm or whatever," he explains. "That is much different than giving somebody a list of written instructions or pictures of what they are supposed to do. With a home program, maybe it gets done, maybe it doesn't. But now someone is calling them two to three times a week who can see their ability level. It gives them some responsibility and accountability and also a comfort level with the exercises."

That level of accountability tends to help patients motivate themselves psychologically, Dawson says. "It's not like they are going somewhere to get their therapy. They are more in charge; they are an active participant. That is consistent with the way health care is going."

He worked with one stroke patient in particular who convinced him that telerehab works.

Six months after completing the home program, Dawson called the patient to check in. The man answered the phone sounding out of breath, and Dawson was immediately concerned — until the man told him he had just finished packing his RV and was getting ready to head out of town for a long trip. "I said, 'Thank you very much; you just answered all my questions.' This patient was living his life after six months. It was exciting to know that through this medium, you could make that much of a difference in someone's life."

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Saving in the long run

Jonathan Linkous, executive director of the American Telemedicine Association, says telerehabilitation is an emerging field with the potential to provide excellent patient care and cost savings.

"The cost is not as much as you might think," he explains. "It depends on the application. If it's a broad-band, high-definition telemedicine application that involves a lot of peripheral vital sign devices and medical infrastructure, you're talking about a $40,000 or $50,000 operation. But for most rehabilitation applications, it can be much lower bandwidth that doesn't have to include all the vital sign monitoring, so it's a fairly reasonable cost to have that installed and to operate on a regular basis. You do still have the physician's time."

But once the technology is in place, a great potential exists to save money. "If you look into a managed care or capitated fee environment where there are substantial costs either with the patient coming in or the doctor going out or a visit to the home by a nurse, there is a huge cost-savings potential," Linkous says. "If you have a telerehabilitation program, you can run through more patients in a typical day. They tend to be

scheduled better; and with the TV, the patients tend to pay better attention and there's not a lot of waiting around."

Besides the teletherapy mentioned by Dawson, some other applications of telemedicine in rehab include:

- A teleshoe clinic, where the patient is filmed running and walking so a rehab specialist can analyze the gait and recommend proper shoes.
- A multimedia record that can be reviewed over time.
- Monitoring of vital signs.
- Speech rehabilitation, with the ability to provide the repetitive activity needed to improve and to record progress on a daily basis.
- Video conferencing to allow patients to get access to specialists in other parts of the country.

"That gives patients greater access to care, particularly homebound patients. But also, a subspecialist who normally sees four to five cases a week all of a sudden has hundreds of cases. Their expertise increases," Linkous says. ■

Program returns rehab patients to active lifestyle

Disabled encouraged to ski, raft, race

As a teenager, **Muffy Davis**' goal in life was to make the Olympics. She consistently was ranked one of the top skiers in the United States.

Fifteen years later, Davis retired from competitive skiing with a bronze medal from the 1998 Nagano (Japan) Games and three silvers from the 2002 Salt Lake City Games.

A success story, but with a twist: Davis medaled in the Paralympics, not the Olympics, and she did it sitting down as a monoskier.

That's because a skiing accident at age 16 left Davis with T5-6 paraplegia. But the accident that broke her back did not break her spirit. "As soon as I was able, I was learning to ski, to water ski, to do all the things I had done before. I just had to do them a little differently," she explains. "I really needed to get out on that mountain."

Now Davis works as a development officer for a unique outreach program at the University of Utah Rehabilitation Center in Salt Lake City that strives to create adaptive recreational opportunities for people with disabilities.

The Rehabilitation Center teams up with community organizations to offer such activities as skiing, wheelchair racing, handcycling, river trips, horseback riding, camp-outs, and adaptive technology fairs.

"My rehab was very important, but it was from interacting with other people with disabilities that I really grew. That's where I learned the tricks of the trade that I use in my everyday life. I learned that I was OK, that there's nothing wrong with having a disability," Davis says. "Our hope is that people who are not out there recreating will get together and meet other people. We want them to get the benefits of recreation, of getting out there and continuing to live a full life."

The University of Utah has demonstrated a strong commitment to helping patients adapt after they leave the hospital, says **Trish Jensen**, MA, MTRS, development officer for the Rehabilitation Center.

"So much of recovery in rehabilitation, especially for people who are left with permanent disabling conditions, is not just helping them learn how to walk or use a wheelchair, it's also something about their attitude, how they perceive themselves, what value they have to contribute to society," she says. "So much of rehab is about allowing someone to learn they have the capacity to contribute and go back to a meaningful lifestyle."

