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INSIDE

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Doctor Wins Defamation Suit Alleging Improper Peer Review Process

Responding to allegations of physician misbehavior is a challenge. A recent court case holds lessons for what can go wrong when a hospital does not follow best practices or even its own internal policies.

An Indiana jury awarded an OB/GYN $4.75 million in damages from a hospital and medical group in January 2020, responding to claims they treated the physician unfairly after a nurse practitioner accused the physician of smelling of alcohol while on duty.

During a four-day trial, the physician's attorneys argued the nurse practitioner's claim was unproven and the hospital failed to conduct an adequate peer review investigation. The doctor suffered lost compensation, damage to her professional reputation, other expenses, and emotional distress, she claimed.

Testimony during the trial indicated the claim originated on a night shift in 2017. The nurse practitioner reported to hospital administrators on Dec. 12 she had smelled alcohol on the doctor's breath the night before.

The doctor alleged she was not tested for alcohol at that time. Hospital policy requires that in such circumstances, the doctor be assessed immediately, relieved of duty, and undergo blood testing at an external facility, according to trial testimony.

The doctor was not told of the allegation against her until Dec. 13, at which point she questioned why the hospital did not follow its own substance abuse protocol.

Nurse Practitioner Reports

The nurse practitioner first reported the allegation to her supervisor by email, and the supervisor contacted the hospital's chief medical officer. That person met with other administrators and physicians. In this meeting, they discussed previous concerns about drinking by the physician. Other physicians in her practice group had

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suggested in 2015 that she enter an assistance program, the jury heard.

The physician did not enter the assistance program but changed her drinking habits and began seeing a therapist, which yielded improvements in her workplace performance, according to testimony. There was no other documentation of concerns about the doctor's drinking or performance after 2015.

The trial revealed the hospital conducted a preliminary review of the allegation through its peer review process before turning it over to the physician's medical group, which then suspended the doctor with partial pay until she underwent an evaluation for alcohol abuse.

The state medical association referred the physician to an addiction treatment center, where she was diagnosed with alcohol use disorder. To retain her medical license, she was required to enter a treatment program and sign a five-year monitoring contract with the state medical association as a condition of her employment, according to the lawsuit.

The monitoring contract requires the physician undergo a breathalyzer test four times a day for the first year, followed by three times a day for the next four years. In addition, she must undergo random drug screenings; for the first year, she was required to attend four Alcoholics Anonymous meetings a week.

Claims No Due Process

The physician's lawsuit alleged the hospital and practice group did not offer her a hearing before a peer review committee, provide any evidence against her, or allow her to respond to the claim. Like many state statutes, Indiana law requires a physician under investigation be permitted to see peer review committee records and be allowed to appear before the peer review committee. The physician's rebuttal has to be included in the record before any decision is made by the committee.

The physician sued the hospital and her medical group, plus the nurse practitioner who made the initial report, claiming fraud, defamation, tortious interference with employment, and negligent misrepresentation. The court dismissed the nurse practitioner from the lawsuit, but the jury awarded the physician $2 million for defamation, $2 million for fraud and constructive fraud, $500,000 for tortious interference with an employer, and $250,000 for negligent misrepresentation.

An attorney representing the physician issued a statement saying she was satisfied with the verdict. A spokesman for the hospital's parent company said it is considering an appeal. The physician is still employed by the medical group and required to follow the conditions of the state medical association's monitoring contract.

Lessons on Due Process

The case raises serious questions about due process rights for physicians, says **Heather Macre**, JD, director with Fennemore Craig in Phoenix. Most hospitals and physician groups have procedures in place for this type of situation. When the need arises, those procedures must be followed to the letter, she says.

"The practice or hospital will have a code of conduct or

bylaws or may spell out rules in an employment agreement. In larger institutions or practices, I typically see some sort of reporting and review process for complaints. Often, you can appeal a decision, particularly one that involves termination," she says. "For a serious allegation like intoxication at work, you can suspend an employee immediately, but after that there is usually some due process. The due process is intended to weed out cases like this one that are false reports."

However, Macre notes administrators cannot avoid their obligation to report allegations of misconduct or substance abuse to state regulators.

