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# Rehab Continuum Report™

The essential monthly management advisor for rehabilitation professionals

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AMERICAN HEALTH CONSULTANTS

## IN THIS ISSUE



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# CMS makes few changes in final 75% rule despite numerous protests

*Providers in shock over final version*

The Centers for Medicare & Medicaid Services (CMS) promised to take a fresh look at the 75% rule when it released the proposed changes to the rule in September. A coalition of rehab providers said it hoped that the fresh look would incorporate at least some of the changes it says are necessary to save the future of inpatient rehabilitation facilities (IRF).

But even after an overwhelmingly negative response to the proposed rule from the rehab field, the final rule released April 30 was not significantly different from the proposal. Changes include an expansion of the definition of polyarthritis and a three-year transition period that lowers the 75% threshold to 50% for the first year. The number of patients who must have one of the 13 qualifying medical conditions for the facility to qualify for Medicare reimbursement as an IRF rises to 60% for the second year, and 65% for the third year. The rule, which takes effect July 1, is available at www.cms.hhs.gov/providers/irfpps/default.asp.

"Frankly, I'm personally frustrated at the failure of CMS to modernize a 20-year-old rule. When I got that rule, I was in shock that little had changed," says **Greg Crain**, vice president of Baptist Health Rehabilitation Institute in Little Rock, AR.

"I felt like the field had given massive amounts of feedback that we were treating more people than this 20-year-old rule allowed us to do. As a frontline caregiver, I'm very frustrated that they won't listen to the advances in cardiac care and in pulmonary care that have been made," he says.

"We get 400 to 500 people a year who have debility because they're living longer with a cardiac or pulmonary disease. Common sense dictates that those are appropriate rehab patients. There's a real disconnect between the rule and the real-life provision of care," Crain explains.

The rule replaces the term polyarthritis with four arthritis-related

medical conditions. For example, CMS now will count toward the threshold a patient who has severe or advanced osteoarthritis involving two or more major joints and who meets other outlined medical criteria. The proposed rule had required three or more joints to be affected. The final rule also will count patients who undergo knee or hip joint replacement during an acute hospitalization immediately preceding the IRF stay if they also meet one or more of three other conditions in the rule.

During the three-year transition period, CMS will monitor the impact the revised criteria have on utilization and patient access to rehabilitation services. CMS also plans to promote a research program to assess the efficacy of rehabilitation services in various settings.

"This research would be intended to provide objective, outcomes-oriented answers with respect to the best way to identify those patients who most need the intensive medical rehabilitation resources provided by an IRF," CMS announced in a press release. "The research would also help identify the most frequent conditions that typically require the intensive rehabilitation treatment available only in IRFs. Based on the findings of this research, CMS may revise the qualifying medical conditions or other coverage criteria as appropriate."

If no further action is taken, the compliance percentage will rise again to 75% for cost-reporting periods beginning on or after July 1, 2007.

**Carmela Coyle**, the American Hospital Association's (AHA) senior vice president for policy, said in a statement to AHA members that the time for such a research panel was before the release of a final rule, not after. "Further study is needed to ensure the rule is based on an appropriate clinical foundation and does not yield harmful consequences for patients," she said. "We will continue to seek a legal resolution to protect patients' access to care."

Other steps taken by CMS in the final rule include:

- Establishing an administrative presumption that if the facility's Medicare patient population complies with the rule, the facility's total population complies.
- Counting toward the new percentage threshold patients whose principal diagnoses match one of the 13 qualifying medical conditions as well as those who have a secondary medical condition that matches. The secondary condition must cause a significant decline in the patient's functioning that would require intensive rehabilitation treatment even without the admitting condition.
- Changing the period of time to review patient data to determine compliance from the most recent 12-month cost-reporting period to the most recent, appropriate and consecutive 12-month time period.

According to CMS, the final rule will allow for appropriate reimbursement as well as improved access to inpatient rehab services. "In developing this final rule, we have tried to make sure our payment system is accurate and promotes access to high quality inpatient rehabilitation services for beneficiaries who need them," said **Mark B. McClellan**, MD, PhD, CMS administrator, in a press release.

"Based on extensive public comments, we have modified a number of provisions in the proposed rule, and will continue to work with the beneficiary

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and provider communities to ensure access to high-quality rehabilitation services," he added.

