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The essential monthly management advisor for rehabilitation professionals

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## IN THIS ISSUE



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# Rehab plays integral part in obesity programs at North Carolina hospital

*Quarterly course trains staff from around the region*

By all accounts, obesity has reached epidemic proportions in the United States. The Centers for Disease Control and Prevention (CDC) reports that more than 44 million Americans are considered obese, with body mass index scores of 30 or greater.

That reflects an increase of 74% since 1991. The National Health and Nutrition Examination Survey 1999-2000 indicated that an estimated 64% of U.S. adults are either overweight or obese.

A recent RAND Corporation study[1] found a link between the rise in obesity and a 50% rise in the number of people ages 30-49 who were disabled from 1984 to 2000.

Given those numbers, it's unlikely that your hospital hasn't come face to face with the challenges of providing good care for obese patients. Gastric-bypass surgeries are rising, vendors are beginning to offer a greater array of equipment for larger patients, and hospitals are searching for resources to help this patient population.

Pitt County Memorial Hospital in Greenville, NC, is setting the standard for bariatric rehabilitation.

Pitt County recently started the bariatric program, one of the results of a year-old, hospitalwide bariatric task force. Staff from nursing, rehab, wound and skin care, material services, the stock room, ergonomics and safety, operating room, and trauma department are working to set procedures in place for bariatric patients.

Obesity rates are on the rise in the area, and the hospital now performs 30-35 gastric-bypass surgeries a week, with a waiting list numbering in the hundreds.

"When we look at bariatric patients in the hospital, you might think that because of the gastric surgery program, that would increase the number of complicated patients. In all reality, those are the patients we expect

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not to have complications," says **Daniel Drake**, RN, perioperative clinical nurse specialist.

"The patients who really impact us from a rehab standpoint are patients who are medical patients with long hospital stays or who have spinal cord injuries," he says.

With a spinal cord injury, staff normally would help a patient develop upper-body strength to be able to transfer to a wheelchair. "But if you're a bariatric patient, your upper-body strength may never be able to get to the point where you can move your weight," Drake explains.

"For those patients, we've had to look at other solutions like lifts. Getting the wheelchairs themselves can be difficult because of the size, and the payer issues are different, too, because the cost is sometimes more for this type of equipment," he points out.

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Editor: **Ellen Dockham**, (336) 778-0371, (edockham@aol.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@thomson.com).
Managing Editor: **Alison Allen**, (404) 262-5431, (alison.allen@thomson.com).
Senior Production Editor: **Ann Duncan**.

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

The rehab staff have developed a program to meet the special needs of bariatric patients. "They come to us for three hours of therapy — half physical therapy and half occupational therapy — a day," says **Debra Jefferson**, PT. "They are treated according to an individual evaluation plan set by the team."

### *Adequate equipment is vital*

A major thrust of the program is ensuring adequate equipment. "In our rehab center, we're faced with the difficulties of room size, doorways, equipment," she says.

"As a rehab center and as a whole hospital, we're working to make sure we have appropriate equipment and rooms for patients of size. We've also started a quarterly course to educate hospital employees and other facilities in the area about bariatric patients.

"We're talking about things like complications for different body types. Another thing I'm trying to get across is that just because a patient weighs 400 or 500 pounds does not mean they can't do anything," Jefferson notes.

The daylong course, "The 3 Ms of Bariatric Care: Movement, Mobility, and Machines," covers surgical issues, skin and wound care, therapy techniques such as how to safely move patients, available equipment, and sensitivity training.

**Steve Randall**, director of ergonomics and a facilitator for the class, says the course includes a trip to the biomechanics lab to learn how to turn patients in bed, ambulate them, and position them in beds or chairs. Class participants also travel to a local bed vendor to learn how to set up the specialty beds and use them for transporting patients.

"We had a bariatric patient in rehab who was in a specialty bed, and we had a fire alarm. It was, fortunately, just a drill, but staff did not know how to break that bed down in order to get that patient out of the room," he adds.

Another situation that underscored the need for a bariatric plan occurred when three staff members were ambulating a large patient. "She coded and took all three staff members down with her," Randall explains.

"We wound up with three event reports because they tried to hold her up. We know that is not the thing to do, that we want to get that person on a controlled descent onto the floor. There are three staff members out of work in

addition to what might have happened to the patient. Our goal now is to get a better plan of action for safe bariatric patient handling and movement," he says.

### The program is multifaceted

Sensitivity issues also are being addressed. "A bariatric patient is a real live human being just like you and I. They have feelings," he says.

The course has attracted participants from around the region. "My gut take is there is really a market for this kind of information," Randall adds. "We've found there aren't many places where you can find this. We've had to put it together on our own and rely on the expertise of our staff."