It is vital for leaders to follow their own internal policies for investigating such claims and provide due process to the physician while fulfilling the obligation to report, she says.

"This is something of a catch-22 because medical directors and other professionals are statutorily required to report suspected unprofessional conduct to the state medical board. In other words, beyond the employment context, if you suspect a physician is intoxicated on the job, you have to report that conduct to the board, or you are guilty of unprofessional conduct," Macre says. "Fortunately, the Arizona reporting statute specifically states that you are immune from defamation for good faith reporting."

Make Policy Practical

When implementing personal conduct policies, patient safety always is paramount, but hospitals also need to make a policy that can be practically followed, says **Callan G. Stein**, JD, partner with Pepper Hamilton in Boston. In this case, the substance abuse policy required the hospital to perform an "immediate assessment" of a physician any time there is a reasonable suspicion the physician is under the influence of alcohol or drugs, he notes. Further, the policy required the hospital to "relieve the physician of duty" and "request that the physician submit to immediate testing at an external facility," he says.

In this case, the suspicion was raised during an evening shift, and the hospital could not perform an immediate assessment, Stein says. He suspects it is likely because the origination on a night shift made it impractical or impossible to follow proper protocols.

The case illustrates the importance of keeping resources available to fulfill those policy obligations at all hours. If that is not possible, avoid creating policy stipulations with which the facility cannot comply in some circumstances, Stein shares.

Also, Stein says to remember the basics. According to the complaint in this case, the hospital suspended the plaintiff indefinitely before ever giving her an opportunity to tell her side of the story.

"Often times, physician disciplinary processes are regimented and laid out in detail through medical staff policies. Having detailed policies is a best practice for hospitals and medical staffs. There is no requirement that those processes confer the same level of due process on physicians as they would enjoy in a judicial proceeding," Stein explains. "Nonetheless, it should be a basic tenet of any process that a physician be given the opportunity to be heard, either through a written statement or an in-person interview, before his or her privileges are suspended. Taking disciplinary action against a physician prior to hearing from them makes the hospital look unreasonable and may contribute to a physician deciding to pursue litigation."

Consider the Source

Always consider the source of a physician complaint, he says. The court in this case ultimately determined the nurse's intracompany statement that she smelled alcohol on the physician was subject to a qualified privilege, Stein notes.

Ordinarily, this would result in summary judgment on the plaintiff's defamation claim. However, the court declined to dismiss the defamation claim because there was evidence the nurse in question had some prior conflict with the physician, Stein says.

"This, the court found, created a genuine question of fact as to whether the statement was motivated by ill will, which would negate the qualified privilege," Stein says. "It does not appear that the hospital considered this possibility when going through its investigation process. The possibility of even the appearance of ill will between an accuser and an accused, which legitimately may not be known to the hospital or its administrators, is another reason why it is so important for a hospital to hear from the accused physician before taking action."

In addition, after the nurse allegedly smelled the alcohol, the physician still performed a medical procedure on a pregnant woman with the nurse's knowledge, Stein notes. This was another flag the court relied on to infer the possibility the allegation was motivated by ill will, he says.

"Given this fact pattern, it is fairly easy to go back and play Monday morning quarterback and identify things the hospital should have done differently. But in reality, this case is a good example of how difficult these cases can be for hospitals and administrators," Stein says. "There are a lot of people who have information. To get a complete and accurate picture of what happened, the hospital really needs to get that information from all of those people so it can make an informed decision. This underscores the importance of a thorough and organized internal investigation. It highlights some of the bad things that can happen when one is not conducted."

Stein acknowledges it is easy to second guess a hospital or medical group when it deviates from its policies and peer review process. But there is significant risk in doing so.

"It is understandable that an allegation this serious would elicit the type of response it did from the hospital," Stein says. "But this case is a perfect example of why it is so important to remain disciplined and follow your policies."

Follow Your Policy

The case is a good lesson in how important it is to follow designated policies and procedures, says **Juliette Gust**, CFE, an expert in workplace misconduct reporting and founder and president of Ethics Suite, an online workplace misconduct and fraud reporting channel. She has led more than 1,500 investigations spanning 75 countries and has advised on close to 10,000 whistleblower reports.