It's easy to let recreation programs go when budget concerns loom, but the Rehabilitation Center presses on, Jensen says.

"In this age when budgets are being slashed and reimbursement is reduced, services that relate to wellness and wholeness are some of the first to go," she says. "We have tried to create a culture where everyone feels some degree of responsibility to think outside these walls, to think about what people need when they leave here."

The problem, Jensen says, is that patients usually are not ready to participate in these types of recreational activities until at least a year after injury. By that time, they may have little contact with the Rehabilitation Center. So Jensen, Davis, and the center's recreation therapist work to keep in touch with patients and to promote activities.

"Here in Utah, we have some great programs like the National Ability Center in Park City that offers adaptive skiing, horseback riding, etc.," Jensen says. "We refer them there, but then we say, 'You can't do this for a year.' That's great, but they're still going through the adjustment process of recovering from their injury. A year later, when it's OK, do you think they remember or will be

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inclined to go talk to somebody they've never met? No."

Jensen and Davis also work to secure funding for patients who can't afford the activities. In the last three years, the center has been awarded about $8,000 in grants to pay for patients' first entry experience in any given activity if money is a barrier.

"We link them to real, meaningful, fun activities. Some of the most powerful therapeutic tools are around the whole concept of fun, self-worth, enjoyment, and pleasure," Jensen says.

Examples of activities the Rehabilitation Center has promoted and sponsored include:

- An annual overnight camp-out.

"It's pretty unique when you've got three people in power wheelchairs in a wilderness environment or somebody who's had a head injury or a stroke and hasn't gotten out, and who has assumed that those activities aren't available to them anymore. It's a huge thing," Jensen says.

- Ski days with the National Ability Center.
- Trips down the Colorado River with SPLORE, a local outdoor accessible adventures group.
- Salt Lake City Marathon wheelchair racing and handcycling.
- The local annual 5K Run and Roll.
- Ice sledge hockey clinics.

"If you want to see the difference these activities make, come with us and watch the transformation of a person in the recovery process who all of a sudden is on a river trip and put next to a person with less function who is doing more independently," Jensen says. "That person realizes maybe he can do more. It's very empowering."

The Rehabilitation Center also arranged for staff to volunteer for the Paralympic Games, which started two weeks after the Olympic Games in Salt Lake City in 2002.

The hospital loaned Jensen's time for one year to the Salt Lake Organizing Committee for the Paralympic Winter Games. She became the classification coordinator, responsible for the process by which athletes are put in classes for competition based on their ability levels.

"A person with a midchest injury who is paralyzed from there down has no trunk muscles; so when they're in a sit-ski, their lean is not as controlled as an athlete paralyzed from the waist down. So they are put in different classes and considered in competition for medals differently. It's similar to weight classes in wrestling," she points out.

The classification process went so smoothly in 2002 — there were no protests of classification levels during the Games — that Jensen was one of eight people in the world asked to serve on a new subcommittee for the International Paralympic Committee in Bonn, Germany. The subcommittee will develop policies on how classification is managed at future games.

Jensen is only too happy to participate in the international committee, because the Paralympics are the ultimate example of her passion for getting disabled people back into active lifestyles.

"The Paralympics are often confused with Special Olympics, but the difference is that Paralympic athletes compete not to inspire but to win," she says.

"These are elite athletes. The only difference between a Paralympic athlete and an Olympic athlete is that the Paralympic athlete might be skiing with only one leg or swimming with one arm. They compete to be recognized as the best in their sport in the world," Jensen adds. ■

Patient grievance policy vital tool for improvement

Policy should fit your organization

They may not grab many headlines, but grievance policies and procedures are, nonetheless, a critical component of a thorough, effective quality improvement effort.

Furthermore, quality professionals say, all grievance policies are not created equal — it really does make a difference who sits on your committee or task force, how your policy is constructed, and whether it is adequately customized to your facility or system.

"There are a number of good reasons [for having patient grievance policies and procedures]," says **Matthew Rosenblum**, chief operations officer for privacy, quality management, and regulatory

affairs with CPI Directions Inc., a New York City-based consulting firm that specializes in performance improvement and regulatory compliance functions.

One important consideration, he says, is the context within which care is provided. "By that, I mean when people come to the hospital they are usually hurt and scared in some way, and as a consequence, their complaints may be easily aroused."

For the provider, he says, it's important to be able to recognize when a complaint also is a grievance. "In medical terms, we generally refer to how patients say they were hurt as a complaint," he explains.