That's not the way some rehab advocates see it. "While the temporary reduction in the threshold and the reduction in the number of qualifying joints for osteoarthritis patients are helpful, the final rule clearly shows that the administration didn't hear the stop-study-modernize message sent by Congress and the field through extensive communication," says **Rochelle Archuleta**, the AHA's senior associate director for policy.

The Medicare prescription drug bill signed into law in December included language that directs delayed implementation and further analysis of the 75% rule.

"As a result, access to care for Medicare beneficiaries will be threatened, even under the temporary reduction to a 50% threshold, and especially in subsequent years," Archuleta says. "Despite the restructuring of the polyarthritis definition, the reality is that very few additional patients will count under the final rule's four arthritis-related categories. In practice, the 75% rule conditions under the final rule are substantially the same conditions authorized 20 years ago."

The AHA supports the idea of a research panel but fears the language concerning that idea is too vague in the rule, she notes. "We strongly urge CMS to commit to authorizing the Institute of Medicine to convene an independent panel of experts in medical rehabilitation to establish a clinical consensus on whether and how to modify the 75% rule qualifying conditions and whether and how to modify the national medical necessity guidelines," she says.

If nothing changes, the rule has the potential to create problems for the whole health care delivery system, adds Crain of Baptist Health.

"CMS has created a potential for a huge logjam. I don't believe there's capacity in many areas of the nation in nursing homes and acute-care facilities for this rule to be carried out the way CMS intends it to be," he says. "I think patients are going to stay in medical-surgical beds longer. That's going to back up critical care patients who are waiting for those beds and, ultimately, emergency departments are going to suffer.

"Common sense tells you this is an unworkable plan. I personally am deeply disturbed by the ethical implications of the 75% rule. It puts rehab facilities in the terrible position of rationing health care on a first-come, first-serve basis," Crain explains. "I can say, 'Today, I can admit you and treat you, but if you come in tomorrow with the same condition, the government says I can't admit you.' If you're approved to treat a diagnosis, you should be able to treat it and not set some arbitrary limit."

He says the positive aspect of the final rule is the temporary reduction of the threshold to 50%. "That was a big thing for the field. Also, they did pledge to convene a research panel, and that at least gives us hope to get a reasonable rule. One of my big concerns is who makes up that panel. I want to make sure we get people from the front lines, people who are credible in rehab to say, 'Let's debate the issue of what is appropriate to being an inpatient rehab facility.'

"I don't have any problem discussing and debating what is and is not appropriate," Crain says. "What I have issue with is when they take the standard of care and try to change that without any scientific proof. Rehab is very attuned to outcomes, and we've got to be willing to debate those issues. But let's do it the right way."

The American Medical Rehabilitation Providers Association (AMRPA) has been one of the leaders in the fight against the 75% rule. Like the AHA, the AMRPA was disappointed in the final rule, says **Carolyn Zollar**, vice president for government relations.

In a statement on the final rule, the AMRPA expresses concern that Medicare beneficiaries may lose access to care. "AMRPA perceives that there is very little relief to the field and beneficiaries under this final rule. We believe that in the long run, there will be large-scale denial of access as facilities will be compelled to revise their admission policies to comply with the rule's requirements," the statement said.

The AMRPA also took issue with CMS' apparent lack of response to congressional directives, as

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well as CMS' assertion "that the lack of scientific evidence to support IRF care for patients justifies their exclusion." The statement added, "There is overwhelming evidence that IRFs care for significantly more patients than those defined by the limited number of diagnostic categories proposed by CMS. It is clinically unconscionable to limit medical practice by narrowly delineating the conditions without compelling evidence to argue against current standards of medical practice." ■

# Rehab hospital program aimed at teen drinkers

*Cruisin' Not Boozin' turns 15*

If you're anything like the staff at Bryn Mawr Rehab Hospital in Malvern, PA, you sometimes despair over senseless accidents that turn healthy young people into your patients. How many of your patients come in with traumatic brain injuries or spinal cord injuries resulting from alcohol-related car accidents? Ever wish you could do something about it?

In 1989, when a Bryn Mawr staff member noticed that half of the hospital's adolescent patients were severely injured in alcohol-related accidents, a unique prevention program was born. Instead of just treating patients after the fact, the hospital began an aggressive campaign to stop these types of accidents in the first place. In 15 years, the Cruisin' Not Boozin' program has reached more than 500,000 teen-agers and young adults with the sobering message of what life is like for permanently injured people.