"Any deviation from the stated policies and procedures is going to invite scrutiny. Why would they not follow their procedures?" she asks. "The other notable question is why she agreed to a rehabilitation program. The only thing I can surmise is that perhaps her history led them to deviate from protocol, but all investigations should be handled the same way to the extent that is possible."

When it is necessary to deviate from your policies and procedures in any way, possibly because of the particular circumstances of an incident or investigation, it is crucial to document the cause of the deviation, Gust says. It also is important to document who approved the deviation, she adds.

Carol Michel, JD, partner with Weinberg Wheeler Hudgins Gunn & Dial in Atlanta, agrees with this point. She notes plaintiffs' attorneys relish the opportunity to use your own documents against you. The hospital's apparent failure to let the accused physician defend herself must have been an important factor in the jury's decision, Michel says.

"I always tell hospitals to treat this physician the way you would want to be treated in a similar circumstance," Michel says. "Give that physician the opportunity to come before whatever the decision-making group is and defend themselves, to make their case before any decision is made."

Create Formal Protocol

Any healthcare organization should institute formal protocols for handling such allegations against physicians. Leaders must consider all relevant state laws or federal requirements in addition to medical staff bylaws.

"If there is not a chief compliance officer who will address that aspect, there must be some sort of committee that will handle all the laws and regulations relevant to all the things that might be investigated," Gust says. "You can't cover every single thing that might happen, but you can cover all the things that could possibly be alleged. Substance abuse is certainly near the top of the list and is important because of the likelihood of harm."

The protocol should include who is responsible for the intake of allegations, who will conduct an investigation, and who will review the results and make recommendations, Gust offers.

"Consistent discipline also is important in this environment. Inconsistency will draw scrutiny," she says. "Why did one physician get a warning or a conversation about the behavior but another got terminated? There may be valid reasons for the discrepancy, but that should be well documented."

Gust also encourages internal hotlines and other methods for reporting impaired physicians or other concerns. Even when a hotline exists, she says peer review professionals often do not know where the calls go or what happens to the information after it is reported. Find out and make sure the hotline is effective, Gust adds. ■

SOURCES

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Aging Physicians May Require Additional Assessments for Credentialing

In many professions in which mental and physical acuity are vital to safety and effectiveness, industries have established mandatory retirement ages and requirements for additional testing. Airline pilots must retire at age 65 years, air traffic controllers at age 56 years, and FBI agents at age 57 years.

There is no mandatory retirement age for physicians, but there is good reason to consider how aging may affect their abilities to safely and effectively practice medicine, especially for surgeons. Some healthcare organizations are addressing those concerns with programs that provide additional monitoring and testing for physicians as they age.

As of 2017, 44.1% of all active U.S. physicians were age 55 years or older, according to data from the American Association of Medical Colleges (AAMC).[1] Some states with a relatively low number of aging physicians still have more than a quarter who are 60 or older. The AAMC reports that the states with the highest percentage of physicians 60 or older are New Mexico (37%), Hawaii (35.5%), New Jersey (35%), Montana (35%), and Maine (34.6%).[2]

Particular Concern for Surgeons

Surgeons are a particular concern because their work requires such precise execution, says **Mark R. Katlic**, MD, MMM, FACS, chair of the department of surgery at Sinai Hospital of Baltimore. He also is director of the Sinai Center for Geriatric Surgery.

Katlic notes older surgeons often are well respected. However, like anyone else who is aging, they can experience subtle cognitive and physical changes that affect their ability to operate safely.

For that reason, Katlic developed the Aging Surgeon Program at LifeBridge Health in Baltimore, which evaluates the physical and cognitive function of older surgeons. Katlic says the program was designed to identify conditions that could affect physician performance. In many cases, the treatments could address those problems. *(Editor's Note: Much more information on the Aging Surgeon program is available online at: https://bit.ly/2wd7lWL.)*

Rather than taking punitive action or trying to force doctors out before they need to retire, Katlic says the program can protect a physician's rights and professional reputation. Data from the program can shield physicians from arbitrary decisions based on their chronologic age and lower the liability risk of credentialing hospitals, he says.