More resources can be found now than just a few years ago, but the market for bariatric equipment still is immature, he notes.

"Some vendors will say it's bariatric, but not anymore. Now we need 1,000-pound capacity. We've found with the bedside commodes that are supposed to be bariatric that patients have so much adipose tissue that the holes don't line up. There is a real mismatch with the physiology of the patient and the geometry of the product," Randall adds.

Most patients who undergo gastric-bypass surgery do not need rehabilitation, but many obese patients come to rehab after becoming deconditioned in the medical units, Jefferson says.

"A lot of times, staff are really scared to help these patients move, so a lot of times they don't get the moving in the acute part of the hospital that they need. That deconditions them even more. That's why it makes rehab integral for them," she explains.

"People with obesity are prone to cardiac problems and respiratory problems, and if they have a lengthy hospital stay, they get deconditioned," Jefferson adds.

With obese patients, special care is taken to provide consistent therapists to build rapport. "Consistent coverage develops confidence for the staff and the patient," she says.

"If it takes two or three people to transfer a patient, everyone knows what to do. It helps develop trust because sometimes they're afraid they'll hurt you," Jefferson stresses.

Consistency also helps overcome staff hesitation. "There is a large staff perception that they got themselves in this fix, and a lot of people don't want to work with these patients," she says. "You've got to be mindful, to respect that patient, too. A lot of these patients really didn't put themselves there. We're finding more and more that it's hereditary."

## Need More Information?

- **Daniel Drake**, Perioperative Clinical Nurse Specialist, Pitt County Memorial Hospital, 2100 Stantonsburg Road, P.O. Box 6028, Greenville, NC 27835. Phone: (252) 847-5135.
- **Debra Jefferson**, PT, Pitt County Memorial Hospital, 2100 Stantonsburg Road, P.O. Box 6028, Greenville, NC 27835. Phone: (252) 847-4443.
- **Steve Randall**, Director of Ergonomics, Pitt County Memorial Hospital, 2100 Stantonsburg Road, P.O. Box 6028, Greenville, NC 27835. Phone: (252) 847-6963.

### Don't assume obese are unable to move

It's also important not to assume that a large person can't do anything. "You can decrease the possibility of staff injury by allowing the patient to do the work," Jefferson adds.

"My goal is do not leave them in the bed. They need to get up, to get mobile, to at least be sitting in the chair. We always try walking, even though that means you may need three people to help," she adds.

Staff members have come up with creative ways to get patients to do as much on their own as possible. Some patients have so much mass in their stomach area that they have trouble reaching the rails in the wide beds, Jefferson points out.

But instead of having a staff member do the work, they might do something as simple as tying a knotted sheet to the rail so patients can pull themselves, she says.

Physical therapists also have to come up with tricks to help patients exercise because often obese patients are unable to bend their arms and legs in traditional ways.

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1. Lakdawalla D, Bhattacharya J, Goldman D. Are the young becoming more disabled? *Health Affairs* 2004; 23: 168-176. ■

# Hospital pushes weight loss without surgery

*Program focuses on underlying problems*

Gastric-bypass surgery is all the rage these days, but rehabilitation can play a key role in reducing the complications of obesity without resorting to surgery.

At the University of Michigan Health System in Ann Arbor, the Obesity Rehabilitation Clinic treats patients in a multidisciplinary, medically supervised program.

"We do refer some patients for surgery, but obesity is a chronic disease, like hypertension, like diabetes, like heart disease. Just doing a procedure doesn't take care of the problem," says **Liselle Douyon**, MD, an endocrinologist who is director of the clinic.

"You have to look at all the things that contribute to the obesity and work on modifying them. Traditionally, psychosocial aspects are ignored, and they cannot be ignored," she adds.

"There are some people who eat for comfort, and the obesity is a manifestation of loneliness or an ongoing traumatic event in their life. They can lose the weight, but the problem that got them to that weight is still there," Douyon explains.

The clinic focuses on four areas of treatment:

**1.** medical issues;
**2.** behavioral issues;
**3.** nutrition;
**4.** fitness.

At the initial consultation, Douyon covers medical issues including comorbid conditions such as diabetes and high blood pressure. A social worker gives patients a psychosocial assessment to identify stumbling blocks, such as depression, that may need to be treated before the patient enters the program. An exercise physiologist gives patients a stress test to assess fitness needs, and a dietitian works on the patient's food choices.

Patients commit to a six-month program in which they are expected to attend the clinic once per week to meet either with the whole team or individually with one of the team members. While at the clinic, patients participate in an exercise program and attend a series of lectures on topics ranging from sports bras to medical problems. They also come once a week for a group therapy session.