"Teen-agers might worry about a DUI conviction or even death as the worst possible outcomes of an alcohol or drug-related crash," says **Carole Flounders**, program coordinator. "But few stop to think about the devastating life long challenges that teens and their families face when a severe brain injury or spinal cord injury occurs. Statistically, severe injuries happen more often than deaths."

Between 12 and 15 former Bryn Mawr Rehab patients who were injured in alcohol-related accidents speak to students at 50-60 schools each year. During the months of April, May, and June — prime season for high school proms — Bryn Mawr ramps up its efforts.

The National Highway Safety Administration estimates that more than 1,200 alcohol-related fatalities will occur nationwide among teen-agers during prom season. In Pennsylvania alone last year, 535 people of all ages died, and more than 13,000 people were injured in drunk-driving accidents.

"The program serves so many purposes. It helps the general public understand what it feels like to be disabled. It also, of course, gives a very important message of warning about mixing drinking and driving," Flounders explains.

The program not only helps students, but it also helps the speakers. "Speaking has a therapeutic effect on the rehab patients. Many of them have attention deficit problems and memory problems, and preparing to speak in front of people helps them organize their thoughts and present themselves clearly," she adds. "The more they do it, the better they get at it. It also has an emotional effect because they get such positive feedback from the audiences."

There is nothing more compelling than a personal story, Flounders says. One of the former patients who speaks frequently for the program tells students about a devastating drunk-driving accident on his 21st birthday that left him in a coma for four months. The 35-year-old speaker was once a high school track star with dreams of running in the Olympics. Now he is paralyzed on the left side and can't run or even walk very well. He also has lingering speech and cognitive problems.

"I just came back from a program today at a high school that is having a prom this Saturday, and you could have heard a pin drop in there," Flounders points out. "They were totally in awe of the personal testimony of what happened to the speaker."

Speakers describe what they were like before, the decisions they made that led to the accident, the accident itself, and what life is like for them now. "People don't understand what brain injury or spinal cord injury is all about and what it takes to go through the rehabilitation process when you've lost your ability to walk, speak, swallow, recognize letters, or even your own family," she says. "They help the audience understand what it feels like to start from scratch again."

The program measures its success through an evaluation survey standardized by the National Highway Safety Administration. The survey identifies and measures attitudes about drinking, driving, use of seat belts, parental communication regarding alcohol or drugs, and alcohol use vs.

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drug use. The anonymous survey is administered prior to the Cruisin' Not Boozin' program and immediately after. The results also illuminate the scope of the problem at individual schools so more action can be taken.

In the 2002-2003 school year, more than 3000 students at 17 schools completed the survey. Following the presentation, 85.6% of high school students and 88.4 % of middle school students stated they were more aware of the consequences of drinking and driving than they were prior to the Cruisin' Not Boozin' program assembly. About 85% of high school students and 95% of middle school students believed they would not drive in the future while impaired, based on what they heard during the assembly.

The program also participates in the Chester County Council On Addictive Diseases' efforts to educate people arrested for driving under the influence of drugs and alcohol. The speakers present to about 3,000 offenders a year. Bryn Mawr also serves as a designated community service site where DUI offenders can satisfy their mandated volunteer hours. ■

# Seniors' wellness program goes beyond exercise

*Plan incorporates goals of Healthy People 2010*

When your elderly patients leave the rehab unit or complete a course of physical therapy, you send them off with a home program and many admonitions to continue exercising. You only can hope they will find the self-motivation to continue the lifestyle changes you have put in place.

A new comprehensive wellness program put together by two companies with expertise in rehabilitation services and strength training does not leave that self-motivation to chance. Instead, the wellness program from Genesis Rehabilitation Services and Keiser Corp. keeps older adults on the healthy path by addressing their total spiritual, medical, physical, and psychosocial needs.

"Therapists never see the end results. They get somebody with issues; they work on them for X number of visits, and then it's, 'Now keep doing this on your own or go somewhere.' There's nowhere for them to go. They're not going to do the correct exercise program at home," says **Don Callahan**, a sales manager for Fresno, CA-based Keiser Corp. Keiser manufactures pneumatic strength-training equipment.

