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No-shows, cancellations demand look at facility, staff, and access

The problem isn't always with the patient, clinics find

When patients don't show up for their appointments, the natural first step for many practices is to penalize the patient. But the problem might not lie with the patient, and if it doesn't, charging the patient a missed-appointment fee or kicking him or her off the patient roster won't improve the clinic's no-show and cancellation rate.

"First of all, you can't relate the no-show rate to the [quality of] the practice," says **James E. Glinn Sr.**, PT, a practicing therapist whose consulting firm, FutureRehab LLC of Bakersfield, CA, specializes in practice development and has extensively studied no-show and cancellation rates. "I've seen practices with great therapists with terrible no-show rates, and practices that I would say are only moderate with very low no-show and cancellation rates."

Glinn started asking his focus groups and seminar participants what the three primary factors were that drive patients to their practices, and the top three boiled down to what he now calls the Triple A's: ability of the staff, access for the patient, and atmosphere of the clinic.

When he tried to get the therapists and managers he worked with to name one of the three that was most important, they couldn't. Excellent therapy, for example, could be undermined by lack of convenience or an unwelcoming atmosphere.

"And I think then I realized how mediocre therapists could excel in their practice, by allowing patients to come in when they wanted and having a friendly, warm atmosphere," Glinn says.

But when does the no-show and cancellation rate signal a problem? Glinn says he has found that if a clinic's rate of nonarrivals borders on or exceeds 10%, it's time to take a hard look at what is causing patients to not come in. Cancellation and no-show rates can't be eliminated entirely, of course, but Glinn says they can be addressed successfully, and the two types of nonarrivals should be examined independently.

There are four sets of data that practices should look at to determine how they are faring in terms of no-shows and cancellations:

- average weekly combined no-show and cancellation rate;
- average weekly no-show rate;
- average weekly cancellation rate;
- average weekly percentage of no-shows and cancellations who reschedule and then arrive for the rescheduled appointments.

He says a struggling practice typically will have a no-show rate that is higher than its cancellation rate.

"It's one thing to call and cancel because the patient can't make it in," he says. "It's another to not respect the practice enough to even call."

Glinn says when practices first start tracking their no-shows and cancellations, they might find them to be in the 14% to 16% range. As soon as they start offering incentives to the front-desk and therapy staff, that figure is likely to drop quickly. "The internal marketing [of a practice] is real important; and if that's not there, if your staff aren't motivated, your arrival rates aren't going to improve," he points out.

As far as which one of the Triple A's a practice should examine if it wants to lower its cancellation and no-show rates, Glinn says it depends on the practice.

"With a large rehab center, if staff aren't motivated, then the problem is the atmosphere and access; they're more interested in their own schedules than in the patients' schedules," he says. "Private practices generally beat up on the larger continuums by accommodating patients and being more friendly, because there's more incentive for smaller practices to see those patients."

A practice that aggressively tracks its no-shows and cancellations and then addresses the internal problems that contribute to the high rates can see its weekly average fall to as low as 3% to 4%, Glinn explains.

He commonly hears that practices blame poor patient arrival rates on cultural or societal causes, but he doesn't agree with that view. "You'll hear in rural areas, patients won't come in on Fridays, or in some urban areas, they won't come in the morning," Glinn notes. "That's nonsense. It's an internal problem, not a patient problem."

Motivating the staff is key to improving patient arrival rates, but Glinn says money isn't always the answer. Examining how much voice staff members have in the practice or in scheduling might be one tool, he says. Because patients have more choice now than they did several years ago, drawing on staff input to develop creative ways to make a practice more accessible, able, and attractive to the patient can result in improvements, Glinn adds.

Staff should be educated about what are acceptable rates for cancellations and no-shows. Rewards for rates falling below a set percentage can be as simple as recognition for a job well done to gifts or cash bonuses.

Staff members who have a negative impact on the practice because they lack the desire to make their jobs a priority should be addressed with training or, if that does not correct the problem, reduced hours or termination.

Note whether no-shows and cancellations took an upturn upon the hiring or firing of a particular staff member, or if rates rise or fall on days that

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specific front-desk staff members or therapists are present or absent. These indicators can signal areas for improvement in troublesome employees or for recognizing staff members who encourage patient arrivals.

It's always good practice for therapists to foster a sense of partnership with their patients, emphasizing the importance of adhering to a physical therapy schedule and the role of the patient as an equal in the relationship, Glinn points out. Success or failure in this effort can be evident in an individual clinician's patient arrival rates.

