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Terrorist attacks show preparedness is more than accreditation exercise

Health care system prepared well, but now is time to review your plans

The Sept. 11 tragedy is causing quality and peer review professionals to revisit their emergency preparedness plans and to view them with a greater sense of importance. Those plans no longer seem like a formality to satisfy the Joint Commission on Accreditation of Healthcare Organizations, and the days are gone when you imagine a tornado or hurricane as the only disaster likely to set the plan in motion.

Specialists in emergency preparedness are getting a lot of calls from quality professionals who suddenly are more interested in their hospitals' emergency plans. **Cameron Bruce**, CSP, PE, a health care consultant in Orinda, CA, says the recent terrorist attacks have convinced some people that emergency preparedness deserves more attention.

Disaster Planning Audio Conference

The unimaginable has happened in New York City. At Saint Vincents Hospital, less than three miles from the site of the World Trade Center attack, the disaster plan was put to the test as dedicated professionals rose to the unique challenge of responding to the attack. American Health Consultants, publisher of *Hospital Peer Review*, invites you to learn from the firsthand experience of the professionals at Saint Vincents how to take a new look at your disaster plans so that you will be ready if the unimaginable happens in your community:

- Responding to the Unimaginable: How Saint Vincents Coped with the World Trade Center Attack
- Wednesday, Nov. 14, 2001
- 2:00 to 3:40 p.m. EST
- An audio conference educating you and your entire staff on how to respond effectively in a crisis situation.

Each participant will have the opportunity to earn 1.5 free AMA Category 1 CME credits or approximately 2 free nursing contact hours. For details, visit www.ahcpub.com, or call (800) 688-2421 to register today! ■

"Some people saw it as a formality a few weeks ago, something you had to have on the shelf for the Joint Commission," he says. "Others saw it as more than a formality, but they still didn't have a solid plan in place. There's a new attitude now that's spurring people to take it more seriously."

Bruce says that "most hospitals are woefully unprepared" for a disaster. His colleague, consultant **Sheila Hennessey,** says that even when quality professionals and safety experts were serious about wanting to create a good emergency plan, the hospital often did not lend much support.

"Let's put it this way: It's not revenue generating," she says. "It doesn't come as a top priority for administration. That's really a pity, because when a disaster happens, it's only through good planning that you can have a quick, organized response that really serves your patients and your community."

That apathy may be pushed aside by the nationwide concern over more terrorist strikes, Hennessey points out. Chances are good that administrators will provide a better budget for emergency preparedness from here on out, she says. And it can take a significant budget to develop such a plan, especially if you use outside consultants.

"It can take you more than 1,000 hours of time to write a good emergency preparedness manual. That can cost you $30,000 to $60,000 if you do it right," Bruce explains. "You can slap something together in a few days before your Joint Commission survey, and it might be enough to get by the surveyor. But that's nothing I would rely on in an emergency."

Now is the perfect time to review your organization's emergency preparedness plan, Hennessey says. And don't get complacent just because the Joint Commission has seen your emergency preparedness plan and given it a stamp of approval.

"The Joint Commission requirements are open-ended and vague," Bruce says. "You can fulfill the requirements with 200 hours of work, 600 hours of work, or 1,000 hours of work. You can show them something that is fairly weak as a workable tool, yet it will pass most surveyors' casual scrutiny. Some surveyors don't spend more than three or four minutes flipping through the emergency preparedness plan."

So passing the Joint Commission's scrutiny doesn't necessarily mean the emergency plan is a practical, workable tool. And Bruce says that you should review your plan now even if the Joint Commission surveyor really studied it and raked you over the coals. The potential hazards are not the same as they were on Sept. 10. **(For more on how to put together an emergency preparedness plan, see box, p. 152.)**

Health care system ready for attacks?

The concern over terrorist attacks is reaching all levels of health care. Overall, the U.S. health care system is ready for terrorist attacks, or at least as ready as it can be, according to Secretary of Health and Human Services (HHS) **Tommy Thompson**. The reassuring comments came when Thompson was speaking before an audience of manufacturers recently. He said HHS now has eight packages containing 50 tons of medical supplies distributed around the country and a network of 81 state laboratories connected to the Centers of Disease Control and Prevention (CDC) monitoring for anything suspicious.

With that plan, the agency could respond within seven hours to either conventional or biological attack, Thompson said. He is "very confident as secretary of health that if a terrorist attack hits us, we are able to respond very quickly." Thompson noted that HHS is continuing to pursue its domestic agenda. He predicted that a patients' bill of rights will be passed soon if Congress can address the differences between the House and Senate versions of the bill.

Thompson also said HHS will be improving security at places such as the CDC and the National Institutes of Health as well as stocking additional supplies of pharmaceuticals and vaccines. Thompson reassured listeners that the health care system is ready for whatever might happen, but not everyone agrees with that assessment.

If one arm of the Chicago-based American

COMING IN FUTURE MONTHS

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Medical Association (AMA) has its way, the Joint Commission will start evaluating health care providers for their emergency plans specifically regarding terrorism. The AMA Council on Scientific Affairs (CSA) issued a report in 2000 on "Medical Preparedness for Terrorism and Other Disasters," calling for substantial improvements. One of the key recommendations was to "encourage the Joint Commission . . . and state licensing authorities to include the evaluation of hospital plans for terrorism and other disasters as part of their periodic accreditation and licensure."

The Joint Commission has not acted on that recommendation, though it did beef up its emergency management plan for 2001.

Effective January 2001, the Joint Commission's emergency preparedness plan (EC.1.4) was expanded and made more specific, requiring providers to address four phases of emergency management activities: mitigation, preparedness, response, and recovery. The new rule calls for providers to conduct a "hazard vulnerability analysis" to determine how the facility might be affected by different threats. The new language in the rule also lays out specific requirements, such as identifying personnel during emergencies, but it is an all-purpose rule on emergency management that could apply to a range of disasters. Terrorism is not mentioned.

The Joint Commission has focused on terrorism, however. In 2001, several congressional committees explored the issue, and the Joint Commission actively participated.

One of the most prominent groups was the Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction, also known as the "Gilmore Commission" for its chairman, James S. Gilmore III, governor of Virginia. AMA representatives presented the CSA report to the Commission and discussed it with them during the Commission's meeting on March 30, 2001. The commission responded positively to the report, and the CSA predicts that the Gilmore Commission's prominence in Washington, DC, will help its efforts to improve the health care response to terrorism.

In the March meeting of the Gilmore Commission, representatives from the Joint Commission and the CDC both spoke about the need for an increased focus on terrorist threats. The AMA council reports that "The [Joint Commission] has taken a significant step toward addressing the AMA's concern that disaster preparedness should be evaluated in hospital accreditation."