Many surgeons continue operating well into their 70s without any difficulty. Each surgeon's abilities must be evaluated on a case-by-case basis, Katlic stresses. Arbitrary cutoffs based solely on age will force many surgeons into retirement long before they develop any performance deficiencies, while at the same time allowing some doctors with early symptoms of aging to continue caring for patients, he says.

The American College of Surgeons (ACS) has advocated for the evaluation of older surgeons' physical and cognitive function since 1992. Currently, ACS recommends voluntary physical examination, eye examination, and online screening tests of cognition for surgeons age 65 to 70 years.[3] However, Katlic says there are no data showing how often this happens. Some hospitals have adopted a late career practitioner policy in their medical staff bylaws, which Katlic says typically require physicians age 70 years and older to undergo the ASC-recommended screening.

Katlic developed the LifeBridge program four years ago after watching chiefs of surgery and chief medical officers making difficult decisions about older surgeons without any objective evidence. They had to base their decisions largely on hearsay of nurses and fellow physicians, he says.

"I've been practicing general thoracic surgery for more than 35 years and been chief of surgery at a number of institutions. I've encountered some older surgeons who should have stopped operating before they did," Katlic says. "We're all human, and our cognitive and physical abilities decrease with age. That's just a fact."

The evaluation program is open to physicians from any facility, not just Sinai Hospital. The Aging Surgeon Program is a two-day, multidisciplinary evaluation of a surgeon's physical and cognitive function that includes neurologic and ophthalmologic examinations, in addition to neuropsychological, physical, and occupational tests.

"They typically come in the night before the evaluation. On the first day, they undergo a physical exam, a neurology exam, and then a couple hours of physical and occupational therapy testing that assess hand-eye coordination, fine motor skills, and balance," Katlic explains. "Then,

they have a nice lunch and an entire afternoon of neurocognitive testing. The standardized tests were selected for individuals with high education levels and high executive functioning." The second day of testing includes more neurocognitive testing and a complete eye exam. Each specialty area in the program prepares a detailed report on the physician's results. The team meets at the end of the week to develop a summary report. The program provides a confidential, encrypted report to the hospital or medical group that commissioned the evaluation. The hospital credentialing committee and physician leadership use that information to decide what action is necessary, if any.

Katlic says the results of the examinations can lead to several outcomes. The hospital may continue granting the surgeon full privileges or revoke all privileges. Perhaps the hospital removes only operating privileges, or allows operating privileges if assisted by another surgeon. The surgeon may be restricted to only routine cases or only assistant privileges. Further, the surgeon may be subjected to a focused review of cases, or could wind up working fewer hours.

"Most of the physicians we've seen came here kicking and screaming. They would have not elected to come to our program on their own," Katlic says. "Most have come reluctantly because their chief of surgery, someone at the hospital, or their state medical society made them come. However, to a person, every one of them who has gone through the evaluation admitted at the end that it was a fair evaluation and they were treated with great respect." Two participants have become spokesmen for the program and the potential difficulties of aging physicians. Katlic also says Sinai Hospital's late career practitioner policy can be a model for other institutions. *(Editor's Note: See the story on page 43 to read more about the Sinai policy.)*

"Ours says that whenever any practitioner, which includes doctors, nurse practitioners, and physician assistants, comes up for recredentialing, and they are 75 or older, they must have a physical exam, an eye exam, and a neurocognitive screening evaluation. That information is given to our credentials committee," Katlic reports. "Our medical executive committee unanimously passed that policy, and so did our hospital board of directors. That policy has worked well, and we've had not a single complaint about it."

Possible Legal Issues

Yale New Haven Hospital recently reported on the results from its mandatory testing policy, which requires evaluations at age 70 years. The hospital found that almost one in eight clinicians tested exhibited cognitive deficits that were likely to affect their performance and patient safety.[4]

Fifty-seven percent of 141 physicians and practitioners who applied for renewal of hospital privileges at Yale New Haven Hospital demonstrated no cause for concern.

The rest were required to undergo yearly recredentialing or further testing, which could then lead to proctored medical practice, resignation, or retirement. In all, 12.8% of clinicians tested exhibited cognitive deficits considered serious enough to warrant concern over their ability to practice independently, the hospital reported, but none of them had been the subject of any reports to their peer review committees or hospital leadership about their abilities.