"We help patients set realistic goals. Some people want to look like Christie Brinkley, and that's probably not going to happen," Douyon adds. "But maybe they can lose 10% to 15% of their body weight, enough to get off that sleep apnea machine or stop the arthritis in their knees or get rid of their back pain."

### *Doing things differently*

Besides losing the initial weight, the program helps patients prepare for the maintenance phase. "That's always the problem — keeping off the weight," she explains. "There is no cure for obesity. It's a lifelong problem so that's why we really focus on the lifestyle issues and help them find out what contributed to their obesity and what they can do to stop it where it is."

Another aspect of the program is vocational rehabilitation. Staff point patients to resources they need to get integrated back into regular daily life.

"We try to see throughout the program how the obesity affects their life. It's not just lose weight to look good, it's lose weight to be healthy," Douyon says.

"Some patients have been so obese they haven't been able to walk, and now that they can walk, they can get out and look for a job. We don't look for a job for them, but we point them to resources and get them mentally prepared," she adds.

A lot of the patients in the clinic haven't been able to exercise at all.

"Being able to walk instead of being in a wheelchair is a drastic difference. Your center of gravity changes, and a whole host of things changes. How people view you, how you view yourself. People are discriminated against and made fun of publicly. There is lots of humiliation, and we try to work with patients regarding that," Douyon explains.

Obesity is a special focus at the University of

## Need More Information?

☎ **Liselle Douyon**, MD, Director, Obesity Rehabilitation Clinic, University of Michigan Health System, 1500 E. Medical Center Drive, 3920 Taubman Center, Box 0354, Ann Arbor, MI 48109. Phone: (734) 647-5875, ext. 222.

Michigan because the state has the third highest percentage of obese people in the country behind Mississippi and West Virginia, according to the Centers for Disease Control and Prevention (CDC).

A 2001 CDC report shows that 24.6% of Michigan residents are obese.

"I think everyone is becoming aware of this as really being an issue. The downside is that a lot of people still see it as a cosmetic problem. It should be looked at like having leprosy," Douyon says. "You don't just have spots on your face; you've got a disease that should be treated. When you're obese, everybody knows you're obese but no one knows why or how you got there."

The clinic offers an open-ended follow-up program that monitors patients and continues to give them the support they need. ■

# MedPAC approves draft LTCH recommendations

*Standardized admission criteria proposed*

If your hospital is not classified as a long-term care hospital (LTCH), you may not be paying attention to the questions being asked by the Centers for Medicare & Medicaid Services (CMS) and some politicians about the need for this level of care. But rehab advocates say you should, because the debate over long-term care ties in with the 75% rule.

The basic question in all of these issues is: Where should patients with differing levels of rehabilitation needs be treated? LTCHs are distributed unevenly around the United States, but the patients still exist. **(See *Rehab Continuum Report*, May 2004, cover story.)** They'll have to be seen somewhere. So will patients who get squeezed out of inpatient rehabilitation facilities because of the 75% rule.

"In a way, this examination of LTCHs and trying to distinguish them is similar to the discussion over the 75% rule with respect to inpatient rehab facilities and distinguishing them from acute care facilities," says **Carolyn Zollar**, JD, vice president for government relations and policy development at the American Medical Rehabilitation Providers Association (AMRPA) in Washington, DC.

In April, the Medicare Payment Advisory Commission (MedPAC) voted unanimously to approve a set of draft recommendations that would urge Congress and the secretary of Health and Human Services to establish new criteria for LTCHs.

The criteria would delineate the types of patients who are treated appropriately in LTCHs and ensure those patients are medically complex and have a good chance for improvement.

MedPAC completed a study on LTCHs that was prompted by the commissioners' concern at the huge growth and uneven geographic distribution of LTCHs in recent years.

### *The role of LTCHs*

The study asked questions about the role of LTCHs, how patients are treated in areas where there are no LTCHs, and how Medicare spending and outcomes compare for patients who use LTCHs and those who are treated in alternative settings. The study included:

- Thirty-four structured interviews with physicians, hospital administrators, nurses and discharge planners in two market areas with LTCHs and two market areas without them.
- Commissioner and staff site visits to LTCHs in three cities that have multiple LTCHs.
- A comparison of characteristics of patients treated in markets with and without LTCHs and examination of the impact of LTCH use on Medicare spending and outcomes.

**Sally Kaplan**, PhD, the MedPAC research director who led the study, reported to the commissioners that patients in market areas with LTCHs had similar acute hospital lengths of stay whether or not they used LTCHs.