"True grievances can include neglect, abuse, payments, insurance, reimbursement matters, or privacy. When a complaint comes in writing or through a third-party organization, then it's official, and it should be responded to with very appropriate actions," Rosenblum notes.

An effective grievance policy can ensure consistent staff responses, he continues.

"If you have designated steps to resolve complaints and mitigate any harmful effects that have occurred, hopefully, situations can be resolved before they become official," Rosenblum adds.

"So, for example, staff should engage patients in a calm manner and express concern about what the patient is saying. This way, the patient feels better about our potential response." A consistent staff response also helps ensure timely and complete responses, and a good policy keeps staff aware that they need be faithful to their ethical and legal obligations — i.e., to treat every patient equally, with no retaliation for complaints.

Finally, Rosenblum notes, such a policy can make an important contribution to your continuous performance improvement efforts.

"The level of satisfaction with the care we provide is a rich source of information for improving. We need processes and technologies in place to accurately capture what our patients tell us, and to analyze it proactively," he points out.

For example, you might want to conduct a failure mode and effect analysis (FMEA) on what patients complain about, or you could study complaints retrospectively through root-cause analyses. "You may also use it to improve patient relations," Rosenblum adds.

"The no-brainer answer is you have to have one because it is a CMS [Centers for Medicare & Medicaid Services] requirement," says **Cathy S.C. Stouffer**, customer service/patient safety officer at Freeport (IL) Health Network. "But besides that, you need to be prepared for the times when patients are concerned that an organization may have made a decision they are not satisfied with," she points out.

"This has grown out of the patient rights movement; it started many years ago, and it has kept evolving," notes **Sue Wedemeyer**, RN, BSN, MBA, clinical manager, loss prevention for Catholic Health Initiatives in Erlanger, KY.

"We always depended on some sort of patient satisfaction survey, but we've gone beyond that. Now, there's a lot more emphasis on patients' rights, and because of regulatory requirements, it became much more formal," she says.

Putting the team together

If you are creating a new set of policies and procedures or re-examining your existing ones, who should comprise your committee or task force? "No. 1, you have to have the customer relations person," Stouffer says.

"Then include the quality department — they are the ones who will spearhead process improvement, and that's the goal, to improve processes. Medical directors also should be included." CMS suggests that it be structured very much like your ethics committee and include someone from the outside, she notes. "It might even be helpful to include the chair of the ethics committee," suggests Stouffer.

"It really depends on the institution," explains Wedemeyer. "Certainly, you must include whoever is designated as the point person. Then the risk manager, the quality manager, the compliance officer, and probably representatives from nursing administration and senior administration [should be included, too]. One of the things every policy needs to have is the governing body's blessing."

The composition of the group will depend on the size of the organization, Rosenblum says.

"In a hospital, the logical composition of such a task force would include a nurse, a doctor, a nutritionist — people who have direct contact with patients and are on the line being confronted on a daily basis," she says.

"You also need representatives from risk management and/or quality management or performance improvement committees, the legal counsel's office and now, under HIPAA [Health Insurance Portability and Accountability Act], from the privacy or security office and a patient

relations official. Also, in intermediate or long-term care facilities, you'd want a patient representative," Rosenblum points out.

When crafting your policy, there is ample help available for at least creating its foundation, notes Stouffer.

"For the bare-bones skeleton of a policy, there are guidelines about timelines to responses, and so on, on both the CMS and Joint Commission [on Accreditation of Healthcare Organizations] web sites," she notes.

Wedemeyer lists these important considerations:

- The governing body should have oversight of the process unless it is delegated to the grievance committee.
- When a patient is admitted, he or she should receive written information about the process — how it unfolds, the process for filing, and so on. "There should be a signed acknowledgement that the patient has received this," she advises.
- You should identify the individual within the organization whom the patient should contact with a complaint and how that contact should occur.
- The policy should include an expectation that grievances be investigated and resolved in a timely manner. It should address time for completion of the review and investigative process, and when the patient will be provided results.
- It should address timely referral of concerns about quality of care or premature discharge to the appropriate peer review body.

Pay special attention to certain issues

In creating your policy, Rosenblum says, special consideration must be given to certain issues that affect the hospital and staff, and to those that affect the patient and staff.

Concerning hospital and staff: "In our opinion, the provider must embrace and encourage a cultural change in staff that is similar to one that pervades all business success: The customer is always right." This should be altered slightly for health care to read: "The patient always has something useful to say," he notes.

"This should pervade good medicine," explains Rosenblum. "Every complaint represents their perception of the care they receive. This begins to preclude staff from getting their backs up.