The emergency management standard requires the health care organization to have an emergency management plan describing an effective response to disasters, with provisions for integrating with the surrounding community's disaster response organization. The standard lists essential elements of a plan, including an annual evaluation of its effectiveness.

But the AMA council notes that the standard "does not include recommended or mandatory strategies for disaster response planning, leaving these specifics to the health care organization. It

Top 12 mistakes in a hospital emergency preparedness plan

Your emergency preparedness plan should be concise and, above all else, practical. Avoid creating a voluminous plan that looks impressive but won't be of much use when an emergency hits.

Too many emergency preparedness plans are long on procedure but short on critical information, says **Cameron Bruce**, CSP, PE, a health care consultant in Orinda, CA. The plan should focus on making crucial information available to the user, rather than spelling out in exhaustive detail exactly what policies and procedures apply.

"You don't want 300 pages of cumbersome, tedious writing when you're in a chaotic environment," he says. "When a crisis strikes, you need information, not somebody's tome on the philosophy of crisis management."

Bruce says these are the top 12 weaknesses he sees in hospitals' emergency preparedness plans:

1. Not based on flexible incident command system
2. Do not contain enough multidisciplinary input
3. Do not consider enough probable scenarios, i.e., no hazard vulnerability analysis
4. Lack essential response information, such as checklists, flowcharts, and data
5. Lack overview of communications backup systems
6. Do not contain adaptable forms for managing information
7. Do not adequately address backup supplies — locations, amounts, and vendor agreements
8. Have not undergone a review by local authorities
9. Lack alarm points signaling that critical supplies are running low
10. Do not include rapid troubleshooting tools for responding to problems such as water failure
11. Have not undergone adequate drilling or testing of the plan and its components
12. Have not undergone continuous improvement of the plan based on drill results. ■

Resources for educating staff, physicians on terrorist threats

Physicians and staff might be eager for more education on terrorist threats and how the health care system can respond. Two sources can help you improve the quality of care:

One is an on-line presentation dealing with medical issues related to potential terrorist activities. The lectures were presented at New York University Medical Center in New York City and are available free on the World Medical Leaders web site at www.wml.com. During the lectures, New York University Medical Center faculty discussed hands-on experiences and emergency preparedness for potential biological and chemical attacks in the wake of the World Trade Center disaster.

The presenters stressed how essential it is that physicians be up-to-date on key diagnostic factors, treatments, and reporting procedures. They reviewed chemical and biological agents most likely to be used in an attack. In addition, the presenters discussed what to expect in the psychological and social arenas following a terrorist attack. Speakers included Robert S. Hoffman, MD, medical director of the New York Poison Control Center, as well as leading experts on infectious diseases, and psychiatry.

Another source of information comes from The Association for Professionals in Infection Control and Epidemiology (APIC). In cooperation with the Centers for Disease Control and Prevention (CDC), APIC offers a bioterrorism readiness plan to serve as a reference document and initial template to facilitate preparation of bioterrorism readiness plans for individual institutions.

Bioterrorism Readiness Plan: A Template for Healthcare Facilities outlines the steps necessary for responding to the biological agents most likely to be employed in any future biological attack: smallpox, botulism toxin, anthrax, and plague.

The *Bioterrorism Readiness Plan* provides information on the unique characteristics, specific recommendations, management, and follow-up appropriate for each of these biological agents. It covers the description, etiology, and mode of transmission of each agent and the necessary isolation precautions, patient management, and post-discharge planning associated with each.

The document also provides details regarding post-exposure management, prophylaxis, and decontamination consistent with each pathogen; laboratory support and diagnosis; and protocols for the cleaning, disinfection, and sterilization of equipment and environment. The plan outlines patient/visitor/public health precautions, and contains some discussion of the psychological and mental health aspects of a bioterrorist event.

APIC says the format of the *Bioterrorism Readiness Plan* is easily adapted to suit the individual needs of institutions, offering what it calls a "cookie-cutter" approach to creating specific bioterrorism readiness plans. With the mounting concerns regarding threats of bioterrorism throughout the country, the timely appearance of this accessible device is meant to allow infection control professionals and health care epidemiologists in all health care facilities to prepare appropriate plans utilizing established networks to satisfy the needs of unique situations.

There is no charge for downloading the plan at www.apic.org/bioterror/bioterrorproducts.cfm. For print and disk copies, the charge for APIC members is $10.00, or $18.00 for nonmembers to cover the cost of handling and shipping. Contact APIC at 1275 K St. N.W., Suite 1000, Washington, DC 20005-4006. Telephone: (202) 780-1890. ■

also does not explicitly describe a role for medical staff to participate in developing the emergency management plan.

However, the Joint Commission representative to the March Gilmore Commission meeting stated that the accrediting body would be willing to participate in the 'public-private entity' described in the AMA recommendation."

The recent terrorist attacks should prompt quality managers to conduct a new hazard analysis, as required by the Joint Commission, Hennessey says. Previous hazard analyses probably underestimated the potential for terrorism, and she says Joint Commission surveyors are likely to be on the lookout for proof that you have considered the risk.

"They're like everybody else now, thinking about it all the time. It's on our minds and will be for a long time," she says. "It's only natural they're going to look for it."

In addition to revising your emergency preparedness plan, Hennessey points out that you also must test it with disaster drills.

"You can go through this whole process of developing a wonderful plan and then not drill it. That would be tragic, because you have no way of knowing if it works until you actually test it," she says.

One of the hospitals in New York City had tested its emergency preparedness plan just weeks before the World Trade Center tragedy. Saint Vincents Hospital and Medical Center had held a disaster drill about three weeks before and

used that experience to improve its emergency plan, according to a hospital spokesman.

In Wareham, MA, Tobey Hospital held its most recent disaster drill in June, but a spokeswoman says the terrorism threat may prompt the hospital to drill again on a more frequent basis.

Tobey Hospital has several disaster drills each year to test its emergency guidelines and to meet the Joint Commission requirements, according to spokeswoman **Joyce Faria.** The hospital's emergency preparedness plan puts all hospital departments on alert, and any staff whose services are not directly required go into a manpower pool to wait for assignments. All on-call staff are called in, and a supervisor assures personnel are available to record incoming patient information and assigns arriving staff members. The pharmacy supplies emergency drugs to treatment areas. Respiratory care provides personnel to proceed to the emergency department to help assist, stabilize, and transfer patients. Social services mobilizes to provide counseling and assistance to families.

"We take the emergency planning very seriously, and we were pleased with the results of our last drill," Faria says. "But there are always ways to improve it, things you find in the drills that you just couldn't see on paper. So we always do drills, and there's no doubt that we'll do more of them now. It looks like we need them now more than ever." ■

Mock surveys help when JCAHO comes knocking

The day surveyors from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) stroll through your facility is always a tense one, with the staff dreading the moment when they're put on the spot. But much of the anxiety can be reduced by using "mock surveys" in which you or a consultant play the role of a surveyor, giving the staff some experience that will ease their fears while also ferreting out the weaknesses in your accreditation program.