What you can do

When faced with a no-show and cancellation rate problem, there are basic steps practices can follow:

- Call the patient once or twice before the appointment as a reminder.
- Call patients who miss appointments to let them know they've missed.
- Have the therapist call the patient personally to discuss concerns over the effects of missing therapy.
- Penalize the patient with a charge for a no-show.

"At first, practices I work with immediately want to penalize the patient," Glinn says. "But if you look at the three A's, you can show them a weak area [in their practice], and they can usually see that the problem is internal."

But practices often will penalize the patient anyway, he says.

"The problem with that is that it makes patients and referral sources mad," Glinn notes. "I think a better approach is to let the patient know that [the option to charge them a fee] is there, but that you're going to forgive it. You build good will with the public and your patients."

In the case of workers' compensation patients, a reminder that missed appointments are reported to the patients' physicians and their case managers can be an encouragement to meet appointments.

Glinn reminds practices that he consults with that their patients are their No. 1 referral source. "Of course, there's the fact that people have less time for physical therapy," he adds. "Everyone's multitasking. Do you want to make them mad by charging them for forgetting?"

In addition, there are some limitations on imposing fees for no-shows. Insurers will not pay fees for missed appointments, so the practice is forced to collect directly from the patient, which, in some cases, may be difficult. Some insurance contracts specifically prohibit charging no-show fees. Finally, Medicaid forbids clinicians from charging its patients for missed appointments.

Glinn offers some suggestions for what to say to patients who miss appointments. He suggests calling the patient within 15 minutes of the missed appointment, and if he or she answers the phone, asking if the patient would like to come in at that time. If there is no answer, phone messages should be left at any phone numbers in the patient's record (home, cell, work), and if the patient's e-mail address is known, an e-mail should be sent.

Glinn says the patient should be called at least five times to reschedule before he or she is discharged as a patient, and the patient's therapist should personally make some of the calls.

Sandra Lloyd, outpatient clinic manager for The Institute for Rehabilitation and Research (TIRR) in Houston, says the patient-practitioner relationship is a critical factor in whether a patient is likely to keep his or her appointments. "There are some [therapists] who patients would not dare miss appointments with," she says.

TIRR uses a two-call reminder process prior to appointments, and Lloyd says her clinics have seen positive results because it gives patients additional notice and reminders that they have appointments coming up.

"It's important because so many physical therapy patients rely on others for their transportation," she points out. "Transportation is absolutely key to getting them in for their appointments."

Another step TIRR took was to put some staff on flex time so that they could work in the evenings, to call patients' homes at a time when they could speak with the caregiver or parent of the patient rather than just the patient. This gives one more opportunity to work out any scheduling or transportation problems prior to the actual day of the appointment.

In areas where patient populations include

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those who don't speak English fluently, leaving phone messages in English won't help much. Some centers have found that hiring bilingual staff or employing part-time staff fluent in their region's prevalent second language to make reminder calls has significantly improved no-show rates among those patients.

Large centers with hundreds of reminder calls to make each week often rely on telephony systems to automatically dial and leave recorded messages for patients with upcoming appointments. While detractors say the recorded calls are too impersonal, advocates of the systems have reported significant increases in their patient arrival rates.

Information on telephony systems may be obtained from several companies, including TeleVox (www.televox.com); iVoice (www.ivoice.com); PhoneTree (www.phonetree.com); and JulySoft (www.julysoft.com). ■

Electrical stimulation therapy gives hope

Improved speech an unexpected benefit

A noninvasive therapy involving electrical stimulation is showing promising results in patients who suffer from dysphagia, or difficulty swallowing.

Dysphagia can be the result of a stroke, traumatic brain injury, cerebral palsy, cancer, Parkinson's or Lou Gehrig's disease, polio, or other degenerative or muscular conditions. Not only are tube feeding and the inability to swallow disheartening to patients and therapists, but complications such as pneumonia send thousands of patients to the hospital each year.

According to **Manuela Corfar**, MA, CCC, speech pathologist at St. Jude Hospital in Fullerton, CA, a relatively new therapy has shown quick, positive results in some of her patients.

"We have had quite good results with it," she explains. "We have had patients, either stroke patients or post-polio syndrome patients, in whom we've been happy with the results."

Approved by the FDA in 2003, the neuromuscular electrical stimulation system [VitalStim, Chattanooga (TN) Group] uses surface electrodes to stimulate inactive swallowing musculature. During therapy, functional muscle-use patterns are created or relearned to initiate or reestablish swallowing.

Corfar describes a stroke patient who came to her department as an inpatient on a nasogastric tube, received the electrical stimulation therapy, and within two weeks was discharged home on a soft diet.