She said LTCH patients were three to five times less likely to use skilled nursing facilities (SNFs), "suggesting that SNFs and long-term care hospitals may be substitutes." LTCH patients had higher mortality rates and cost Medicare more that patients using alternative settings. However, LTCH patients had lower readmission rates than similar patients in alternative settings.

"The main conclusions from our study are that when admissions to long-term care hospitals are largely unrestricted, long-term care hospitals tend to cost Medicare more than patients treated in alternative settings," Kaplan told commissioners.

The recommendations include:

**1.** Requiring a uniform patient review process that screens patients prior to admission, periodically assesses the patient throughout the stay, and

assesses the available options when the patient no longer meets the continued stay criteria.

**2.** Instituting a uniform patient assessment tool across the industry that would emphasize clinical assessment of the patient.

**3.** Requiring multidisciplinary care treatment planning that establishes patient-specific care plans. LTCHs would be expected to have such services as wound care experts, respiratory therapists, end-of-life counseling and home ventilator training depending on their patient mix.

**4.** Retaining the current average length-of-stay requirement with the option to reevaluate over time.

**5.** Requiring daily physician presence that would include care planning, daily patient assessments, and medical interventions when needed.

**6.** Developing criteria for a weaning success rate for ventilator dependent patients.

**7.** Developing national admission and discharge criteria for each major category of patients. The criteria would specify clinical characteristics such as blood pressure, respiratory insufficiency, and the presence and severity of open wounds.

**8.** Developing discharge criteria for patients depending on their discharge destination.

**9.** Requiring that a high share of patients, possibly 85%, be classified into major categories of patients. Possible categories include respiratory, complex medical, wound care, ventilator weaning, infectious disease, and cardiovascular. A high share of the patients would also need to have a high severity level.

**10.** Requiring a minimum number of nursing hours per patient day, possibly 6½ hours.

Kaplan told the commissioners that the above criteria are not the only measures needed.

"We also want to point out that it will be important in the longer term to make refinements to existing PPSs [prospective payment systems] for acute care hospitals and SNFs. As currently designed, these payment systems may have had the unintended consequence of encouraging long-term care hospital growth," she pointed out.

Kaplan also urged the development of strong rules regarding hospitals within hospitals "to ensure that hospitals do not discharge patients prematurely for financial gain."

Zollar says the AMRPA is following this issue closely, even though LTCHs make up a minority of its membership.

"We are watching MedPAC's actions very carefully. I think it represents a concern in various policy thinkers here in DC that if Medicare is paying for excluded hospitals based on different and more costly payment systems, that it wants to be certain there is a difference in the nature of the hospitals and patients," she adds.

The American Hospital Association (AHA) also is following the issue. "The MedPAC staff are doing a good job with the LTCH research," says **Rochelle Archuleta**, the AHA's senior associate director for policy.

"If the commission's recommendations to develop and implement facility and patient characteristics for LTCHs are acted upon by Congress and CMS, it would be appropriate to convene an independent panel of clinical experts, perhaps under the auspices of the Institute of Medicine, to establish a clinical consensus on the content of these standards, rather than have CMS oversee the effort," she adds.

"We concur with the commissioners who stated that a moratorium on certification of LTCH hospitals within hospitals is premature," she explains.

### *What are the long-term goals?*

Archuleta says the long-term goal for looking at how the various PPSs work together is wise.

"They're looking at developing a greater understanding about the connection between the PPSs to ensure they are devised appropriately," she says. "We feel there are some protections in place now to be sure patients are treated appropriately, but we feel the long-term approach is reasonable."

## Need More Information?

- **Rochelle Archuleta**, Senior Associate Director, Policy, American Hospital Assoc., 325 7th St. N.W., Washington, DC 20004. Phone: (202) 638-1100.
- **Sally Kaplan**, Research Director, Medicare Payment Advisory Commission, 601 New Jersey Ave. N.W., Suite 9000, Washington, DC 20001. Phone: (202) 220-3717.
- **Carolyn C. Zollar**, JD, Vice President, Government Relations & Policy Development, American Medical Rehabilitation Providers Assoc., 1710 N St. N.W., Washington, DC 20036-2907. Phone: (202) 223-1920. E-mail: czollar@13x.com.

Standard outcomes measurements also would be welcome, Archuleta says.

"We think it would be wonderful to ensure the outcomes measurements would be comparable with the outcomes measurements of other systems, which is not the case now. Right now the outcomes generated in a skilled nursing facility are not comparable to those generated in an inpatient rehab facility. Those segments do have patient assessment instruments; LTCHs aren't quite there yet," she adds.