Late career practitioner policies may be challenged as discriminatory and illegal. On Feb. 11, the U.S. Equal Employment Opportunity Commission (EEOC) filed suit against Yale New Haven Hospital over its policy. *(Editor's Note: See story on page 43 for more details about the case.)*

Katlic says he hopes the EEOC's lawsuit will not be successful because labor law provides an exception for bona fide occupational qualification exemption, which allows employers to require specific abilities necessary for the job. He expects the hospital to argue that the policy is reasonable because physical and cognitive abilities required for the job are known to diminish with age. "The patient safety issue may outweigh the age discrimination issue when it comes to doctors being qualified to take care of patients," Katlic offers. ■

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SOURCE

- **Mark R. Katlic**, MD, MMM, FACS, Chair, Department of Surgery, Director, Aging Surgeon Program, Sinai Hospital of Baltimore. Phone: (410) 601-5843.

EEOC Sues Hospital for Mandatory Exams for Employees at Age 70 Years

The U.S. Equal Employment Opportunity Commission (EEOC) is suing a Connecticut hospital over a policy that it says violates two antidiscrimination laws by requiring eye and neuropsychological exams for employees age 70 years or older when they seek medical privileges.

The Yale New Haven Hospital late career practitioner policy has been in place for four years. The EEOC filed a lawsuit on Feb. 11, alleging that policy is illegal because it singles out individuals for testing based only on their age, not any suspicion about a decline in cognitive or physical abilities.[1]

That is a violation of the Age Discrimination in Employment Act, the EEOC says.

The policy also violates the Americans with Disabilities Act because it subjects employees to medical examinations that are not job-related, the lawsuit claims.[1]

The hospital issued a statement saying its late career practitioner policy is designed to protect patients from potential harm. The statement says the policy is modeled on certain protections in other industries. Further, the statement says that the hospital intends to vigorously contest the lawsuit.[2] ■

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Late Career Credentialing Policy Addresses Physicians Age 75 Years and Older

The following bullet points contain more information about the late career practitioner policy that has been instituted at Sinai Hospital of Baltimore:

Practitioners who are age 75 years or older and applying for initial appointment at LifeBridge Health System entities, as well as current practitioners at their first reappointment after age 75 years and at each subsequent reappointment, are subject to the following procedures:

• **Comprehensive history and physical examination.** This will be at practitioner expense or, if appropriate, at his or her medical insurance company's expense.

The examining practitioner will provide a confidential written report directly to the credentials committee.

• **Comprehensive ophthalmology examination.** This will be at the practitioner's expense or, if appropriate, at the expense of his or her medical insurance company. The examining practitioner will provide a confidential written report directly to the credentials committee.

• **Screening cognitive examination.** Estimated to take two hours by a certified neuropsychologist, this will be at system expense. Practitioner will be provided a list of approved neuropsychologists and their contact information.

The examining practitioner will provide a confidential written report directly to members of the credentials committee. ■

Targeted Rounds Reduce PICU CAUTIs to Zero

Children's Hospital of Philadelphia (CHOP) has achieved a rate of zero catheter-associated urinary tract infections (CAUTIs) through the use of daily targeted rounds. The hospital has maintained that zero rate for more than one year.

An interdisciplinary team took a proactive approach to identify and address barriers to CAUTI prevention in its 55-bed pediatric ICU (PICU), says **Megan Snyder**, MSN, RN, ACCNS-P, CCRN, director of nursing professional practice at CHOP. The PICU was one of the highest CAUTI risks in the hospital, she says.

The CAUTI work group included an attending physician, nurse practitioner, unit-based clinical nurse specialist, unit-based safety quality specialist, clinical nurse leader, staff nurse, infection control specialist, a data analyst, and an executive sponsor. They met once or twice a month.

CHOP deployed five specific CAUTI prevention elements, achieving a compliance rate of 84% in the PICU and an overall rate of 2.7 infections per 1,000 catheter-days. All patients in the PICU had appropriate indications for catheter placement, Snyder reports.