Electrical stimulation therapy is not new, and it's used in several other conditions and for many other purposes. Some uses are invasive, while others are not, and researchers are steadily testing other uses for electrical stimulation of muscles and nerves.

A team at the University of Illinois at Chicago (UIC) is testing an implanted electronic device that could bring relief to patients who suffer chronic lower back pain, a common impediment to recovery. The device, already approved by the FDA, functions like a cardiac pacemaker, according to **Konstantin Slavin**, MD, assistant professor of neurosurgery at the UIC College of Medicine.

Slavin says the prevalence of chronic pain, and the extent to which it can cause disability, drives the need to research potential treatments, and in some patients, use of electrical stimulation can increase normal activities and reduce the need for medications.

But electricity is a tool that requires special care in administering, just like a drug, Corfar says.

"The good news is that the company [that sells the VitalStim device] does it in a very controlled way," she says. "You don't just order it, get it, and use it. You have to be certified to use it."

The device is calibrated for specific uses by physical therapists, occupational therapists, and speech therapists; and its settings are fixed, so that the only adjustment therapists can make during use is to change the intensity at which the current is delivered.

According to Corfar, the unit is FDA-approved only for treating patients with swallowing disorders, but there have been reports of other benefits. "There are incidental reports that patients who have lost speech capabilities have gained increased vocal intensity [as a result of the therapy]," she explains. "And that makes sense, when you look at it, because you're stimulating the area around the larynx."

Corfar says St. Jude has experienced no difficulties in getting insurance coverage for treatment using the electrical stimulation unit, though she has heard reports from other centers that have encountered resistance.

Not all dysphagia patients will benefit from the

electrical stimulation therapy, but good results in patients with stroke, post-polio syndrome, cerebrovascular accidents, cancer, and head injuries have made believers out of the staff at St. Jude-Fullerton, she notes.

"We had a patient with post-polio syndrome who has been battling swallowing for 50 years, and has been admitted several times with pneumonia," she says. "He had six sessions and was able to take a regular diet and thin liquids; and in six months, I don't believe he's been back."

The number of therapy sessions required depends on the patient and the severity of the dysphagia, Corfar explains. Some patients with stroke or head injuries show improvement after just a few sessions. For other patients, particularly those with chronic or degenerative conditions, it's too early to tell.

"In cases with patients with progressive diseases, sometimes it is necessary to come back [following the initial series of sessions] to get a few — two or four — tune-up treatments," she says. "But since we've been using the device for less than a year, I really can't state specifics."

One aspect of the treatment Corfar is watching carefully is research into training able family members of patients who need ongoing therapy to do the stimulation therapy at home. "The family would lease the device and administer the treatment under the supervision of a speech pathologist," she says.

Appropriate selection of patients who receive electrical stimulation therapy is important, adds Corfar, because it won't work for all forms of dysphagia.

But among the patients who have had some of the best results are children with congenital syndromes or cerebral palsy. "It really makes a huge difference, when it works, in the quality of life for the patients," she says. ■

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Hospital gets close to zero — in WC claims

With lifts, workers comp drops by 98%

Ceiling lifts save backs. That is what Salina (KS) Regional Medical Center concluded, and the investment paid off.

After installing tracks throughout the hospital, in patient rooms and some hallways, with 138 lifts, the hospital saw its workers' compensation costs related to patient handling drop from $213,000 to $5,279 — a reduction of 98%.

Average lost workdays dropped from 17 in 2001 to zero in 2003. Average restricted workdays declined from 22.3 in 2001 to 7.8 in 2003. "It certainly has improved the life of our employees," explains **Barb Herrman**, RN, employee health coordinator.

The Salina experience showed "how you can save money by doing the right thing," says **Esther Carlson**, MSN, ARNP, BC, FNP, a cardiovascular advanced practice nurse who was involved in researching and developing the program.

Patient handling incidents were causing one or two life-altering injuries each year, with nurses who could no longer work. For example, one nurse injured a disc, required back surgery, and was permanently disabled.

An ergonomics equipment vendor provided an analysis of ceiling lifts at no charge to the hospital. It reported that nurses performed an average of 14.4 lifts per day at an average weight of 173 pounds. Research supported the use of ceiling lifts to reduce injuries, Carlson explains. So did the hospital's own experience, where floor lifts often languished unused in storage areas. It was too difficult and time-consuming for nurses to retrieve those lifts, she says. "We weren't going to throw money away on something that wasn't going to work."

Carlson couldn't find an example of a hospital that used ceiling lifts throughout the facility. Salina Regional was convinced that was the only way to make a difference.