Genesis, based in Kennett Square, PA, developed the wellness program along with Keiser for use in skilled nursing facilities, assisted living facilities, and continuing care retirement communities. Genesis hires a wellness coordinator with a background in exercise physiology to work at the facility — the salary is partly covered by the facility — and Keiser provides the strength training equipment at a discount.

The wellness coordinator caters the program to existing wellness initiatives at the site and works with the on-site occupational, physical, and speech therapists to set goals for individual residents, says **Laura Caron-Parker**, OT, rehabilitation clinical specialist for Genesis.

"Everyone talks about wellness, but people usually think of exercise only," she explains. "True wellness encompasses so many other pieces. We want to expand the scope of what defines wellness, and we think that the more people understand it and talk about it, the more it will happen. It's really the way we all should be living anyway."

One unique feature of the program is that it incorporates 17 of the 28 focus areas of the federal government's Healthy People 2010 initiative, which seeks to increase the quality and years of healthy life as well as eliminate health disparities.

The focus areas featured in the wellness program are: access to quality health services; arthritis, osteoporosis and chronic back conditions; diabetes; disability and secondary conditions; educational and community-based programs; environmental health; health communication; heart disease and stroke; medical product safety; mental health and mental disorders; nutrition and overweight; oral health; physical activity and fitness; respiratory diseases; substance abuse; tobacco use; and vision and hearing.

"The whole philosophy of what the United States is looking at is improving the health of

people and communities, and we've agreed to say if the nation is looking at this, then we need to incorporate it as well," Caron-Parker says.

"It meets our mission of providing pathways to healthy living. It matches. No other large organization has taken that on and incorporated Healthy People 2010 into their wellness program," she adds.

## Seniors see benefits

While exercise is not the only component, it certainly plays a starring role. "When you put a 60-, 70-, 80-, 90-year-old person on a strength training program, their lives change. It's not like a young person. Their balance improves. It's the best fall prevention program you could have," says Callahan of Keiser.

Keiser's approach is to provide senior-friendly fitness equipment that is not intimidating and then to teach people how stability and mobility training can improve their quality of life. When Callahan teaches older adults how to use the equipment, he invariably gets a roomful of stares if he talks about strengthening quadriceps. If on the other hand, he asks who in the room has ever had trouble standing up from the toilet, he suddenly has everyone's attention.

"They all react, and I'll say this is really the 'getting off the toilet' machine. If you're having trouble with that, you better get on this machine twice a week," Callahan says. "You're talking to a group of people who have never really exercised before. They don't know what it's going to do for them. They're saying 'I'm 78, 88, years of age. What is this going to do for me?'"

Callahan shares the following benefits of strength training for an aging population:

- Builds muscle.
- Improves balance.
- Improves coordination.
- Strengthens accident resistance.
- Increases muscle strength and endurance.
- Strengthens and builds connective tendons, ligaments, and supporting bony structures.
- Improves physical appearance.
- Builds power, an important factor in preventing falls in older adults.
- Aids in weight control.
- Increases joint mobility.
- Prevents constipation, diverticulitis, colitis.
- Increases flexibility.
- Improves posture.
- Enhances self-esteem.
- Improves sense of well-being.
- Fosters independence.
- Improves emotional outlook.

The wellness coordinator helps residents set fitness goals, track progress, and find varying ways to meet fitness goals through such efforts as walking clubs, stretching classes, aquatics, tai chi, yoga, and instruction on proper breathing and relaxation. For the medical component of the program, Genesis offers a clinical practice department with specialists who consult on clinical and quality issues. Services offered include routine vision and dental screenings, overall wellness assessments, health promotion, classes on such topics as how to talk to your doctor, and collaborative health care programming.

For the psychosocial component of the wellness program, courses are offered on such topics as relationships, stress management, dealing with death and dying, and making healthy lifestyle choices. Activities to enhance relationships and challenge minds also are offered, including games and book groups.

On the spiritual end, program coordinators work to enhance affiliations with local clergy to provide worship services on-site or transport residents to houses of worship in the community. Classes are offered in the arts and in disciplines such as journaling. "What we want to do is get them out of their rooms to develop relationships, to feel good about themselves, and have the opportunity to help others," says Caron-Parker.