Another long-term goal the AHA would like to see concerns patient access. "One MedPAC goal that is very important is to ensure that the skilled nursing facility PPS does not discourage access to care for medically complex patients," Archuleta says. "The regulations should ensure that medically complex patients are reimbursed appropriately, which is widely agreed at this point to not be the case. We're strongly in favor of that. That's a major issue we've been pushing on for years."

*(For more information, the transcripts from the March and April meetings concerning LTCHs can be found on the MedPAC web site: www.medpac.gov.)* ■

# Lift teams boost the bottom line

*Fewer injuries saves more than $200,000*

The verdict is in on lift teams at Tampa (FL) General Hospital: They save money and backs. They win kudos from nurses. They're here to stay.

Last year, the hospital's modified duty days declined by 50% — a savings of at least $200,000. Patient handling injuries among nurses went down by 62%.

"We didn't have any back surgeries last year for probably the first time ever. Our hospital has really seen a value of injury prevention," says **JoAnn Shea**, MSN, ARNP, director of employee health and wellness.

Tampa General began using lift teams about two years ago, and has two teams that work from 8 a.m. to 7 p.m. (They overlap during the peak hours of 10 a.m. to 4:30 p.m.) Nurses dial a pager (332-LIFT) and punch in the code for their floor and room number. It takes about 15 minutes for the lift team to arrive.

It didn't take long for the nurses to become accustomed to calling for a lift. "We started with 500 lifts or repositionings a month. Now we're up to 1,800 to 2,000 a month," says Shea.

**Kassie Basnight**, RN, nurse manager in surgical trauma intensive care, has seen the difference the lift teams make.

"The median age in my unit is probably 40. I don't have a high turnover rate so my nurses are just getting older," she notes. "The population in my area has changed. The patients are much sicker. The medication used to sedate them makes them dead weight."

Typically, two or three nurses would be out of work at one time, going to physical therapy or on bed rest to recuperate from back strain, Basnight adds. Two nurses in the unit had significant back injuries and became permanently disabled.

"When that occurred, not only was it a loss for me to lose seasoned nurses, but it's also a financial loss to the hospital and a loss for those nurses to become disabled," she says. "Because I had had the loss of those nurses, my goal was to make sure my nurses knew they were not to lift and to call the lift team."

It took a couple of weeks of diligent reminders to change the habits of nurses in the unit. Now, says Basnight, "On my day shift, they do almost no lifting or turning."

There hasn't been a single injury on the day shift since implementation of the lift teams, she explains. Basnight's unit celebrated the lift team with a recognition luncheon.

Meanwhile, the lift teams have contributed to nurse retention. The hospital virtually has no openings, says Shea.

### *Not macho weight lifters*

The lift teams are not macho weight lifters who come in to manually move patients. They rely on equipment purchased by the hospital, including four mechanical lifts on every floor, ceiling lifts in the every room and the hallways of the rehabilitation center, and sit-to-stand and repositioning devices.

The hospital pays a starting salary of $10.50 to the lift team members, which has helped reduce high turnover on the team, says Shea.

Her goal now is to expand the lift team into the evening shift and weekends and to purchase more equipment. Shea's message to those considering ergonomic interventions: "It works. Everything we've done works." ■

# Myth-buster: Patients like ergo equipment lifts

*Survey shows comfort level with devices*

**Myth:** Patients won't like being transferred with lift equipment. They prefer the hands-on touch of nursing staff.

Duke University Health System, based in Durham, NC, busted this common assumption about ergonomic equipment with a patient satisfaction survey that showed patients like the mechanical lift devices.

Some 87% of patients said they were "very comfortable" or "mostly comfortable" when transferred with lift devices, says **Tamara James**, MA, CPE, ergonomics director in the department of occupational and environmental safety at Duke. Only 80% felt comfortable with manual lifts.

Although those differences aren't enough statistically to claim victory for lifts over manual efforts, the survey shows that patients are at least as happy to be transferred with ergonomic equipment, says James, who presented her preliminary results at the recent Safe Patient Handling and Movement Conference in Orlando.

The conference was sponsored by the VHA Patient Safety Center at the James A. Haley Veterans' Hospital in Tampa and the American Nurses Association in Washington, DC.

With the help of a "Best Practices" research grant from the patient satisfaction firm Press Ganey Associates, based in South Bend, IN, Duke randomly surveyed 100 patients discharged from a unit that used lift devices and 100 patients in a different general medicine unit that did not use devices.

The survey spanned a three-month period and represented one-fourth of the discharges in those units during that time frame.

There were no differences in the patients' fear of falling, feelings of being treated with respect, or amount of time they had to wait for transfers. Anecdotally, the patients told nurses they felt secure with the mechanical lifts. "They heard from patients how much they loved the equipment," James adds.