"The answer is to put a lift in every room, and then look at changing practice," explains **Jane**

Criteria for Ceiling Lifts

These are the criteria used by Salina (KS) Regional Medical Center when the hospital evaluated ceiling lift systems:

- ✔ Automatic stop if lift is too high or too low
- ✔ Emergency stop
- ✔ Sling base safety latches
- ✔ Quick release capability
- ✔ Meets International Organization for Standardizations standards
- ✔ 400- and 800-pound lift units
- ✔ Slings in small to extra large sizes
- ✔ Walking slings
- ✔ Hours of on-site training
- ✔ H design with exposed mounting leg support (offers most flexibility)

Wahlgren, RN, MA, vice president of patient care services. "It won't be any good to put them in half the rooms because half the patients won't be in those rooms."

Salina spent $450,000 on the ceiling-lift system. The hospital's board of trustees was willing to make a major investment in lifts to stop the costly and debilitating back injuries.

Getting the right lift was crucial and so was employee buy-in. Salina developed a multidisciplinary task force, including floor nurses, and the team created a list of criteria for the equipment. The lifts should have an automatic stop to keep the slings from going too high or too low and an emergency stop, the hospital decided. They should have slings that could hold at least 400 pounds and some that would hold at least 800 pounds. The H design for the tracks would allow the lifts to move in multiple directions in the rooms. (Some patient rooms have C-shaped tracks.)

Salina narrowed the choices from six vendors to three, then conducted pilot tests. The vendors installed tracks for the evaluation. The hospital's board of trustees chose Wy'East Medical in Clackamas, OR (www.wyeastmed.com).

Based on published research on ceiling-mounted lifts in nursing homes, the hospital expected to recoup its investment within 2½ to four years.

The hospital then began a training program with the ultimate goal of creating a no-lift workplace. Wy'East provided 11 days of training, available for all shifts. Salina's challenge was to incorporate the lifts into daily practice.

One nurse suffered a serious shoulder injury shortly after the lifts were installed. The workers' compensation committee asked her to explain why she hadn't used the lift. "This is to save your life and not just your nursing practice," Wahlgren told the nurses. "That is probably what began to resonate."

Salina wanted the nurses to sign a no-lift commitment, but the nurses wanted more guidance on when to use the lifts. After some additional research, Carlson and her colleagues created a needs assessment and flowchart. It asks simple questions about whether a patient can bear partial or full weight, or how cooperative the patient is.

"You have to change the way people practice," Wahlgren points out. "You have to incorporate it into orientation. You have to have an assessment tool, so nurses assess the need for a lift. If a patient meets the criteria, the nurse has to use the lift. It's not really optional. The goal is to reduce injuries."

Salina continues to look for other interventions to reduce patient-handling injuries. For example, the hospital is purchasing air-based lateral transfer devices, such as the Hover Matt.

The lift system has greater potential, as well. Walking slings allow patients to be hooked to tracks in the hallway in the orthopedic and rehabilitation units, so they can be ambulatory but protected from falling. The hospital also is testing the use of slings to reposition patients in bed — a significant cause of patient-handling injuries nationally. Based on feedback from nurses, the hospital adapted its policy to allow minimal lifts for those patients who can assist.

"We continue to investigate each [injury] as it occurs, to see what we can do to prevent it from happening again," Herrman says. ■

Long hours may lead to injuries, poor health

NIOSH reviews studies on work schedule

Long hours and overtime are linked to higher injury rates, more frequent illnesses, and even increased mortality, according to a review of 52 published research reports by the National Institute for Occupational Safety and Health (NIOSH).

The health effects were magnified when shifts of 12 hours or longer were combined with a work week of more than 40 hours. For example, two

studies of physicians who worked very long shifts reported a decline in cognitive performance.[1] Although the review was not limited to health care, 19 of the studies were conducted in the health care arena.

This NIOSH review adds to the findings of a 2003 Institute of Medicine report, which recommended restricting nurses from working more than 12 hours at time or more than 60 hours in a week to prevent error-producing fatigue. While the IOM focused on patient safety, the NIOSH study relates overtime and long hours to worker health.

The relationship between work schedule and worker health is a complex one, says **Claire Caruso**, PhD, RN, a NIOSH research health scientist based in Cincinnati and an author of the report. "When you have a combination of several demanding work characteristics together, it seemed to produce more consistently negative outcomes," she says.

For example, working night shift or rotating shifts adds to the burden if someone also had long shifts with mandatory overtime, adds Caruso. "There's an issue about the pattern of workdays to rest days. Are you working seven 12-hour shifts in a row and then you've got four days off . . . or are there interspersed short runs of workdays?"

8- or 12-hour shifts?

Having time to rest improves function and health outcomes, she says. Yet researchers still have much to learn about how longer shifts affect worker health, she says.