Mock surveys can be used as a way to test your program, and in fact, the more you use them, the more comfortable your staff will be with the idea of having a surveyor look over their shoulders and quiz them on various policies and procedures. Some experts on Joint Commission accreditation recommend incorporating a series of mock surveys, sometimes culminating with a final dress rehearsal just before the real survey. A mock survey can be enormously helpful, says **Susan Mellott,** PhD, RN, CPHQ, FNAHQ, a consultant in Houston.

The surveys can be done in different ways, but the idea is to pretend that your facility is actually being surveyed. How seriously you get into the role-playing will vary, but all mock surveys should serve two purposes, Mellott says.

"You're using the survey process to gather information, to see what's actually going on in the facility and how people respond to questions," she says. "But you're also allowing the staff to do a dry run and see what the survey process is. They've probably heard a lot about how important this is for the organization, and they're nervous about trying to do the right thing. People can get very anxious when they hear the surveyor is coming down the hall."

The mock survey itself is only one part of an overall plan to prepare for the survey, but experts say some form of the role-playing should always be included. You can do it all internally if you have the resources, but any accreditation consultant will be able to help with mock surveys. The surveys can be all-encompassing, in the manner of a real Joint Commission survey, or they can concentrate only on the areas where you know your program is weak.

"If you've never done this before, one way to start is to look at the standards and all the areas where you received Type 1s before, plus the new standards you'll be surveyed on, and the list of the Joint Commission's top 10 Type 1s," Mellott says. "Those things can tell you what areas to focus on, the major spots where your Type 1s are likely to come from."

Plan early and work to the last minute

Planning for a Joint Commission survey should start at least 18 months before the anticipated survey date, Mellott says. Some organizations will make survey planning a year-round function for the quality leaders, but smaller organizations might find that impractical. The overall survey planning can entail a wide range of activities, but mock surveys can be seen as the tests — periodic tests while you work on the project and then a final exam.

The survey planning team should schedule several mock surveys throughout the planning period, and one consultant in Portland, OR, says

you should finish with a dress rehearsal at the last minute. **Michelle Pelling**, MBA, RN, recommends doing the first mock survey about a year before the real one, then about six months before, and a final one anywhere from 30 days to one week prior to the actual survey.

The first one is a comprehensive survey that spots problems of a general nature, and the second one is more of a fine-tuning opportunity. The final dress rehearsal occurs when it's too late to really change much about the hospital's policies and procedures, but it can highlight problems with how that information is related by the staff and how easily documentation is provided to the surveyor.

After each mock survey, Mellott and Pelling recommend holding a review session with the team leaders to review the findings. That meeting should include devising an action plan for the team to address any shortcomings revealed by the mock survey and a time line for when the tasks should be completed.

Both consultants emphasize that you can get carried away with the mock surveys and start to think they are a panacea for your accreditation program. Bad mistake, they say. "Don't think the mock survey is the whole ball game," Mellott says. "It's just the data-gathering part. There's plenty more work to do." ■

How to play the role of a Joint Commission surveyor

How do you conduct an actual Joint Commission on Accreditation of Healthcare Organizations mock survey? There's more to it than just walking around with a clipboard and asking questions. Here's some advice from the experts:

• **Take it seriously. Play the role of a Joint Commission surveyor.** The whole point is to simulate the actual survey, so you should try to play the role instead of just asking questions as a coworker, says **Michelle Pelling**, MBA, RN, a consultant in Portland, OR. How much you get into the acting opportunity will depend on the individual, but Pelling encourages people to pour it on.

"I play the role of the surveyor and walk them through the exact process," she says. "Each surveyor has unique approaches, but they're supposed to follow certain patterns and so there is a certain predictability. We sometimes try to be a little harder than the surveyor will be because we want people to be prepared, but we don't get disrespectful or bully people at all. That's not what you'd expect from the real surveyor either."

• **Carefully select observers and participants.** If you are using an outside consultant, he or she probably is the best person to play the role of the surveyor. Having a stranger from outside the organization ask the questions will make the mock survey seem more real. If you're not using a consultant, the best person is probably the quality manager or someone in an equivalent position. But also be a little flexible if one person is more comfortable with the acting. It might be better to select a team member who is more willing to role-play, rather than someone who will be reticent about that.

The mock surveyor should be accompanied by observers from the organization, says **Susan Mellott,** PhD, RN, CPHQ, FNAHQ, a consultant in Houston. The peer-review or quality professional should be on hand to observe, possibly with other members of the accreditation survey team. Performance improvement professionals, nursing leaders, and someone involved with clinical records documentation also are good choices.

In addition, look for leaders within different departments who may provide valuable insight during the survey. "You might want a clinician doing the patient care questions but not the functional care issues, because of the judgment calls that need to be made," Mellott says.

But be open-minded about who might be useful. Pelling suggests including a facilities management representative, for instance.

"The surveyor might ask what to do in a fire, and sometimes the facilities management person can offer ways to improve the response, or answer questions that come up during the survey," Pelling says. "Sometimes the staff person will realize she doesn't know the answer well enough and ask for clarification. If you have the department representatives there, it can act as an inservice right on the spot."

• **Be willing to break out of the survey role for on-the-spot education.** While it's important to act out the surveyor role as much as possible, don't forego opportunities to answer questions and offer suggestions. The only exception might be the final dress rehearsal, in which you're trying to maximize the simulation. But even then, don't get so carried away with the playacting that you forget the real goal is to improve the survey results. If you limit yourself to doing the survey exactly like a real Joint Commission survey, you'll

miss the opportunity to give valuable advice, such as suggesting a different way to answer a question.

Remember that your mock surveys will take considerably longer than a real Joint Commission survey. The real surveyors do this for a living and can be very efficient, and they don't have any need to stop and educate staff along the way.

• **Schedule staff members who are likely to be present for the real survey.** The organization often knows when the surveyor will visit, or at least have a good idea, so Pelling recommends trying to schedule those staff members to be present for your last mock survey. This will give those staff more exposure to the process and more practice with responding to questions.

• **Look for staff who just can't handle the pressure.** The mock surveys will help you see how individual staff respond when a surveyor asks a question or requests certain documentation, with their bosses and other observers standing by. Some people can't handle it.

"There have been times when we realized some people just are too uncomfortable and freeze up," Pelling says. "They may be good staff people and do their jobs well, but they're just too uncomfortable to be put in the spotlight like that. It doesn't do you any good to have them there when the real surveyor shows up."