"Provide workshops to help staff calmly approach patient complaints with more objective consideration for what patients have to say. This way, you help them resolve the issue or elicit their cooperation in resolving it," he adds.

Your approach should include educating and training staff on the importance of consistency, better patient relations, and mitigating harmful effects, he recommends. "Workshops that use the concept of root-cause analysis can encourage discussion of frequent complaints, their causes, and how to resolve them," Rosenblum says.

When you're planning significant changes in service — such as a new specialty, or a rapid expansion — it's usually a good idea to perform an FMEA, he adds.

"This way, you may be able to think about the potential for patient complaints and approach it proactively," Rosenblum explains.

Your facility also should provide step-by-step guidance for staff on how to accept and process a complaint, identify the chain of command, and assign responsibilities.

As for patient/staff issues, the patient must know how to initiate a complaint to the provider and, when necessary and when the facility is legally obligated, how to contact a third party. There should be time restrictions for filing and an outline of what staff are responsible for doing when they receive a complaint.

"'Staff' could virtually be anybody — a guard at the door or someone in the medical records office," Rosenblum continues. The policy should include the forms or reports staff need to fill out and the time windows for each.

The policy also should provide patients with an explanation of their rights to appeal:

- the process, who does the review, and who participates;
- how to file a complaint to a third party;
- the time window;
- whether those authorities have the right to investigate a complaint and whether there is a finding of noncompliance, those third parties may have the obligation to provide written notice to the patient.

Dissemination, implementation

Once the policy is created, dissemination and implementation should be carried out "just like any other policy," Wedemeyer says.

"For dissemination, normally your facility has a designated method — i.e., give it to the managers, who review it with staff, who then sign a document to the effect that they have read it. The follow-up problem lies in the hands of the point person, the quality person, and possibly

the compliance officer," she adds.

"You've got to use the existing QI staff to disseminate the information and continuously improve the process," Rosenblum stresses.

"But the most important thing a provider can do is to embrace and encourage cultural change in the staff," he says.

"We have 1,500 employees, and everyone is really an advocate for patients, so the most difficult part is getting educational information out for all of them," Stouffer says.

"We cannot ignore grievances, and our response has to follow a more particular process, so we have a learning charter — a patient advocate course that talks about the service recovery program and educates employees about our grievance policy," she adds.

Every employee is required to take this course, Stouffer notes. "We also have an opportunity for on-line learning, and our policy is always available on our intranet."

Policies can have positive effects

Just having a policy in place can have a positive effect on patient attitudes and avoid costly problems, she continues.

"Primarily, it's the perception that we have established a process that allows a patient to have a second voice with a more neutral party, if necessary," Stouffer says.

Wedemeyer agrees. "Patients are sometimes reluctant to talk about their health care, or they don't know where to go to do it. This process gives them an avenue to do this. Also, it gives the facility a means to measure service.

"You can go back retrospectively or look at it concurrently, to see if it's being followed," she says.

"Your grievance policy is just as important as a fire policy," Stouffer emphasizes. "So, if you can put policies and procedures somewhere inside mandatory training, this should be one of them." ■

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Stop harmful staff from getting hired

Experts recommend anonymous reporting

If a nurse applied for a hard-to-fill night shift at your organization who had left a previous facility under suspicion of murdering several patients, do you think she'd be hired? Would it be possible for a technician to intentionally harm patients at your hospital over a period of years, with absolutely no action taken?

If you find yourself shaking your head in disbelief, consider the much-publicized killer nurses and physicians who eluded detection at many facilities, and you may feel differently. So what steps should be taken to ensure problem practitioners don't fall through the cracks — and how can you prevent them from getting hired in the first place?

Here are some suggestions:

- **Encourage staff to report suspicions.**

You need to draw upon the observations of staff throughout the facility and encourage gut instincts to be reported, says **Kathleen Catalano**, director of regulatory compliance at Provider HealthNet Services in Addison, TX. "Education of the nursing staff is key, with a periodic review of what types of behavior to look out for, to avoid this scenario."

After a sentinel event occurs, a literature search is required in addition to a thorough internal investigation, she notes.

"Search the literature on this subject, and glean from that the behaviors that fall into this type of scenario," Catalano recommends.

For example, a red flag might be an individual who prefers to work with little help or interruption. "Most nurses want help and accept it gratefully. That's a clue," she says.

In general, nursing staff share their suspicions

with quality, risk, and human resources, urges Catalano.