One study linked shifts of 12 or more hours to increased risk of back disorders for nurses, compared with those who worked an 8-hour shift. The combination of 12-hour shifts and 40 or more hours of work per week also was associated with greater risk for neck, shoulder, and back disorders compared with nurses who worked five 8-hour days.[2]

"Are 8-hour shifts better, or are 12-hour shifts better? We don't have a clear-cut answer to that," says Caruso. "One of the problems is that the studies often don't give us enough details about the work schedules."

Overtime is a research area that is just gaining more attention, she notes. In a handful of studies, overtime was linked to "unhealthy weight gain," increased smoking and alcohol use, and poorer neuropsychological test performance.

Yet there are far fewer studies on the effects of overtime than on other work schedules, such as night shifts and rotating shifts, says Caruso. She is midway through a comprehensive study that will use overtime diaries and sleep/activity diaries to track the work life of nurses.

The study will include information on demographics, home environment, child care, second jobs, elder care, educational courses, health history, medications, the family's health history, and sleep characteristics, she says.

"Coping styles probably influence how people respond to these work schedules," she says.

Nursing shortages have led to increased pressure on nurses to work overtime. The American Nurses Association (ANA) has lobbied for state and federal legislation to restrict mandatory overtime for nurses.

A number of states have responded. For example, a new West Virginia law prohibits hospitals from mandating nurses to accept an assignment of overtime. In Connecticut, hospitals may not require a nurse to work more than a predetermined scheduled work shift except in certain circumstances, such as a public health emergency.

In Oregon, nurses may not be required to work more than two hours beyond a regularly scheduled shift or 16 hours in a 24-hour time period.

"We've always been concerned about overtime and its implications for patients. Our concern has broadened also to consider the implications for nurses and other health professionals in terms of health and safety," says **Katherine Kany**, RN, of the ANA's Department of Nursing Practice and Policy.

Studies will shed light on how much a person can work safely, she says. "We have people working 12 hours [in a shift], anyway. You keep them overtime for even half a shift, and that's 18 hours. I've actually talked to nurses who worked 20 hours in critical care areas.

"The reality is that people are working way too long," Kany adds. "There are implications for patients and implications for health care workers."

References

1. Caruso CC, Hitchcock EM, Dick RB, et al. *Overtime and Extended Work Shifts: Recent Findings on Illnesses, Injuries, and Health Behaviors.* Cincinnati: National Institute for Occupational Safety and Health (Publication No. 2004-143); 2004.

2. Lipscomb JA, Trinkoff AM, Geiger-Brown J, et al. Work-schedule characteristics and reported musculoskeletal disorders of registered nurses. *Scand J Work Environ Health* 2002; 6:394-401. ■

Finish to-do list for HIPAA security rule

Check faxing, log-in practices

If planning isn't already under way, the time is now for your hospital to get ready for implementation of the Health Insurance Portability and Accountability Act's (HIPAA) security rule, which takes effect April 21, 2005. And although the rule doesn't apply as specifically to access departments as does the HIPAA privacy standard, there is definitely an access to-do list, say those leading the preparation effort.

The privacy rule, which became effective April 14, 2003, had more impact on day-to-day access operations because, among other things, access personnel were on the front lines, handing out the notice of privacy to patients, notes **Rita Aikins**, MBA, CHS, system director, privacy and information security, for Providence Health System's West Coast hospitals.

But she adds that if access departments are using systems that don't have unique log-ins and passwords for each individual, "whoever is managing the department will have to figure out what to do about that" as part of the security rule implementation.

Providence began doing away with generic log-ins "years and years ago because we didn't think it was good practice," Aikins says.

However, there are many hospitals that have not taken that step.

Access managers also need to conduct a departmental analysis, she says, to look at issues such as how they handle the faxing and photocopying of protected health information.

Meanwhile, a report released at the end of April by URAC, a health care accreditation organization, recommended that hospitals begin preparing immediately for security rule implementation, suggesting that most security risk management programs can take up to a year to fully implement.

That report said key challenges encountered by the sample of health care organizations studied included incomplete or inappropriately scoped risk-analysis efforts; incomplete or poorly executed risk management strategies, limited or faulty review of information system activity, and ineffective security incident reporting and response.

The American Hospital Association reports it is working with the consulting firms Ernst & Young and Computer Associates to provide hospitals with additional resources to help jump-start their security efforts.

Providence Health System is "right in the middle of the pack" in terms of its security rule preparation, says Aikins. "What's on everyone's mind is getting the risk assessment done. Once that's done, we can figure out the workload and the cost."