When you spot those staff, try to have their work schedules temporarily altered so that they're not on duty for the real survey. That's acceptable as long as you're doing it only because the person is nervous about the survey, not because the person is insufficiently trained, she says.

• **Use the last mock survey to concentrate on records review and accessibility.** By the time you do the dress rehearsal just before the actual survey date, it's too late to make significant changes to operations. Instead, Pelling suggests you consider the organization's improvement essentially finished at that point and concentrate on how well your staff can demonstrate the organization's compliance with Joint Commission standards.

"We're in more of a fine-tuning mode by then," she says. "When we see that staff are having trouble finding certain documents or directing the surveyor to the right documentation, we address that immediately. That's the kind of thing you can fix at the last minute, not policy issues."

• **Be sure to communicate the results of the mock survey.** Pelling and Mellott say this is the biggest mistake that health care providers make with mock surveys. They may gather useful information from the survey, but then they don't disseminate it. After each mock survey, meet with the survey process team to discuss the results. Establish what tasks are necessary to improve the results and then compare the next mock survey to look for improvement.

"You have to report the results back to three levels: the medical executive committee, the hospital administration, and the quality steering committee," Mellott says.

"Responsibility is the key there, holding them accountable for what they're assigned to improve," she adds. ■

HIPDB raises query fees, makes other changes

The U.S. Department of Health and Human Services (HHS) has announced that the query fees for the Healthcare Integrity and Protection Data Bank (HIPDB) and possibly the National Practitioner Data Bank (HIPDB) are rising.

The fee for querying the HIPDB was raised to $5 per query on Oct. 1, 2001, up from the previous $4. The same increase might be made for HIPDB queries, according to HHS. Also, there is a new system for performing a self-query. Previous versions of self-query applications will no longer be accepted.

Self-queries now must be completed and transmitted through the HIPDB-HIPDB web site at www.hipdb-hipdb.com. After completing the application on the web site, you will be able to print it and then mail a notarized copy to the data banks. ■

Joint Commission's task force making progress

The Joint Commission on Accreditation of Healthcare Organizations reports that its Standards Review Task Force is making progress in rooting out the redundant and overly burdensome portions of its standards.

The task force, whose mission is to review Joint Commission standards for anything unreasonable or unnecessary, recently held its second meeting. At its first meeting in June, the task

force reviewed the Patient Rights standards and standards compliance requirements. The Joint Commission reports that the second meeting was devoted to reviewing the Governance standards and approximately half of the Leadership standards. Task force members noted that these chapters have a great deal of redundancy.

"They also suggested modifications to the survey process for many of these standards that would allow surveyors to focus on specific, applicable issues and standards, and 'drill-down' in other standards areas if needed," according to a Joint Commission report. "There was a general sense that the Governance chapter could be incorporated into the Leadership chapter. Interestingly, prior to 1994, Governance standards represented a small section of the Leadership chapter."

In another change, the task force said the Leadership and Governance standards should not be subject to on-site survey review. Many of the Leadership and Governance standards are concepts and principles that can be used as a road map for effective management of an organization, the task force said, but now they are practiced so uniformly that on-site survey review is unnecessary.

Two standards cited as too burdensome

Two standards were identified as overly burdensome. Standard LD1.7.1 states that "each department provides patient care according to its written goals and scope of services." In most instances, the task force says, hospitals create these documents solely to meet the JCAHO standard — without any meaningful contribution to improving health care. Instead of serving as a useful tool to assist in decision making, the binder of department-specific goals and services "typically sits on a shelf until it is updated prior to the next survey," the task force reports.

Standard LD1.3.4.2 also was cited for its administrative burden and political nature. That standard calls for medical staff approval of sources of patient care provided outside the hospital. In effect, that means that the medical staff reviews every contract for outside sources of care, such as physical therapists and laboratories. That's too broad, the task force concluded.

Task force members suggested that health care organizations seek medical staff input into the quality and associated measures of the external provider rather than provide a detailed review of all contractual provisions. ■

JCAHO's accreditation categories changed

In an effort to make its accreditation categories more user-friendly for consumers, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is renaming two of them, effective Jan. 1, 2002. The categories were renamed in order to better convey to consumers an organization's level of performance.

Accreditation without Type I Recommendations becomes Accreditation with Full Standards Compliance, which is awarded to health care organizations that demonstrate satisfactory compliance with applicable JCAHO standards in all performance areas.

Accreditation with Type I Recommendations becomes Accreditation with Requirements for Improvement, and will be awarded to health care organizations that demonstrate satisfactory compliance with applicable JCAHO standards in most performance areas but have deficiencies in one or more performance areas or accreditation policy requirements that require resolution within a specified time period.

Also, the Accreditation Committee modified the 2002 Conditional Accreditation decision rules to increase the summary grid score threshold for a recommendation of Conditional Accreditation from 75 to 79.

If applied to 2000 survey results, the new threshold would have increased the incidence of Conditional Accreditation decisions from 2.3% to 4.1%.

Another development at the Joint Commission involves when to include physician practices in organization surveys.

Under new rules adopted by the Executive Committee, the physician practice will be included in an organization's survey if:

1. The organization includes the practice in its Medicare cost report as a provider-based practice.

2. The physician is an employee of the organization and the organization and / or the physician practice affirmatively portrays to the public that the physician practice is part of the organization through either:

— using common names or logos;

— placing references on letterhead, brochures, telephone book listings or web sites;

— putting representations on other published materials. ■

Address e-mail security in the quality department

By **Patrice Spath**, RHIT
Brown-Spath Associates
Forest Grove, OR

Computer-based electronic mail is changing the way quality managers do business. E-mail provides a means to create, transmit, and respond to messages electronically. An increasing number of quality departments use e-mail systems to distribute memos, circulate drafts of committee minutes, disseminate quality directives, send external correspondence, and support various aspects of their operations. A well-designed and properly managed e-mail system can speed up communications and eliminate paperwork.

But the opportunities for increased efficiency are lost if your e-mail system and the electronic documents it handles are not managed effectively. The same e-mail system that delivers information instantaneously and reliably also can create chaos for quality managers. Potential loss of control over sensitive quality records and important documents and concerns about privacy, security, and public access are just a few of the issues that quality managers must address.

E-mail is just like any other official record created within the quality department. The courts have confirmed that information stored in a computer is as much a business record as a written page in a procedure book or a paper report stored in a filing cabinet. Therefore, e-mail must be subject to the same controls and security as paper documents. Accessibility and retention policies and procedures should apply equally to e-mail and other forms of communication that are created or received by the quality department.