## Real-world experience

The pilot site for the wellness program is Waterford Glen Assisted Living in Wall, NJ. The facility has assisted living, a memory-impaired wing, and 30 skilled nursing rehabilitation beds, says **Mary Ann Bryan,** executive director. "This is a new concept coming into assisted living to have a wellness coordinator who is professionally trained in this type of program," she says. "Most places have exercise classes, but it's more of a benefit to the residents to have someone who understands the physiology of the body, who can do the measuring tests to see if progress is being made. We can see the improvements."

The coordinator at Waterford Glen is working with the maintenance director to build outside exercise stations along the walking paths and to put in a putting green. Waterford also is talking with a local swim club to provide swim time for the residents on Saturday mornings. The facility

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also is working to provide a variety of on-site medical care, including visits from a physician, podiatrist, dentist, ophthalmologist, psychiatrist, and psychologist, Bryan says.

"We want to help people maintain the physical and cognitive level they have when they come here so they are able to enjoy living here for a lot longer before they need the next level of care," Bryan says. "People are coming to assisted living at much older ages than in the past. We have an average age of 90. Sometimes, it takes a crisis to make them come here, and we want to prevent further crises." ■

# Program targets domestic violence

*Employee attitudes shift*

An innovative workplace-based program targeting domestic violence has succeeded in engendering significant change in terms of employee awareness and attitudes, according to an evaluation report from the San Francisco-based Family Violence Prevention Fund (FVPF).

The fund was retained by Harman International Industries Inc., a manufacturer of high-end consumer stereo and audio equipment that employs about 3,500 employees across the United States "to provide expertise and knowledge and to design the program from the bottom up," says **Beverly Younger Urban**, PhD, LCSW, a professor at Governor State University in University Park, IL, and author of the evaluation report.

While FVPF had a pre-existing template for such a program, this project was customized to meet Harman's needs. And, significantly, "We included an evaluation component" in the services provided to Harman, Younger Urban explains.

Here are some of the key findings in the evaluation report:

• After the domestic violence training, 91% of the employees said they were now more likely to know where to refer someone who is abused for help; 89% said they were now more likely to be supportive of a colleague who is abused; and 86% said they were now more aware of what to do if there is a threat of domestic violence at work.

• The training caused "a highly significant increase" in the number of employees who said they know the signs of abuse, they know where to refer a victim to get help, and they know who to contact if they know of an employee who might be attacked at work.

• Employees' attitudes about domestic violence were more supportive of victims after the training than before it. In this statistically significant finding, about 20% more employees had highly supportive answers after the training.

• Responding to questions about the training, about three-quarters of Harman employees agreed that the training sessions increased their awareness and readiness to respond to domestic violence.

### *Death sparks initiative*

Younger Urban, who was involved in the project from the beginning, looks at the success of the program from two different perspectives. "From the research perspective, statistically there was a change that was big enough to measure in what people know and understand about domestic violence," she notes. "When we teach them, they can respond in ways that are much more helpful to others."

She also had a very personal reaction to the experience. "Every inch of the way, from planning to training, to doing to evaluating, there has just been a groundswell of support from employees and management to really buy into this," she says.

The initiative at Harman arose following the death of an employee from domestic violence. Chairman Sidney Harman "took a deep interest, and tasked his daughter, Lynn Harman [an attorney with the firm], to seek out best practices in

the prevention of domestic violence," Younger Urban explains.

The first step in the Harman/FVPF initiative was to set up regional teams that knew the individual facilities very well. "There were HR [human resource] representatives on each team, who knew the culture," says Younger Urban, noting that this was extremely important because each facility had its own distinct culture.

"We even formally assessed the cultures, the demographics, and the need for training," she continues. "There was a lot of upfront development," including handouts in numerous languages.

For each facility, a community domestic violence service provider was brought into the process. *(Editor's note: Community domestic violence providers are what used to be known as shelters.)* "We identified the provider who was closest to the facility, then brought them in as a full partner in the training program," says Younger Urban.

This was followed by train-the-trainer and planning meetings. "Getting to know the people on the teams really helped and connected them to the hometown," Younger Urban notes. "It provided a long-term partnership between that immediate facility and community. In the future, if someone has a problem with their partner, they already know a person in the community and can call them."

This really has been a win-win situation, she continues. For the employer, these providers function as informal consultants. The benefit for the provider is financial. "They tend to have very little money," Younger Urban explains, "And we encouraged these Harman facilities to support them through employee drives that collect food and clothing. It's an ongoing collaboration."