The results of the study have helped gain administration support for lift equipment, and the hospital is now considering installing ceiling lifts, she says. ■

# A nightmare situation yields valuable lessons

Imagine a scenario in which a patient dies from a medication error and then things just go downhill from there. As things get worse and worse, the only good thing is that you're bound to learn something useful from the experience.

That was the situation faced by **Monica Berry**, BSN, JD, LLM, DFASHRM, CPHRM, regional director of risk management with SSM Health Care of Wisconsin in Madison, and past president of the American Society for Healthcare Risk Management (ASHRM) in Chicago.

She spoke on the topic at the recent ASHRM meeting in Nashville, TN. She tells a story from her own experience that illustrates how the most painful experience can yield valuable lessons.

The incident involved a diabetic patient after surgery with an order for 10 mg morphine sulfate every four to six hours. The patient was under the care of a hospitalist, who ordered a dressing change and indicated the pain medication should be given 20 minutes before. But the nurse misread the order as calling for 20 mg of the drug, and the patient ended up with an overdose and died.

The family was notified of the death and, at 5 a.m., the hospitalist called the risk manager to report that the death was caused by an accidental overdose. The risk manager cautioned the hospitalist not to jump to the conclusion that the overdose caused the death and role played with him to prepare for him for how to inform the family of the circumstances.

The hospitalist met with the family without any other hospital representative, and the charge nurse overheard him saying, "The nurse gave an overdose of pain medication and killed your mother." One of the family members became enraged and physically attacked the charge nurse, who was not the nurse in question, prompting a security response that ended with the family being escorted off the campus.

Soon after, five physicians reported to the risk manager that the hospitalist was telling everyone the nurse "killed the patient," and the family created a disturbance in medical records demanding the patient's chart.

By 6 a.m. the next day, the risk manager was

on site to gather facts and review the medical record. Upper administration was notified by 7 a.m., and an administrative huddle occurred at 8:30 a.m.

"The window of opportunity to interface with the family is lost, and the campus rumor mill is very active," Berry says. "The risk manager was called at 5 a.m., and by 7 a.m., the window of opportunity is closed. It closed very quickly and very soundly."

Berry never knew what to expect when she tried to contact the family, as each family member seemed to have a different temperament and there was no consensus on how they wished to proceed.

The situation only got worse from there — the night nurse involved in the medication error was involved in another the very next night and had to be put on administrative leave.

The nurse who was attacked by a family member had multiple sclerosis and suffered an exacerbation of the condition. She filed a workers' comp claim and was on leave for 10 weeks, during which she was admitted to rehab.

"I simply could not have imagined a worst risk management nightmare," Berry says. "My imagination is not that good."

## Failings made error possible

In addition to the inevitable lawsuit against the facility, Berry herself was sued for fraudulent concealment when her superiors ordered her not to reveal certain clinical findings to the family.

With a situation that bad, it's nearly impossible not to learn something useful. Here's what Berry took away from the experience:

- Processes that are changed midstream create an opportunity for things to run amok. The modification of the physician's orders late in the day shifted the dynamics of the work flow and the team functionality.
- The mind sees what is expected. Human factors research refers to this phenomenon as "slips." In this case, the nurse expected to see "mg" in the second medication order just as she had in the first order. Instead, the second order actually said "mins" for minutes.
- The night nurse was a recent graduate who was not assigned to the patient but was helping out when asked to give the medication. She thought 20 mg was a lot but justified it in her mind because of the patient's size and was hesitant to question the order. She referred to a carbon copy of the medication order to confirm the dosage.

"We subsequently found out that they were in the habit of using the carbon copy as their working copy of the medication order," Berry says. "Imagine the carbon copies you've seen that are not at all clear — smudged and blurred because they had many things stacked on them and scratched out. So you could easily see how milligrams and minutes could easily look alike."

- The night nurse was on her first shift after orientation. She came from a long-term care setting and had no previous acute care experience. The length of time a nurse has practiced is not as important as the need for acute care experience in the past three to five years, Berry says.
- She had had multiple preceptors in orientation and several recommended that she stay in orientation longer because she was not ready to solo. The unit manager disregarded that advice because she was short staffed. The hospital decided to limit the number of preceptors and improve communication among them. Policy also now requires that the preceptors and unit manager all agree the new nurse is ready to come off of orientation.
- The nurse took three attempts to pass the orientation medication test. The hospital subsequently changed its policy so that only two attempts were allowed and then the nurse had to go back for orientation focused on medications or process.
- The organization did not have a medication order template. Pharmacy had not had an opportunity to clarify the orders.
- The automated drug dispensing system allowed 20 mg of morphine sulfate to be removed, but a more modern version of the system would not. An upgrade of the system had been denied in the previous two budget cycles.
- Senior leadership at the hospital wanted notification as early as possible. Risk managers naturally try to gather information before alerting senior leaders, but it is better to go ahead and notify them even if that means having to say, "I don't know yet" when they start asking questions.
- The hospitalist blamed the nurse for killing the patient when the family members backed him into a corner and he couldn't think of anything else to say.