Existing organizational policies for telephone, fax, or written communications may not address all issues raised by e-mail, because e-mail combines some characteristics of electronic communications with elements of written documents. Therefore, your facility should have a specific policy on the use of e-mail, access and privacy protection of e-mail messages, and on retention of e-mail. The policies governing e-mail use by the quality department may need even further clarification. Information created or stored in e-mail systems is considered an official record and therefore subject to discovery proceedings in legal actions. For this reason, the e-mail policies of the quality department should comply with the intent of the state laws governing protection of peer review and/or risk management documents. While responsibility for functions such as security and disaster recovery usually is assigned to a network administrator in the information services department, the quality manager should have input into e-mail practices related to sensitive and confidential information.

The traditional roles and responsibilities of people in the quality department may change as new technologies such as e-mail are introduced into the workplace. All e-mail users in the quality department should be informed of their responsibilities for proper use of e-mail and records in the e-mail system. These responsibilities may include:

- Limiting use of the e-mail system to official business.
- Responding promptly to messages.
- Protecting e-mail messages and attached files or records from unauthorized release.
- Removing personal and transitory messages from personal in-boxes on a regular basis.
- Protecting e-mail messages from inadvertent loss or destruction by complying with backup requirements and procedures.

To prevent conflicting directives and confusion about responsibilities, written policies should identify the individuals in the quality department who are responsible for each element of the departmental e-mail policies and services. New employees in the quality department should receive an orientation to e-mail policies and user responsibilities.

Enforce e-mail security

To ensure the security and authenticity of records communicated through e-mail systems, the quality department may wish to restrict who can read, write, change, and delete files. Password protections can be used to restrict access to authorized users. The quality department may wish to have an e-mail system that has message protection and authentication controls to prevent users from changing an e-mail message once it has been received by at least one recipient.

When transmitting protected documents such as performance reports or committee minutes, security labels, such as "urgent," confidential," or "acknowledgement requested," should be attached to the e-mail message by the sender to alert recipients of special privacy and handling requirements. Other security measures such as encryption, virus protection, and backup procedures provide additional protection against unauthorized access, alteration, or loss of vital information.

Staff in the quality department should make every effort to ensure that the confidentiality of electronic mail is appropriately maintained. It is important to remember that security cannot be assured when messages are sent over outside networks such as the Internet. Because of the insecure nature of the Internet and the number of people to whom the messages can be freely circulated without the knowledge of the quality department, you may wish to limit transmission of highly sensitive reports.

Some of these concerns may be avoided with the use of encryption techniques. Encryption is like an electronic combination lock: The sender encodes the text of a message, causing it to appear as a series of seemingly random characters and symbols. Whether or not the quality department wishes to use encryption with a particular transmission is a question that depends on the sensitivity of the information being conveyed. As with any communication, there is a risk of interception. If an unintended interception of the information would cause harm to the hospital, a member of the medical staff, or to a patient, extra precautions must be taken to preserve the integrity of the correspondence.

A greater security risk to quality departments communicating via the Internet may well be simple human error. Improperly addressed Internet e-mail is just as likely not to reach its intended recipient as improperly addressed postal mail. A computer does not know, for example, that mail addressed to *patrice@bronspath.com i*s really intended for *patrice@brownspath.com.* A simple typographical error in addressing easily can result in a confidential message or report being sent to an unintended recipient.

It should be pointed out that the confidentiality risks in using e-mail are perhaps no greater than in other commonly used forms of communication. Cellular phone conversations can be monitored with readily available scanner technology. Fax transmissions pass through many hands on their way to the ultimate recipient and are commonly in public view in the "fax room" until delivered. Postal mail can be misaddressed. While quality departments should not be dissuaded from using e-mail, it is important to adequately address the security concerns.

E-mail often is treated as an informal or private method of communication, and this could cause problems for the quality department. Staff should be made aware of the rules and conventions surrounding the use of e-mail.

The organizationwide information plan that

CE questions

17. The Council on Scientific Affairs from which organization last year released the report *Medical Preparedness for Terrorism and Other Disasters*?
    A. The Joint Commission on Accreditation of Healthcare Organizations
    B. The National Commission for Quality Assurance
    C. The American Medical Association
    D. The American Hospital Association

18. List one of the top 12 mistakes in emergency preparedness plans, according to Cameron Bruce, CSP, PE, a health care consultant in Orinda, CA.
    A. contain too much multidisciplinary input
    B. inadequate drilling or testing of the plan and its components
    C. consider too many probable scenarios
    D. none of the above

19. According to Susan Mellott, PhD, RN, CPHQ, FNAHQ, a consultant in Houston, planning for a Joint Commission survey should start at least 18 months before the anticipated survey date.
    A. true
    B. false

20. On Oct. 1, 2001, the fee for querying the Healthcare Integrity and Protection Data Bank rose from $4 to what amount?
    A. $5
    B. $7
    C. $10
    D. $12

describes policies and guidelines on managing and maintaining e-mail records may not adequately address the issues of concern for the quality department.

As a general rule of thumb, don't commit anything to e-mail that you wouldn't want to become public knowledge. There is always the chance that a message could end up in someone else's hands. Assume that your message, and any attached files, could be around for a long time. It is easy to copy, store (electronically or in hard copy), resurrect, and forward anything you write in e-mail. And remember, e-mail messages often are retained on system backup tapes and disks in central computing facilities long after they are deleted from the mail system. ■

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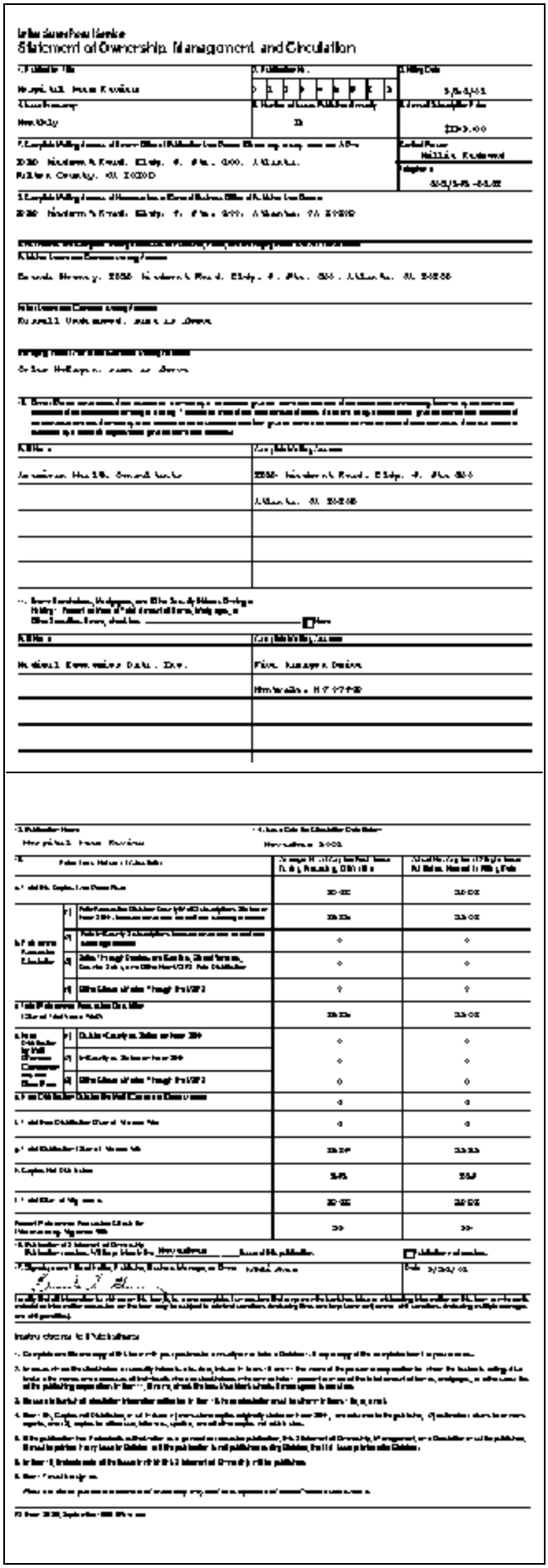
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To earn continuing education (CE) credit for subscribing to *Hospital Peer Review,* CE participants should be able to meet the following objectives after reading each issue:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and / or based on independent recommendations from clinicians at individual institutions.