### Policy is critical

Another critically important piece was a new company policy on domestic abuse, which was part of the employee training about domestic violence. "We included workplace violence risk, but we went beyond that to the needs of people being abused who come to work," Younger Urban observes. "They are much like people with life-threatening illnesses or disability; for some period of time, they are not able to function as fully as they'd like, and they need resources for help."

In light of this vision, the policy went beyond safety and security to how to reach out to help people, and how to address presenteeism. "This *had* to be our foundation," Younger Urban notes. "It sends a message of strong corporate support."

The program, she continues, was highly successful first and foremost because the company was so committed. "I've measured [employee] attitude change before [at other workplaces] and seen a slight shift, but in this one, it was statistically significant — from less positive to more positive attitudes," she says.

"We had employees who had lived through domestic violence and through this program became stronger," she reports. "They found a way out, and said they now wanted to help others. They became some very supportive partners in the training process."

The Harman experience can be duplicated by any company, Younger Urban asserts. "The fund has done a lot of work in this area; I helped them create training manuals that can be adapted to different workplaces." This includes a training manual on developing best practices, for which she served as lead author. The evaluation of the project is available at www.endabuse.org (click the workplace program button). ■

### Need More Information?


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# Dollars and sense: Making a case for ergonomics

*Managers respond to bottom-line presentation*

Are you comfortable talking about "return on investment"? How about "loss run analysis"? Those business concepts may sound like someone else's job. But if you talk the language of the hospital's financial officers, you may win unprecedented support for your ergonomics program.

That was the approach taken by **Lori Zinnecker**, OTR/L, ergonomics specialist in the safety management department at Northwestern Memorial Hospital in Chicago. "You have to know what your

problem is and the direction you're heading. Then you need to know how to justify and present your case to upper management."

Zinnecker used consultants such as ErgoLogix of Portland, OR, to analyze the cost of back injuries. The basic information used to calculate costs, called a "loss run," is available from the hospital's risk management department.

"What we do is help them figure out exactly how much money they've spent over the last three years on workers' compensation claims for musculoskeletal injuries," says **Ken Aebi**, ErgoLogix managing director.

"We use three years of the most recent workers' compensation loss runs. We then calculate how much will be spent on lift and transfer injuries over the next three years if no action is taken to mitigate the risk, such as the purchase of lifting equipment," he notes.

The consultants also calculate how much could be spent on equipment, with the cost offset by the reduction in workers compensation claims. Ergonomics could reduce that cost by as much as 70%, Aebi says. "It's a very simple, straightforward, and unequivocal analysis"

The insurance loss runs contain information about each workers' compensation claim: the employee's name, the date and cause of injury, and the total amount spent on the claim.

Workers' compensation information is not covered by the Health Insurance Portability and Accountability Act, therefore, there are no privacy issues related to gathering and sharing the information.

### Details may be sketchy

Sometimes, the loss run may have only general information about the claim, and the employee health professional will need to fill in the blanks. Was it a lifting injury in materials management or patient handling? For your analysis, you would want to look at those separately, Aebi notes.

"What you quickly figure out in most hospitals, the cost of lift and transfer injuries run between 40% and 60% of the money being spent on workers' comp costs. It just jumps out at you." Yet most top administrators haven't seen those numbers. "It's a surprise to them when they see it," he explains.

"I've yet to see a [chief financial officer] look at these numbers and just pass them off. They are aghast at what [workers' comp] money has already been spent," Aebi points out.

After determining the costs, Zinnecker needed to set some goals. She needed to figure out how long hospital administrators could expect it to take before they would see a return on their investment in ergonomic equipment. She also considered other related costs.

"If you're going to reduce your lost or restricted days, it is helpful to turn them into a money value," she says. "As you're writing your goals, you want to make sure your return on investment is going to neutralize out pretty quickly."

### Assessing needs on the front lines

Meanwhile, as Zinnecker developed her proposal for the hospital administration, she also worked with frontline health care workers in the units.

She conducted physical demands assessments to determine the ergonomic hazards. Using forms developed by the Patient Safety Center at the James A. Haley Veterans Hospital in Tampa, FL, she asked employees to describe and rank the difficulty of their daily activities.