For that reason, Berry says it is a good to always have another representative with the primary discloser so that when that happens, the second person can speak up and redirect the conversation.

"You need the other person to break in and

give the primary discloser a chance to gather himself, regroup, and get the message back on target," she says. "That was an important lesson for us." ■

## Latest HIMSS survey shows slow compliance

*Only half completed TCS testing*

The latest survey of 631 providers, payers, companies, and clearinghouses by the Healthcare Information and Management Systems Society (HIMSS) indicates that only half had completed testing for the Transaction and Code Standards (TCS), which standardized what information must be contained in electronic claims and how it should be transmitted.

Consultants who provide services to physicians say that even though enforcement remains complaint-driven, physicians will have an increasingly compelling incentive to comply with the law as claims that do not follow the regulations are rejected.

**John Thomas**, CEO of MedSynergies Inc. in Dallas, has estimated that only 15% to 20% of physician claims are in compliance with the standard.

He says that as accounts receivable numbers show more and more unpaid claims, physicians will get the message.

**Karen Trudel**, director of the Department of Health and Human Services (HHS) Office of Health Insurance Portability and Accountability Act (HIPAA) Standards, says the agency has not set a time frame for ending contingency plans.

"TCS represents an activity, the magnitude of which the health care industry had never attempted before," she says.

"You've got so many different moving parts that a lot of people underestimated the complexity of the process." Trudel estimates that two-thirds of Medicare claims being received by HHS are compliant.

HIMSS officials say the stumbling block for providers is more culture than technology. Many delays, they say, simply relate to the fact that physicians have many demands on their times and assign those a higher priority than technology.

"With any systems upgrade, the technology is probably the easiest part and culture change the most difficult part," says **Joyce Sensmeier**, director of professional services at HIMSS.

The HIMSS survey showed that while 45% of providers and 56% of payers were ready to accept or transmit the standardized transactions, only 40% of the companies that make software for the industry were prepared. That was down from an earlier survey in which 47% of the companies reported they were ready to handle the transactions.

The consulting firm Frost & Sullivan has estimated that providers such as hospitals, managed care organizations, and physicians have spent $1.2 billion on HIPAA. Apparently, most of that spending was by organizations characterized as early adopters, especially large organizations with the resources available to use for experimenting with new initiatives.

But most physicians practice in small groups; approximately two-thirds of all physicians are in group practices of eight or fewer members, and they may have only recently installed a computer and assigned information technology duties to the office manager. Thus, they're dragging their feet on coming into compliance with TCS, even as the deadline for compliance with security requirements is only 12 months away.

The security standard requires health care groups to assess their systems' susceptibility to unauthorized access and put a policy in place to deal with that concern. Trudel says the security standard may not pose as much of a problem as TCS because of flexibility built into the requirements. "We're saying you have to think about your risk and how you can best mitigate that risk," she said. "But a lot of people are going to be asking us to tell them exactly what they have to do." ■

## Web sites suggest ways to push access boundaries

*Open visiting, patient safety highlighted*

Health care is evolving, and managers must evolve with it, says **Karen McKinley**, RN, CHAM, vice president of patient access and care management for Geisinger Health System in Danville, PA.

"As the cost of health care continues to grow, we can't continue to do things the way we've always done them."

With that in mind, McKinley lists some web sites she says might suggest ways to push the boundaries of access services, as well as some Geisinger initiatives that don't fit neatly into conventional health care boxes:

**www.qualityhealthcare.org**

The web site of the Institute for Healthcare Improvement (IHI) contains information on a wide range of topics, including patient safety, patient flow, and a concept known as "open visiting" that is new to most organizations.

Among the offerings on open visiting is an article looking at Geisinger's experience with allowing family members to visit loved ones in the intensive care unit "whenever they want, for as long as they want, 24/7."

The experiment came about as the result of a challenge issued by Donald Berwick, IHI's president and CEO, to the hospitals enrolled in the Critical Care Settings domain of IHI's IMPACT network. IMPACT is described as "a community of change-oriented health care organizations working together to achieve new levels of quality."

In response to Berwick's plea that "at least some member hospitals execute a two-month trial of entirely open visiting in a critical care unit," Geisinger Medical Center implemented such a program cold turkey in August 2003.

The hospital agreed to let IHI report on the experiment's progress periodically during the next year.