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Quality field still promising, but consider employers' needs

Peer review and quality improvement still hold promise as a career path, but the savvy professional should recognize the changing needs of employers and put themselves in a position to help, experts say.

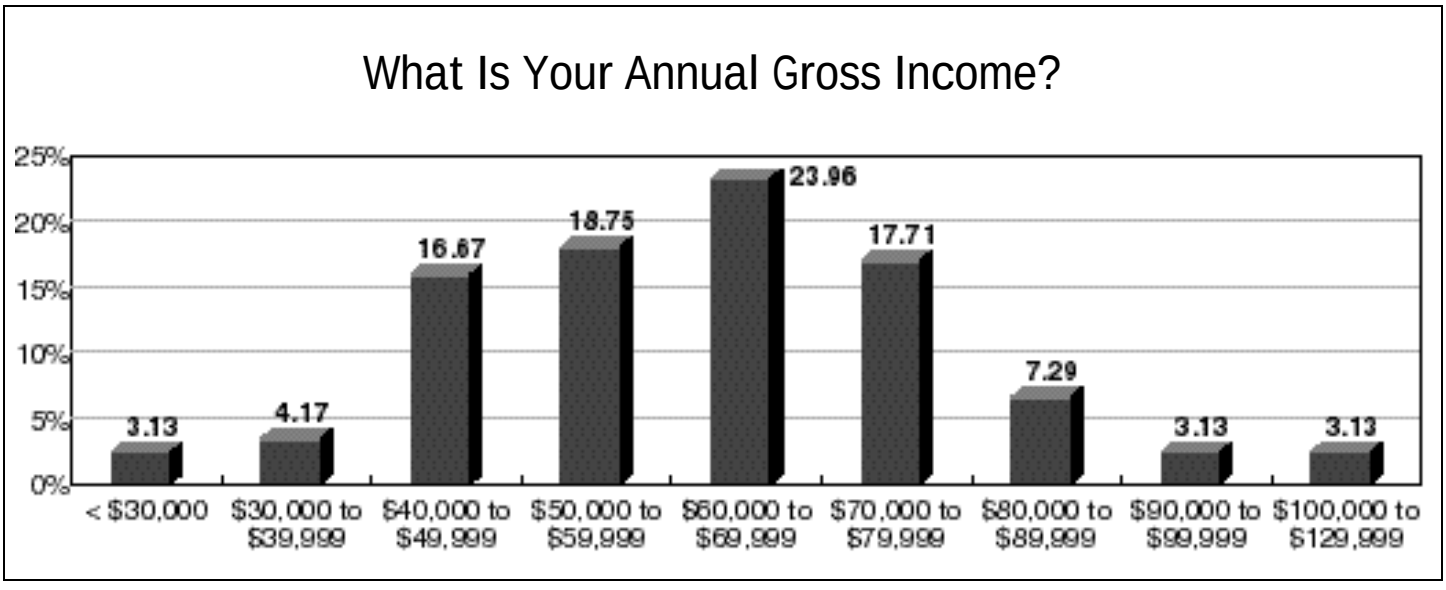
Watch changes closely

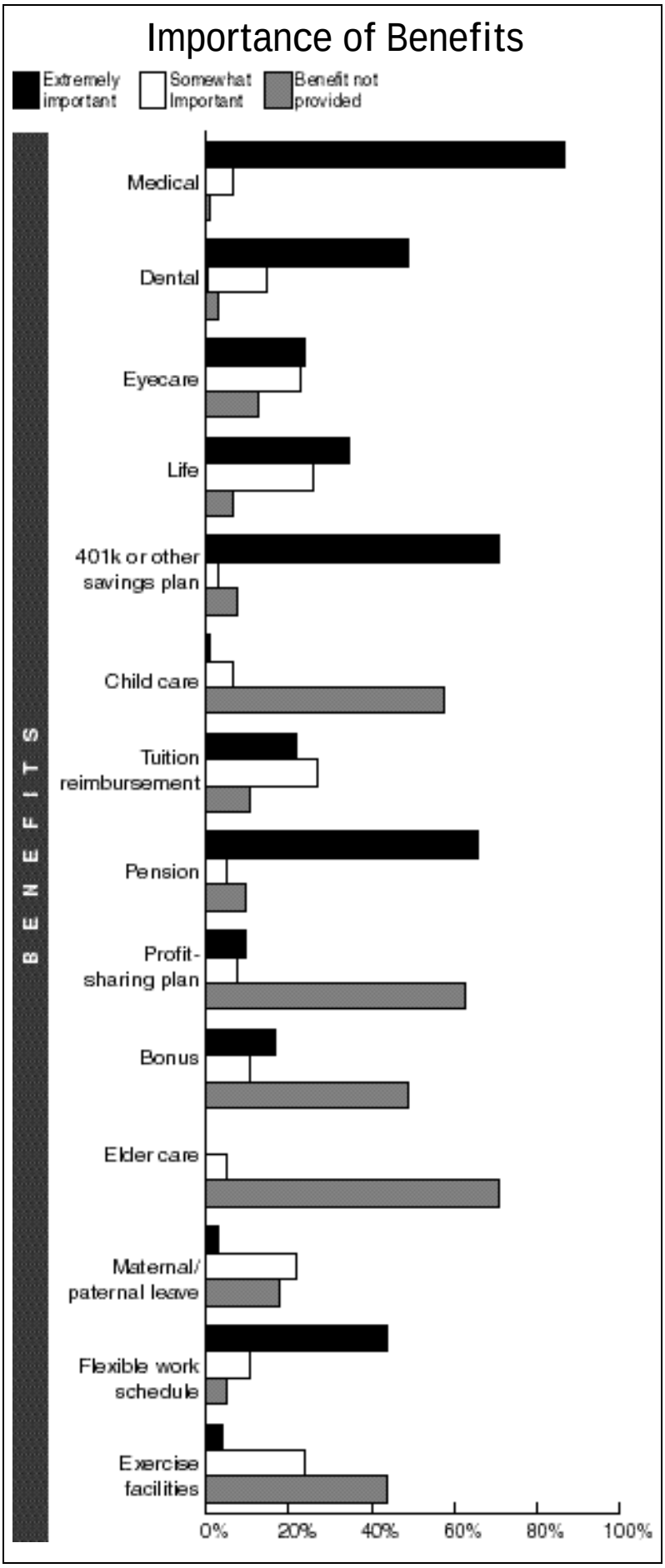
There are a lot of changes going on right now, but you have to look closely to figure out how they might affect you. **Janet Brown**, RN, CPHQ, head of JB Quality Solutions consulting in Pasadena, CA, says she is seeing an interesting trend in the classes she teaches for those seeking CPHQ certification. Lately she has noticed that about a third of her classes are comprised of people who are either new to the field or have been in it for less than two years.