Providence began its risk assessment — "a very complex" process — in September 2003, she notes. "The complexity of it [means that] you have to look at every computer system that stores or uses electronic protected health information [EPHI], and there's not a good inventory to work with. We're trying to create an inventory as we go along, trying to reach compliance."

In addition to the systems that information systems support, Aikins points out, there are "departmental systems and access databases that departments have created, and they're all covered under the security standard if they have EPHI in them. That's my opinion as to what makes the security rule more complex — this identifying, fact-finding, analytical phase you have to go through before you do anything."

With the privacy standard, on the other hand, "when you read it, you knew what to do here, here, and here," she adds.

Aikins says she has the gap analysis — an accounting of issues the risk assessment has indicated need to be addressed — for the health system's Oregon region, but not for the Alaska, Washington, and California facilities.

"The biggest challenge is the audit requirement, because systems will need to set a standard around their auditing," she notes. "The security standard says you have to audit, but doesn't tell you how often or what to look at, and it says you have to have a sanction policy."

One concern is that the policies must be consistent throughout the organization, Aikins points out. "For us, we don't want California to say, 'We're going to audit this way,' and then another state say, 'That's too much work. We won't audit that way.'"

Aikins says she puts the various systems at Providence into three categories, defining what each category should include, and how stringent the auditing practice should be for each:

- **Category I** includes the main hospital information system, with all registration, admission and transfer functions, the order-entry system,

and the electronic medical record, if there is one.

• **Category II** includes systems to which only a single department has access, such as a laboratory system, Aikins adds. "It will still require auditing, but not as stringently, because only a small percentage of people have access."

• **Category III** includes systems with "small applications, few users, and smaller data repositories," she says. "This might be a database that someone created that has three users in the department, or a database that tracks mammograms and sends reminders when a woman needs to come back."

All categories will be audited, Aikins adds, but with Category I, the auditing will be proactive, and with II and III it will be done only for cause.

"Auditing will be labor-intensive," she says, "and we have to be careful that the parameters we put around auditing are realistic. If we set the bar too high, we won't be able to achieve anything."

"Getting one's arms around the [HIPAA security] regulations is challenging," says **Gillian Cappiello**, CHAM, senior director of access and chief privacy officer at Chicago's Swedish Covenant Hospital. "Most hospitals — and Swedish Covenant is no exception — have so many systems and databases that need to be up to snuff. I would have to say that while we are not in panic mode yet. There is much to be done."

The hospital's senior information technology director is "leading the charge," and likely will be named the hospital's chief security officer, says Cappiello. "He is in the process of creating a charter to define the purpose, scope, roles and responsibilities, risks and vulnerability assessments, and processes" for complying with the security standard, she explains.

Swedish Covenant has engaged a consulting firm to do a facilitated risk analysis project (FRAP), and also is using information from the gap analysis and road map developed by another firm during preparation for the privacy standard, she notes. "It was done mostly for the privacy regulations but [also addresses] what was known of the security rule before it was final."

The hospital also is using and updating some of the strategies from its Y2K planning, Cappiello says, "particularly, as they relate to threats or hazards, the risk to security or integrity of data, disaster recovery, backup systems, continuity plans, and business impact assessments and contingencies."

Such initiatives come with a price tag that is likely to be substantial, she suggests. While implementation of the HIPAA privacy standard was "pretty low cost," adds Cappiello, "security is a whole different story. Some of the requirements are going to be more expensive to implement.

"We had difficulty finding a consultant, for the fee we wanted, that could also do the physical plant assessment," she notes, "so that is not included in the FRAP."

Aikins says that until the Providence assessment is completed, she won't know what the cost of preparing for security rule implementation will be. She points out, however, that she expects much of it to be paid from operating dollars.

"I'm not sure some of this [expense] can come out of capital, with the rules around capital dollars having changed," Aikins adds. "There are certain rules for health care organizations as to what qualifies to have capital spent on it."

"If you don't have an audit trail and have to have one created, can you use capital for that? These are the questions people will have to ask and answer," she notes. "The way one organization wants to handle it, another may not. With the current business environment, some have strengthened and tightened up their accounting practices and may say, 'No, we can't spend capital for this.'" ■

Living wills called useless: Power of attorney is better

Living wills don't work and waste your time when you promote them to patients, according to researchers at the University of Michigan (UM) in Ann Arbor. Even aside from what's best for patients, living wills may lull risk managers into a false sense they have avoided potential difficulties by encouraging patients to address them up front, they say.

They base their conclusions on a comprehensive review of hundreds of studies of living wills, end-of-life decisions, and the psychology of making choices.