Employees were involved as she began to evaluate equipment. She set up an equipment fair with vendors and invited employees to check out the equipment. They filled out questionnaires and commented on the features they preferred.

They provided feedback after working with equipment for a 90-day trial period. "You have to incorporate employees when you're making these recommendations," she says. "You don't want to bring in equipment and have no one using it."

With a multidisciplinary task force that included infection control, materials management, and biomedical engineering, she thought through the logistical issues of storing and maintaining the equipment, Zinnecker adds.

"How do you make sure the slings are cleaned? What are the infection control protocols you're going to have in place? We had everybody from employee level to manager level on our task force

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[to consider those issues]," she says.

The financial analysis — along with the physical demands assessment, unit profile, patient handling equipment inventory, and employee feedback assessments — can be conducted in-house or with the help of vendors. The key is to get buy-in from all levels at the hospital, Zinnecker adds. "It comes down to two things. One is justifying the cost. The other is changing the culture." ■

# Team nursing improves staff morale, patient care

*Teamwork improves employee retention*

Do you want to increase satisfaction scores, improve patient care, and boost staff retention all in one shot? Consider switching to a team model of nursing.

"There is a growing trend toward team or zone nursing," reports **Lisa DiMarco,** RN, BSN, MBA, CEN, administrative director for emergency services at Edward Hospital in Naperville, IL. Morale of nursing staff has improved dramatically since the team model went into effect in August 2000, she reports.

If you are planning to switch to team nursing, consider these significant benefits:

• **Nurses help one another more readily.**

Previously, attitudes such as "it's not my patient" were all too common, says DiMarco.

With the team model, if a nurse is caring for a trauma patient while assigned to two other patients, another nurse automatically steps in to cover these rooms for them.

Nurses are more eager to assist their peers without being asked, says **Randy Schmidt**, RN, charge nurse for the ED. "Often, you will hear a nurse say 'I'll take that patient,' only to hear another nurse say, 'No, I can take them, you already have three,'" he says.

Now, every nurse knows at least something about all the patients, says Schmidt. "This makes it easier to assist a patient or answer questions when you might not be their primary nurse," he adds. "Assistance is generally acknowledged with a sincere thank you, which is in itself a great morale booster."

• **Employee satisfaction scores increase.**

Staff satisfaction is measured by South Bend, IN-based Press Ganey Associates every other year, and an internal survey tool is used during the off years, says DiMarco.

"After we get the results, we sit down and have sessions with staff to talk about problems," she says.

Employee satisfaction ratings for the 2002-2003 year scored in the 58th percentile, a significant increase from two years earlier when it was in the 22nd percentile, reports DiMarco, who attributes this to the team nursing model being implemented.

However, about 10% of nurses still are resistant to the team model, DiMarco acknowledges. "You will always have a handful that never will buy into this, and they do create a lot of stress for the group," she says.

To combat this, insist that resistant nurses be included in any decision-making process, advises DiMarco.

"They are not allowed to just complain. If they are going to complain, they have to give a suggestion to fix it," she says.

For instance, several nurses complained about doing the lion's share of the workload, and were told to share their concerns directly with their colleagues. "Their tendency is to avoid confrontation and just complain to the management. But we just keep sending them back to the team," DiMarco explains.

• **The system provides additional mentoring opportunities.**

The team concept pairs expert nurses with novice nurses, says DiMarco. "The thing we were most surprised about was that retention is so much better," she says. "I believe that speaks to the mentoring atmosphere of the team model."

Previously, if a novice nurse needed help but didn't go out of her way to ask, experienced

## Need More Information?


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nurses weren't necessarily going to jump in and offer assistance, says DiMarco.

Now it is much easier for new nurses, interns, and transitional nurses to approach more experienced nurses, says DiMarco. "The preceptors are typically assigned to a new hire and follow that person's schedule," she explains.

Having the correct skill mix on each team is key to success, says DiMarco.

"The nurse manager does the scheduling and considers individual unit clerks, technicians, nurses, and doctors to make sure there is the right combination of skill mix on the team," she points out.

Many of the less experienced nurses have gained significantly in self-confidence, patient care skills, and efficiency, notes Schmidt.

"They have been less hesitant to ask questions, and the more experienced nurses have been less reluctant to offer assistance," he says. ■

# How likely are staff to misidentify patients?

*JCAHO calling for two patient identifiers*

If asked, "How do you ensure patients are not mistakenly identified before medications are given?" during an accreditation survey, would every nurse in your facility be able to answer the question?