"I think that tells me that some people are getting out, but I have a sense that the passion lives, and health care organizations are certainly hiring, based on the fact that there are folks new to the job," Brown says. "I would worry if we saw the classes dwindling or never saw any young faces. It's a good thing to see new people because it means somebody has job openings."

Quality roles are changing

The role of the peer review and quality professional is changing, however. Brown says the person is becoming "less of a doer and more of a resource."





There is so much information available now that health care organizations need a filter of sorts, someone on staff who can interpret quality standards and other information, Brown says.

Learn how to be a resource

"The resource center concept is what organizations are looking for these days," she says. "They're looking for people who know how to help them make the best decisions. I'm not sure we have to have answers to all the questions, but we have to have enough understanding to know where the better options and practices are.

"I think the value of the professional is that they can offer process solutions, have answers to questions," she points out.

Brown says quality professionals should take steps to move in the direction of being a resource center, mainly by becoming familiar with the relevant literature, web sites, and other information.

She says you should work toward becoming "the resource center for quality" and know where to get practice guidelines, where to find valid performance measures, and which software vendors have the best products.

Field holding steady as some move up

The other big change in the field is that the scope of a quality professional's work is growing ever wider. Fewer professionals have departmental concerns these days, and Brown says many are moving up into much higher positions within the organization. That's a trend she's watched for the past five years.

"Quality has gone organizationwide, so we're not seeing so much of the old situation where you had one person or a few in an organization whose job was to maintain and improve quality," she says.

"Quality also has moved into more of an overall integrated delivery system, with health care systems taking a broader approach instead of keeping it at a lower level with a quality improvement person focusing on just one facility," Brown explains. That can open up career opportunities. As quality becomes a regional concern for many health networks,

many quality and peer review professionals are earning higher salaries. Brown says one colleague recently confided in her that she's earning close to $100,000 a year, which represents a significant milestone in her career.

Job consolidationss

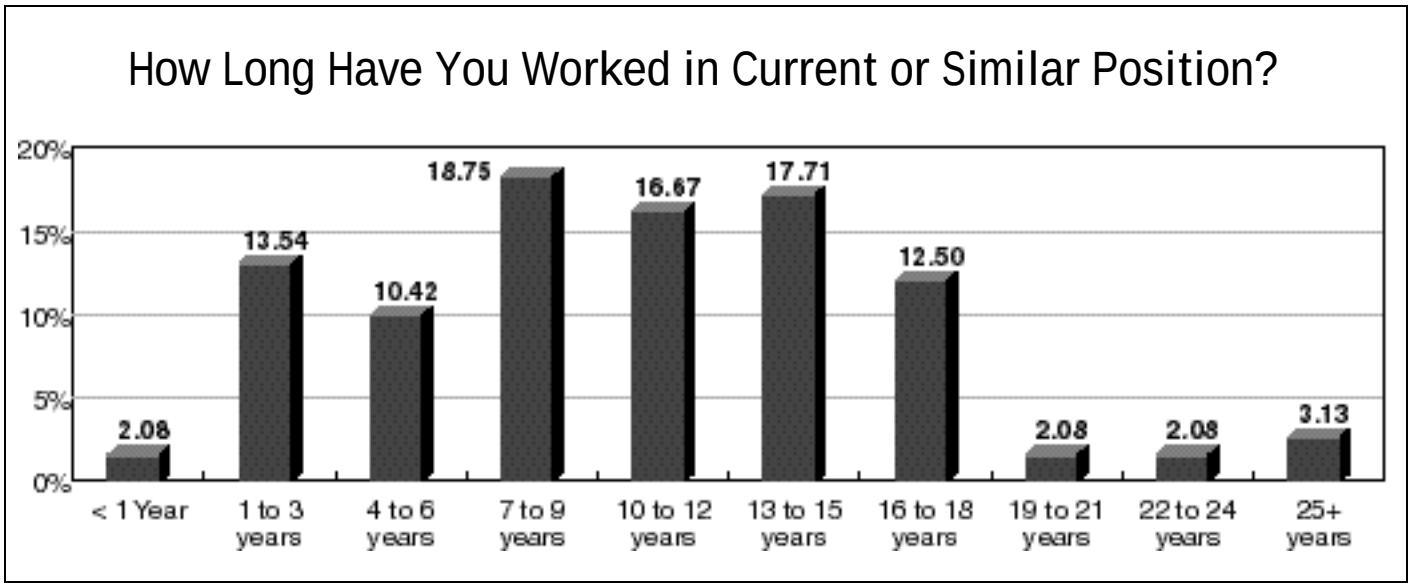
Another observer says she has seen a lot of job consolidation in recent years. **Patrice Spath**, RHIT, a consultant in Forest Grove, OR, says many quality managers are moving from positions where they managed a department to overseeing several hospitals or a hospital system. Quality managers also are getting more involved in patient safety and serving as patient safety officers.