"It is extremely important, in spite of everyone's workload, that nonpatient care managers get out of their offices and know the staff working on the units, so that they aren't intimidated about discussing possible suspicious behavior with them," she explains.

Similarly, the lines of communication must remain open between quality managers, human resources, and risk management, says **Kathryn Baikie**, the facility's director of human resources.

"Employees must feel they are able to confide in human resources professionals so that they can feel safe to blow the whistle on their co-worker if they see problems or issues, without fear of retaliation," Baikie stresses.

• Follow all steps in a process.

Catalano points to the case of physician Michael Swango, who is believed to have killed more than 60 patients over a two-decade period.

"All of the things that should have been done were somehow missed," she says. "Even when processes were in place, they were not necessarily followed."

The scenario shows that if procedures aren't followed to the letter, a harmful practitioner could slip through the cracks, Catalano warns.

"Even if something that didn't seem quite right showed up in the file, Swango would talk his way out of it," she says. "He was a master at this. The physicians decided there was no need to investigate further — he's a physician, and we'll take his word for it."

For this reason, Catalano strongly advises that each step in any process be followed, such as credentialing and privileging processes.

"Disaster can lie right around the corner when you skip steps to save time," she says.

• Have an anonymous reporting system.

An anonymous reporting system is key, says Catalano.

"Staff often don't want to rat on a colleague," she says. "With that in mind, put your anonymous compliance or patient safety hotline to work and be certain that retaliation does not occur when something is reported."

The best system to use is a hotline allowing staff to report their concerns anonymously, Catalano recommends. "The hotline must be outsourced and not a number called in-house. There must be safeguards in place for keeping the anonymity of the person.

"And there must be a system allowing the

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- **Kathleen Catalano**, Director of Regulatory Compliance, Provider HealthNet Services, 15851 Dallas Parkway, Suite 925, Addison, TX 75001. Phone: (972) 701-8042, ext. 216. Fax: (972) 385-2445. E-mail: Kathleen.Catalano@phns.com.
- **The Compliance & Ethics Hotline** is a toll-free number your employees can call 24 hours a day, 365 days a year to speak anonymously with a hotline specialist trained to receive reports of perceived misconduct or wrongful behavior. For more information, contact: National Hotline Services, 620 Kenmore Ave., Suite B, Fredericksburg, VA 22401. Phone: (877) 267-1930. Fax: (540) 368-1411. E-mail: nhsmail@hotlines.com.
- **The Fraud and Abuse Control Information System (FACIS)** is a web-based information service that allows subscribers to look up the sanction history of individuals and entities associated with the health care field. Possible types of sanctions include exclusions, termination of license, suspension, revocation, probation and debarments, etc. FACIS reports from approximately 800 state and federal sources. To subscribe, contact FACIS, 112 S. West St., Suite 300, Alexandria, VA 22314. Phone: (800) 718-5753 or (703) 683-3453. Fax: (703) 836-5256. E-mail: facis@facis.com. Web: www.facis.com.

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person making the call to check back and see what is being done regarding the reported issue," she adds.

The facility uses National Hotline Services, which gives the caller a number and a date to call back. "If action is taken, that action is reported back to the hotline, and they pass it on to the person if they choose to call back with their special number," Catalano says. "This works extremely well."

Another such system is the Compliance & Ethics Hotline, a toll-free number your employees can call 24 hours a day, 365 days a year to speak anonymously with a hotline specialist trained to receive reports of perceived misconduct or wrongful behavior. **(For more information on how to subscribe to this and other hotline services, see resource box, p. 59.)**

• Use a web-based information service to check the disciplinary history of health care providers.

"In my opinion, the National Practitioners Data Bank (www.npdb-hipdb.com) does not provide enough timely information, and that makes it difficult to rely on," says Catalano.

Instead, the organization uses the Fraud and Abuse Control Information System (FACIS) based in Alexandria, VA. FACIS is a web-based service that allows subscribers to look up the sanction history of individuals and entities associated with the health care field.

FACIS reports from approximately 800 state and federal sources.

Possible types of sanctions include exclusions, termination of license, suspension, revocation, probation and debarments, etc.

"This is valuable, because it makes you aware of sanctions by the local, state, and federal government and adverse actions taken by various agencies," Catalano says.

"We have notice of any action that has been taken against a person at a state, local, or federal level," she points out.

All new prospective employees are screened through FACIS to be certain that they are not on the Office of Inspector General's list of excluded individuals or entities, or the General Services Administration debarment list.

"If they were on either of these lists and we billed for services they rendered, we would be committing fraud," Catalano explains. ■