During your next survey, you'll need to show compliance with the requirement for two patient identifiers whenever medications or blood products are given and whenever blood samples and other specimens are brought for clinical testing.

The requirement is a national patient safety goal from the Joint Commission on Accreditation of Healthcare Organizations.

Surveyors probably will ask staff about patient identifiers, says **Kathleen Catalano**, director of regulatory compliance for Provider HealthNet Services in Addison, TX. "They will then observe the care given to see if staff adhere to policy."

To comply, use the following practices:

**• Use acceptable identifiers.**

According to the Joint Commission, the intent of the two identifiers is twofold: first, to verify the correct patient for the intended procedure and second, to match the service or treatment to that patient. The two patient-specific identifiers must be directly associated with the patient, and the same two identifiers must be directly associated with the medication, blood products, or specimen tube.

Acceptable identifiers are the patient's name, an assigned identification number, telephone number, or other person-specific identifier such as age or Social Security number. Bar-coding that includes two or more person-specific identifiers is acceptable, but patient room numbers cannot be used.

"The patient's armband can be used if it has two to three identifiers such as patient name, account number, age, and medical record number," says Catalano.[1]

At New Britain (CT) General Hospital, prior to registration, the patient's name and date of birth are used as identifiers, and after registration, name and medical record number are used, reports **Robert G. Flade**, RN, director of the ED.

**• Get information directly from the patient when possible.**

"We are using the birth date and the Social Security Number as identifiers. We have the patient identify themselves and give us the information if able, in addition to checking the identification bracelet," says **Kathie Carlson**, RN, MSN, CEN, ED manager at Sentara CarePlex Hospital in Hampton, VA.

When the patient is awake and alert, a verbal response as to who they are will work as one identifier, explains Carlson. "I personally like to ask the patient to tell me their name and Social Security and birth date," she points out.

If the patient is comatose, Carlson recommends using the information contained on the armband or barcode and having family members identify the patient if they are present.

If an unidentified patient is unresponsive and unable to communicate, use identifiers such as the temporary name assigned, and an account number or medical record number, Catalano advises.

"These same identifiers should be matched against specimen labels, medications ordered, or blood product labels," she says.

**• Address any problems with electronic documentation.**

At Sentara CarePlex's ED, electronic charting is used. "Our only problem currently is that we do not have two identifiers on our discharge instructions which are part of the medical record. Currently, only the patient's name is on there," says Carlson.

The vendor is fixing the problem, but meanwhile, a patient label is placed on the discharge instructions containing all the information on the patient's armband, to comply with the two-identifier requirement, she explains.

**• Make identifiers accessible if the patient's chart is unavailable.**

"One of the biggest concerns is that nurses also must bring the paperwork into the room with the medication," says Flade.

The facility is planning to switch to paperless charting in about two years, but currently uses paper charts, he explains. "So if the physician should happen to have the chart, the nurse cannot do treatments such as starting intravenous lines or administering medications without a piece of paper with the patient's name and date of birth," says Flade.

To address this problem, nurses use labels that are printed with the patient's name and medical record number, he reports.

**• Consider using three identifiers**.

"We do use three identifiers to identify patients," says Carlson. "This is done for all lab tests."

The specimen is left in the patient's room, and the person who does the collection initials the label that this is the correct patient by looking at the armband and speaking to the patient if possible, explains Carlson. A second staff member then comes in, if not already in the room, and does an independent second check.

"In our system, a label is printed for each specimen required, so all labels must be matched to the armband and patient interview," she says.

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The three identifiers are name, medical record number, and birth date or Social Security number, says Carlson.

By using the new identification process, the staff have discovered incorrect birthdates and the wrong Social Security numbers such as the husbands instead of the wife's, she reports.

"We interact with the patient when possible, to elicit information directly from them," Carlson notes.

"We are very careful because we want to avoid 'mis-IDs.' We just want to be cautious to make sure it is the right patient for the right test."

## Reference


1. Joint Commission on Accreditation of Healthcare Organizations. 2004 National Patient Safety Goals — FAQs. Updated 3/9/04. Web: www.jcaho.org/accredited+organizations/patient+safety/04+npsg/04_faqs.htm#goal1. ■