The authors are taking on a document that has become ingrained in American medical culture that the law of almost every state specifically recognizes, and that hospitals are required by federal law to tell their patients about.

Carl E. Schneider, JD, the Chauncey Stillman Professor of Law at the UM Law School and professor of internal medicine at UM, says living wills don't fail for lack of effort, education, intelligence,

or good will. They fail because of basic traits of human psychology, he says.

For instance, studies show that people have great trouble predicting their own preferences about even simple, everyday things like what snacks they will want or what groceries they will buy next week.

"If they have trouble predicting what is familiar," Schneider asks, "why should we expect them to succeed when they are predicting what they will want in circumstances they have never experienced and can't foretell?"

Conventional wisdom is wrong?

The need for living wills has become conventional wisdom among many health care providers without any proof that they work, Schneider says. The news that living wills don't work may hit hardest at the institutions where risk managers have encouraged more than a perfunctory mention of their availability, the minimum required by the federal Patient Self-Determination Act. Many health care professionals may be surprised to learn that the latest research indicates that trying to get patients to sign living wills is "at the very least, a waste of your time and energy and money."

Schneider and fellow researcher **Angela Fagerlin**, PhD, a research scientist with the UM Medical School and Veterans' Administration Ann Arbor Healthcare System, recently released a study in which they analyzed how living wills actually were used and how much they reduced the end-of-life debates they were intended to address.[1]

Their basic conclusion was that a living will is "a nice idea, but it doesn't work," Schneider says.

The living will, Fagerlin notes, was designed by bioethicists who wanted to give patients a chance to spell out what treatment they would want and what treatment they would reject if they became unconscious or unable to make their own decisions for some other reason. The idea of the living will is to allow people to maintain control even at the end of life, but they have proven to be impractical.

Fagerlin says she thinks most health care professionals would be surprised by just how useless living wills tend to be. "It might not be the best use of a health care provider's limited time to discuss living wills. People want living wills to work, and it seems like they should in an ideal world. So there's some disappointment that they don't."

Fagerlin says there is no evidence that living wills work, yet health care providers spend thousands of dollars every year promoting them to patients, partly because the law requires them to and partly because there is a strong belief that living wills are "the right thing to do."

"Our research might be welcomed by those who already suspected that there were limits to living wills and might be relieved that they don't have to engage in this futile exercise," she says. "It's important to note that this isn't just our opinion, but that it's based on solid research with how living wills are actually used."

A kind of malpractice

Schneider urges others to reconsider how living wills are promoted in their institutions because he says they are, at best, a waste of time. But he goes a step further and suggests that you are doing your patients a disservice by encouraging them to sign something that ultimately will not be useful.

"I do think it is a kind of malpractice to be pretending to patients that these documents are really going to have an effect," he says. "People are making these really serious decisions based on little information, seeing it as just one more form to fill out. And you're telling them that they have addressed a very serious matter when, in fact, they have not."

It is unlikely that patients could find a successful way to sue the provider when a living will does not fulfill its promise, but Schneider says health care professionals are fooling themselves if they think that living wills will help them avoid thorny situations like the Terri Schiavo case in Florida, in which a patient's husband and parents have fought a long legal battle over whether she should be kept alive.

Courts are reluctant to uphold living wills when push to comes to shove, and largely for good reason, Schneider says.

"The courts recognize that the document was signed before the patient was in the current state and before they could even understand what specific issues are being contested," he says. "Courts are likely to say that the living will is not legally binding."

Fagerlin notes that a living will would not have made any difference at all in the Schiavo case, yet the media were suggesting that it was a good example of why everyone should have a living will. In the Schiavo case, the dispute centers on exactly what the patient's condition is, a question that is not answered in a living will.

"But if she had had a durable power of attorney saying she wanted a particular person to make that decision for her, then there would be

no conflict," she says. "That is a good example of the usefulness of a durable power of attorney vs. a living will."

Challenging common practice

Schneider says he can imagine circumstances where the living wills may be useful for patients who are facing imminent death, know their medical circumstances, and have strong, specific beliefs about them. But far more often, he says, living wills offer a false promise of control over end-of-life treatment.

The best patients can do, the researchers argue, is to use a durable power of attorney to appoint someone to make decisions for them when they can no longer make their own decisions.

Schneider says the way many health care providers encourage patients to complete living wills is part of the problem. Often, the living will starts as a blank form for patients to fill out in writing, stating their individual preferences. The instructions might suggest that patients write down whether they'd want to be kept on life support machines if they had a catastrophic accident or were terminally ill.