Targeted rounds provided a systematic approach to rounding only for patients with an indwelling urinary catheter, Snyder explains.

Originally, the PICU CAUTI team leader conducted these daily targeted rounds, but the task proved to be too much for one person. CHOP assigned each clinical member a day to conduct rounds each week.

"One of the biggest things we noticed from our data was that those patients at some of the highest risk for CAUTI were those who had had a catheter, and then we removed it but then they weren't voiding on their own, so we replaced the catheter," Snyder says. "They made up half of the CAUTIs. We would round and talk to the nurses about all the patients who had catheters. If they thought the catheter was coming out, we would talk about tips and things they could do to keep the catheter out." Those options include medications, straight catheters, and bladder scanning.

CHOP DEPLOYED FIVE SPECIFIC CAUTI PREVENTION ELEMENTS, ACHIEVING A COMPLIANCE RATE OF 84% IN THE PICU.

Rounding for Bundle Compliance

During rounds, the team member checks for bundle compliance. The team member also can conduct real-time training to address any issues immediately, Snyder says.

The CAUTI team also developed a data review dashboard with information from the electronic health record and other sources to track bundle compliance and access bedside review data. Anyone in the facility can review compliance data, identify trends, and see harm metrics in real time.

Bundle compliance in the PICU increased steadily, but avoiding dependent loops in the drainage tubing was consistently identified as an area for improvement. The CAUTI team focused more on compliance; with that element, overall compliance rates improved.

The unit's overall CAUTI rate had been 2.7 infections per 1,000 catheter-days, but the daily targeted rounds sustained a rate of zero CAUTIs for longer than a year, Snyder says. "Often, the nurses were busy in the PICU, so we would take the conversation to the bedside where the nurse was caring for the patient rather than expecting that nurse to come to where we were meeting with other nurses," Snyder says. "Sometimes, taking little things off the plate made it easier to get the results we wanted. Our team approach gave us enough team members to be able to take that kind of approach."

Snyder notes the team benefited from significant buy-in from physician leaders. One of the medical directors for the PICU sat on the CAUTI work group and participated with rounds, along with a nurse provider. "We had good cross representation from the provider side and the nursing side, which really helped move the needle. If we had any issues, we could use our team to navigate from both of those angles," Snyder says.

Pics Help With Loop Issue

One of the biggest challenges involved the dependent loop, in

which the drainage tubing creates a U shape that leads to urine stasis and can promote urinary infection. Snyder says the team had to focus specifically on that issue because it had not been addressed well in previous CAUTI prevention efforts.

"They didn't know what we meant until we showed them pictures of what it normally looks like and how to fix it. That was a gamechanger when we illustrated it like that and it clicked for them," Snyder says. "For our pediatric patients, we usually keep their beds in the lowest position. A lot of the urinary catheter drainage bags are made to accommodate the adult population, so we had to look at altering the way we did things to better suit our patients."

Snyder notes that after the year of zero CAUTIs, there was an uptick. An investigation revealed the hospital had brought in a trial product to manage catheterization in a different way. The increase in CAUTIs directly correlated with that trial. The hospital stopped using the trial product, and the CAUTI rate fell again.

There was another blip in infection rates when Snyder left her role in the PICU for her current position at the hospital. Staff were less diligent about rounding without her leadership, but infections declined when the rounding was reinforced.

In fiscal 2020, which started Oct. 1, 2019, the PICU has logged three months without an infection and two months so far with one infection per month, Snyder reports.

"We've had stumbles but no spikes like we've had in the past. We're trying to keep those numbers as low as possible. The good news is that even when we have a small increase, we can trace it to a specific deficiency, which just reconfirms that our practices work," Snyder says. "Reinvigorating the staff by reminding them what good results we achieved with such little effort and low cost makes them want to sustain that progress." ■

RESOURCE

- Snyder MD, Priestley MA, Weiss M, et al. Preventing catheter-associated urinary tract infections in the pediatric intensive care unit. *Crit Care Nurse* 2020;40:e12-e17.

SOURCE

- **Megan Snyder**, MSN, RN, ACCNS-P, CCRN, Director, Nursing Professional Practice, Critical Care Nursing, Children's Hospital of Philadelphia. Phone: (267) 426-5968. Email: snyderm1@email.chop.edu.