**www.clinicalmicrosystem.org**

This site, as well as the one mentioned above, "provides a broader picture of health care improvement, and offers ideas and strategies for how to change the actual delivery of health care," says McKinley. "You find an interesting perspective on how individual work units function and their contribution to the whole macrosystem."

As defined on the web site, a microsystem in health care delivery is "a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. It has clinical and business aims, linked processes, shared information environment, and produces performance outcomes. They evolve over time and are often embedded in larger organizations.

"As a type of complex adaptive system, they must: 1) do the work, 2) meet staff needs, and 3) maintain themselves as a clinical unit," notes McKinley. "Inpatient admitting, for example, would be a microsystem, as would emergency department registration. I think [the microsystem concept] gives a perspective that's a little different than teams because it actively involves patients."

The model is similar to what Geisinger did in implementing its open visiting program, bringing patients and families into the discussion of how it would be done, McKinley explains. "They said, for example, that there was not enough waiting space, that they felt crowded, and that there was difficulty getting updates on their loved ones.

"What we did," she adds, "was incorporate all of those things and incorporate limits that made sense. If you need sterility, for example, family members can't be there, so they are excused for a brief period and then allowed back in."

Stage two of the project, McKinley says, will be to involve family members in the care of the patient. "They'll be told, 'These are the things your dad has to have done every day. Which would you like to do?'"

**www.qualitymeasures.ahrq.gov**

"This is a quality-measures clearinghouse," she says, "with some of the latest news on [which] measures people will have to be reporting. [The health care industry] is moving toward more public reporting of all kinds of measures, access to care, or quality indicators."

A group of Wisconsin hospitals and Dartmouth-Hitchcock Medical Center have gone public with measures from their health care delivery, McKinley notes. "This [site] is sort of a connection to what's happening with measures, what people are going to be accountable to do. As we get more focused on delivering error-free health care, we will all be reporting in this manner."

**www.josieking.org**

This site deals with the story of a young child who died because of medical errors, she says, and, in part, because hospital staff didn't listen to her mother's concerns. "Things started to go bad,

## COMING IN FUTURE MONTHS

- Drunk driving prevention program
- Covering vacation schedules
- New technology for swallowing problems
- An integrated wellness approach

and her mother saw it," McKinley adds. "It's about health care personnel not listening and actively involving families in care."

Such examples are helpful for access personnel, she notes, "because if we don't listen carefully, we do things like create duplicate medical record numbers or collect the wrong information and label things incorrectly. This could result in errors."

"We're all accountable for our piece of this complex health care puzzle," McKinley points out, "and for making sure that we pay attention to detail."

**www.iom.edu and www.jcaho.org**

Geisinger has made extensive use of the web sites of the Institute of Medicine (IOM) and the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) in its patient safety initiatives, she says.

"They both have patient safety goals or aims, and we're using them as a foundation to build a systemwide program," McKinley adds.

The IOM's six aims contend that patient care should be patient-centered, safe, timely, efficient, effective, and equitable, she says, while JCAHO lists the following seven National Patient Safety Goals, approved in July 2002 by the organization's board of directors:

1. Improve the accuracy of patient identification.
2. Improve the effectiveness of communication among caregivers.
3. Improve the safety of using high-alert medications.
4. Eliminate wrong-site, wrong-patient, wrong-procedure surgery.
5. Improve the safety of using infusion pumps.
6. Improve the effectiveness of clinical alarm systems.
7. Reduce the risk of health care-acquired infections.

The idea promulgated on both sites, she says, is "everybody at every level of the organization pays attention to both patient safety and staff safety."

At Geisinger, "we're trying to create an environment that is nonpunitive, that allows us to open discussions about incidents that happen," McKinley continues.

"We find that most are a result of system problems, not individual problems, so we approach them from that perspective — looking for the root cause and trying to fix them, and not blame an individual," she adds.


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"Rarely does an individual intentionally do something wrong," McKinley points out.

An example, she says, would be a case in which two patients on a nursing unit have the same name. A test is ordered on one patient, and somehow things get mixed up and the test is done on the wrong patient.

"Somebody made a mistake, but probably there was a series of events that allowed that to happen," McKinley explains. "Did anyone take time to put a middle name on the patient's name band? Did anyone put an alert in the medical record? Did the person checking identification go through a double-check?"

"It's like when you get on an airplane, the pilot goes through a massive series of checks," she notes. "The plane doesn't take off until everything is perfect. Unfortunately, in health care, we don't always apply the same rigor." ■

## Need More Information?


☎ **Karen McKinley,** RN, CHAM, Vice President, Patient Access and Care Management, Geisinger Health System, Danville, PA. E-mail: kmckinley@geisinger.edu.