For instance, according to the instructions for the form on the UM Health System web site, a patient could write, "Do whatever is necessary for my comfort, but nothing further," or "I authorize all measures be taken to prolong my life." Patients also can write about their wishes regarding specific medical interventions, such as respirators, cardiopulmonary resuscitation, surgery, and blood transfusions. And they could say how they feel about receiving food and water administered through feeding tubes.

But what do those options really mean? When a living will is called into play, it is very common for family members and others to find room for argument, Schneider says. Is the patient "terminally ill" as required to use the living will? If the doctor says the patient has a 50% chance of living six months, a case can be made on both sides that the patient is or is not terminally ill.

What about pain relief? Does that include inserting a Foley catheter to relieve a full bladder?

"People sign these documents thinking they have made some important decisions, but in reality, they have no way to anticipate the specific circumstances," Schneider says. "You end up with someone saying, 'But he has a living will,' and someone else saying, 'Yeah, but it doesn't apply to this situation here.'"

What to do?

But risk managers cannot just have their staff stop promoting living wills altogether because the Patient Self-Determination Act requires hospitals to tell patients about living wills and other advance directives. Fagerlin and Schneider recommend focusing much more on the alternatives to living wills.

"Durable powers of attorney only require a few simple choices, and they don't differ significantly from the existing system of allowing family members to make medical decisions about incompetent patients," Schneider says. "They also allow the decision maker to use the information about the patient's condition that's available at the time a decision is needed, rather than asking the patient to guess about something far in the future. And they're inexpensive."

Legally, the hospital is relieved of the burden to make decisions for the patient when a durable power of attorney is in play, he notes. The durable power of attorney is legally clear and enforceable — everything a living will is not.

"They're documents that the court understands, and the court can just say yes," Schneider explains. "But when you present them with a living will that has all these vague terms and health care situations the court is unfamiliar with, they often start looking for someone else to make the decision for them, like the bioethics committee. The ball comes right back to you."

The Schiavo case, and many others in which parties fought over end-of-life decisions, could have benefited from a durable power of attorney, Schneider says. That is what elevates a living will from merely useless to potentially dangerous. They are dangerous when they lead patients to stop there and not create the more effective legal document, he says.

"That can lead to sticky legal problems that

hospitals surely want to avoid," he says. "If I were a hospital risk manager thinking about reducing friction between me and my patients, I don't think living wills will do that; whereas, a durable power of attorney can."

Fagerlin advises risk managers to review their policies and procedures to ensure patients are encouraged to complete both a living will and a durable power of attorney. The living will, even if it is not entirely enforceable as a legal document, can help guide the person assigned the durable power of attorney, she says.

Schneider says that if he were a risk manager, he would want the patient to assign decision-making capabilities to one person who can then address those difficult issues with guidance from the health care providers. That way, a patient's end-of-life concerns don't become fodder for academic questions and legal maneuvering.

"I wouldn't want my care and end-of-life decisions to be settled in a meeting of the bioethics committee," he says.

Reference

1. Fagerlin A, Schneider CE. Enough: The failure of the living will. *Hastings Center Report* 2004; 34:30-42. ■

NEWS BRIEF

NIOSH: Healthy lifestyles mean healthy workers

The National Institute for Occupational Safety and Health (NIOSH) plans to launch a new national initiative this fall called "Steps to a HealthierUS Workforce," aimed at integrating worker healthy lifestyle promotion with the NIOSH mission of protecting and improving working conditions and work environment.

NIOSH, along with several co-sponsors, will convene a three-day symposium on the campus of the George Washington University in Washington, DC, Oct. 26-28, 2004. The initiative recognizes that workers, families, and employers share the goal of wishing to protect, preserve, and improve the health of people at work.

"By bringing together the health promotion and occupational safety and health communities, we are seeking to highlight common interests and develop mutually supportive strategies for research and practice to improve worker health, safety, and well-being," said NIOSH director **John Howard**, MD, in making the announcement.

According to NIOSH, the symposium will:

- **Provide** researchers, policy-makers, practitioners, academics, employers, and labor leaders an opportunity to share their experiences with integrated and coordinated health promotion and protection programs.
- **Assess** the scientific basis for integrated approaches and suggest future directions for relevant research and improved practice.
- **Explore** economic issues related to the interrelationships among work, health, health care needs, and productivity.
- **Highlight** successful programs, practices, and policies of protection and promotion resulting in improved health for people at work.

NIOSH is identifying organizations interested in contributing to this new initiative by participating in agenda development, outreach, and publicity and assisting in follow-up activities. For more about the initiative, e-mail Tanya Headley at theadley@cdc.gov. For additional information, visit the STEPS to a HealthierUS Workforce web site: www.cdc.gov/niosh/steps. ■