Global Standards Help Improve Patient Safety and Outcomes

A Louisiana health system is improving safety and patient outcomes by expanding its use of barcodes and other tracking under the commonly used GS1 standards. The effort also is yielding better inventory management. Along the way, the health system developed a GS1 implementation program that other organizations can use.

The Franciscan Missionaries of Our Lady Health System (FMOLHS) is a nonprofit healthcare system in Prairieville, LA, that serves more than half of Louisiana's population. It includes eight large hospitals and 350 physician clinics.

Its recent implementation of the global GS1 standards means OR nurses can scan product barcodes to capture product data, such as expiration dates and recall information, while also entering product-related information into the patient's electronic medical record (EMR).

The system could also help improve patient outcomes by allowing the chief medical officer to access detailed information

about the variability of items used in procedures and the impact on care, notes **Sandi Michel**, system director of supply chain strategy at FMOLHS.

GS1 is a not-for-profit organization that maintains global standards for business communication, including the well-known barcode on retail products. GS1 standards are designed to improve the efficiency, safety, and visibility of supply chains in many industries.

Standardizing Across System

To fully adopt GS1, FMOLHS began by reviewing its standardization vision and strategy with about 80 suppliers and group purchasing organizations, Michel reports.

The health system asked them to start using the GS1 Global Trade Item Number (GTIN) in barcodes to uniquely identify each of their products, Michel says.

FMOLHS plans to standardize the use of the GTIN for all items used in the health system. Manufacturers now are required to use them when selling to the health system, Michel notes.

About 85% of implantables in the system now have unique GTINs, Michel adds. FMOLHS also adopted the GS1 Global Location Number (GLN), which identifies each location within the FMOLHS health system.

The use of barcode scanners improves efficiency and accuracy, Michel observes. Even when part numbers or other identifiers were available, numbers and letters could be mistyped into a patient's records. Scanning the barcode ensures the correct device number is entered in the patient's medical record, which can be vital in the event of a recall for an implantable device, for instance.

The effort began in 2012. Michel and other FMOLHS leaders attended conferences and consulted other resources to learn about the potential improvements for safety, outcomes, and inventory management. Once the potential benefits became apparent, they looked for a sort of master plan for how to implement GS1 standards in a large organization, but they could not find one.

SCANNING THE BARCODE ENSURES THE CORRECT DEVICE NUMBER IS ENTERED IN THE PATIENT'S MEDICAL RECORD.

So, leaders decided to create their own.

Opening Their Own Warehouse

FMOLHS worked with seven vendors in developing a GS1 implementation plan, with the intention of making it available to other health systems afterward. FMOLHS started by establishing an Office of Data Standards and Interoperability. Divisions within the office addressed particular areas of GS1 implementation, such as the GLN, pharmacy, and interoperability.

FMOLHS opened its own warehouse in 2015, allowing the organization to better control its inventory and provide "just in time" delivery of products throughout the health system. The GS1 program tracks the products, and the GLNs indicate exactly where the item is at any moment, Michel explains.

The inventory system also allows FMOLHS to provide the "best unit of measure" for any product to any location identified by a GLN, Michel says.

If a particular clinic needs only two pieces of an item from a case of 24, the GS1 program allows the warehouse to properly divide the case and deliver only what is needed rather than sending an entire case because that is the only unit available.

"Typically, this would mean that surgery will request the specific products and quantities they need, transmit that to us, and our warehouse has already broken down that case into the individual items. We will put together what they need in a tote and have that delivered directly to the location using the GSN," Michel says. "We went a little further and used the GSN to create a hierarchy tree, all the way down from the top of the health system to each facility location, to each storage location. It could be a closet, a shelf, a bin. The tote with what they need is delivered directly to that location, just in time for the procedure."

In 2017, FMOLHS started scanning into the EMR any supplies or product that was used on a patient, Michel says. Not every supplier uses GS1, but the outliers are minimal now, she adds. "We started four years ago

telling suppliers that this was the expectation. Eventually, we will get to the point that we will make buying decisions based on whether you use the GS1 standard for your product so that it can fit in seamlessly with our system," Michel notes. "Recently, we changed our group purchasing organization and realized this was a chance to get all of our suppliers using GS1."