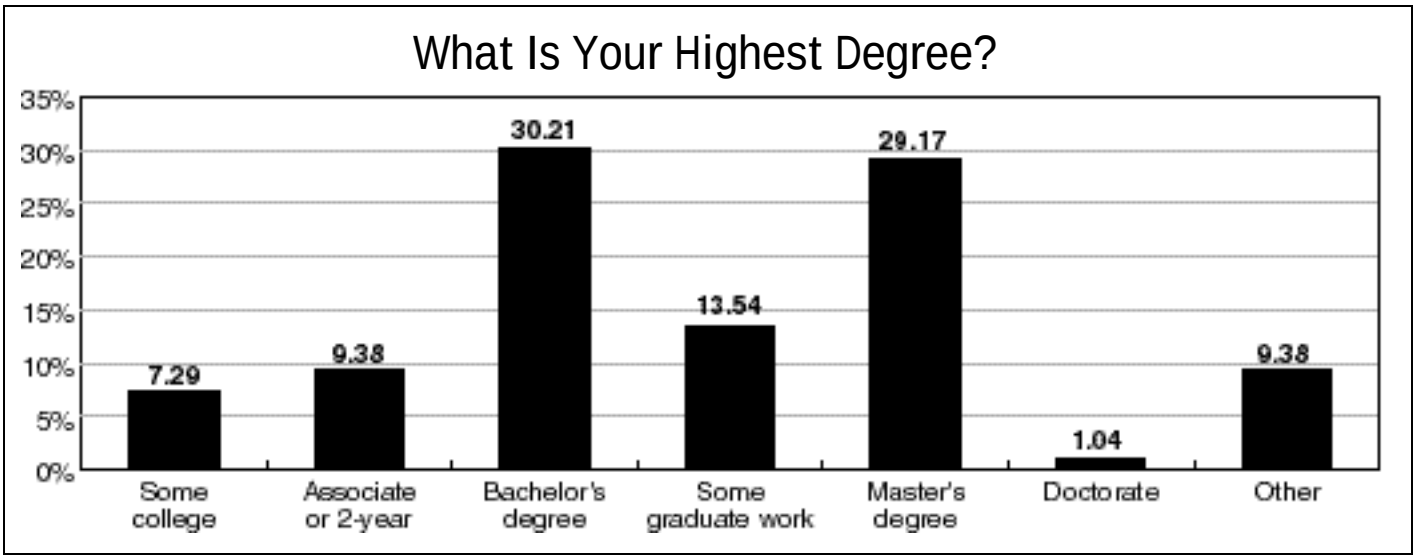
"They're getting more responsibilities on their desk, but not much change in income," she says. "A lot more on our plate without the time to do it or any additional money." Many quality managers also have the opportunity to get involved in compliance issues and could move into compliance officer positions. That's more likely if you have a medical records background, Spath says.

More work for the same pay?

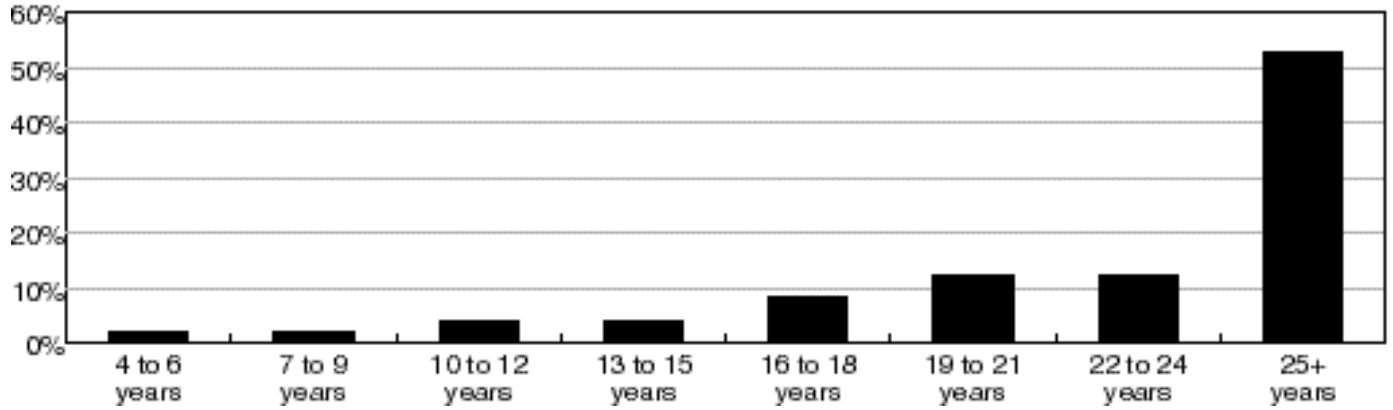
Much of the trend toward more responsibility, with or without a better income, can be traced to increased public awareness about medical errors and quality, Brown says. The Institute of Medicine report on medical errors and the work done by The Leapfrog Group have focused more attention on quality and made the work of quality professionals more valuable, she says.

"Organizations are leaning strongly toward a quality emphasis and focus is clearly on very specific performance issues," she says. "They have to





How Long Have You Worked in Health Care?



make quality a high priority, and that means employing people who know quality is a high priority."

Data management becoming a high priority

Spath says health care providers increasingly are focused on data collection and analysis, so the quality manager who is skilled in that area will find better career opportunities.

"More and more people are getting into benchmarking projects using the data to judge quality for their own organization," she says. "That demands that you have better statistical analysis skills than you ever had before. As we move into patient safety and start applying some failure models and criticality analysis tools, we need a better understanding of those tools and even engineering principles."

Those skills will make you more desirable in the marketplace, but Spath says she still isn't sure they will result in much more money in your pocket. The only health care professionals getting more money lately seem to be nurses and others who are in short supply, she says.

Be watchful for opportunities

"Holding steady" is a term used by both Brown and Spath, and both say they see opportunities on the horizon. Brown says she hasn't seen any downturns in the career field, and she expects the emphasis on quality to continue for a long time.

"It's a good time to be in this career," she says. "Pay attention to the changes, and I think you'll find good opportunities." ■

Salary by Region

West

$50,000 to $59,999	60.0%
$60,000 to $69,999	20.0%
$70,000 to $79,999	20.0%

West Coast

$40,000 to $49,999	20.0%
$60,000 to $69,999	30.0%
$70,000 to $79,999	40.0%
$100,000 to $129,999	10.0%

Midwest

Less than $30,000	2.9%
$30,000 to $39,999	8.6%
$40,000 to $49,999	20.0%
$50,000 to $59,999	20.0%
$60,000 to $69,999	25.7%
$70,000 to $79,999	17.1%
$100,000 to $129,999	2.9%
$130,000 or more	2.9%

Northeast

Less than $30,000	5.6%
$40,000 to $49,999	11.1%
$50,000 to $59,999	11.1%
$60,000 to $69,999	27.8%
$70,000 to $79,999	11.1%
$80,000 to $89,999	22.2%
$90,000 to $99,999	5.6%
$100,000 to $129,999	5.6%

Southeast/Southwest

Less than $30,000	3.7%
$30,000 to $39,999	3.7%
$40,000 to $49,999	18.5%
$50,000 to $59,999	22.2%