The health system determined that when considering vendor options, any company using the GS1 standard would be its first priority. Companies moving to adopt GS1 might be considered, but those with no GS1 plans would be considered last.

Educating Nurses About Scanning

Implementing the system required educating nurses about which barcode to scan when several are on an item.

Michel says nurses have embraced the program because the scanners reduce their workload and improve accuracy. Sometimes, nurses will hold onto a package that did not scan properly so FMOLHS can notify the vendor and fix the problem.

FMOLHS also provides feedback to vendors on how they use barcodes, suggesting better ways to label the products. In one case, the health system reported the labels on small tubes were not scanning properly. The manufacturer switched to a different type of barcode more suitable to the small tube size. In another case, the health system reported barcodes on reflective material were difficult to scan properly. "We want a device that can be scanned so the OR nurse doesn't have to manually type in a lengthy number, which can include a serial number, a manufacturer number, and an expiration date," Michel says. "We've been consistent over the years and communicated well with our suppliers, so we can record accurate information provided by the supplier themselves into that patient record. It helps us with recalls, decreases errors, improves efficiency, and it allows us to feel confident that this isn't a counterfeit product that was just brought in off the street."

The program has improved patient safety through both the increase in information put in the patient record and the reduction in errors with that information, Michel says. The GS1 implementation also can be useful if The Joint Commission conducts an audit, Michel says. In an audit, FMOLHS can provide an accurate assessment of inventory throughout the system.

FMOLHS makes all of its GS1 implementation plans available for use by any healthcare organization.

"There is a myth out there that this is very difficult to do, but it's really not that difficult to do because we've done all that early discovery and design," Michel says.

Many more details about the FMOLHS model are available at the link in the resource list below.

"That is available to anyone who wants it," Michel adds. "It will provide a framework for implementing GS1 as effectively as we have at FMOLHS." ■

RESOURCES

- GS1. What we do. Available at: http://bit.ly/2Tzo5zv.
- GS1, Franciscan Missionaries of Our Lady Health System. FMOLHS-GS1 US Data Standards Master Process Implementation Plan. Available at: http://bit.ly/32KW6AY.

SOURCE

- **Sandi Michel**, System Director, Supply Chain Strategy, Franciscan Missionaries of Our Lady Health System, Prairieville, LA.

CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes;
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general;
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

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CE QUESTIONS

1. **In the lawsuit in which a physician sued a hospital and medical group following a claim that she had smelled of alcohol on duty, what was one of the physician's claims?**
   a. The hospital and practice group did not offer her a hearing before a peer review committee.
   b. The hospital falsified evidence against her, with the medical group's knowledge.
   c. The hospital and medical group unfairly influenced the decision made by the state medical association.
   d. The hospital and medical group imposed discipline beyond what was allowed in their physician bylaws.

2. **What does the American College of Surgeons recommend regarding the qualifications of older surgeons?**
   a. Mandatory retirement at age 65 years, extended to age 70 years under some circumstances
   b. Recommended retirement at age 65 years, regardless of any objective indications of failing ability
   c. Voluntary physical examination, eye examination, and online screening tests of cognition for surgeons age 65 to 70 years
   d. Mandatory physical examination, eye examination, and online screening tests of cognition for surgeons age 65 to 70 years

3. **After the rounding program reduced catheter-associated urinary tract infections to zero in the PICU at Children's Hospital of Philadelphia, what was one reason for an uptick in infection rates?**
   a. The rounding program was discontinued.
   b. PICU nurses rejected some elements of the bundle.
   c. A trial product was introduced for catheterization.
   d. The bundle was changed to allow longer catheterization.

4. **How does the Franciscan Missionaries of Our Lady Health System encourage vendors to use the GS1 system it has adopted?**
   a. Vendors using GS1 will be the first considered.
   b. Vendors using GS1 will receive more valuable contracts.
   c. Vendors using GS1 will receive longer-term contracts.
   d. Vendors using GS1 will have access to the health system's warehouse for short-term storage of products.