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27

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# Joint Commission wants to see new effort on terrorism plans

*Cooperating with other local providers now a big focus for surveyors*

Health care providers must step up their preparations for terrorist attacks and other disasters, according to a new Joint Commission on Accreditation of Healthcare Organizations directive that says past requirements for emergency preparedness are not enough in the post-Sept. 11 era.

In the immediate aftermath of the attacks, the Joint Commission urged providers to review their emergency preparedness plans and update them in light of the new threats. But as the health care community took a closer look, the organization determined that previous standards were inadequate and recently added a new requirement to EC.1.4, the standard requiring each organization to have an emergency management plan.

Added to the "intent" section, that new clause calls for cooperation among health care organizations on a local level. The addition is prefaced by a stark explanation that it is needed because of "the experiences of health care organizations responding to the September 2001 terrorist attacks in New York City and Washington, DC."

This is the text of the new requirement:

"Cooperative planning among health care organizations that, together, provide services to a contiguous geographic area (for example, among hospitals serving a town or borough) to facilitate the timely sharing of information about:

• essential elements of their command structures and control centers for emergency response;

• names, roles, and telephone numbers of individuals in their command structures;

• resources and assets that could potentially be shared or pooled in an emergency response;

• names of patients and deceased individuals brought to the organizations to facilitate identification and location of victims of the emergency."

**Robert Wise**, MD, vice president in the division of research at the Joint

Commission, tells *Hospital Peer Review* that the organization had been reviewing EC.1.4 for some time in an effort to improve how providers respond to disasters. Based on incidents such as major storms, the researchers already were starting to think that local cooperation among providers needed improvement. The New York terrorist attack made that a certainty.

"As we changed our assumption that these types of large-scale attacks were highly likely in major metropolitan areas, we found that the thing that was still missing in some cities was some type of cooperative planning among health care organizations," he says. "If you're going to have a disaster hit at a communitywide level, something that large, it's not going to work to have each organization trying to decide what to do on their own."

Wise notes that the new language has been added only to the intent section of the standard, meaning it is technically not a new part of the standard. The revision also states that the addition is only "clarified language, not additional requirements." But Wise says that distinction is irrelevant. Surveyors will check for compliance with this new clause.

"This is viewed as an important part of the emergency management standard," he says. "We will want to see evidence of this later on. This is a change in a requirement; it's not important whether it's in the intent or the standard."

Almost all providers will have to revamp their emergency management plans in light of this new requirement, he says. The Joint Commission wants to see providers develop an extensive, detailed coordination plan with each other before disaster strikes, and Wise emphasizes that this needs to be more than the type of plan that currently exists for mutual aid, diversions, disaster drills, and disaster plan activation. Much of the new work will involve administrative coordination among providers, which could prove challenging, he says.

"The system needs improved coordination, cooperation, and planning throughout the entire health care delivery system," Wise says. "We thought it was so important that we decided to bring it up to a standards level. This is important. People need to act on it immediately."

### *Information-sharing is a key goal*

In the past, much of the disaster coordination among local providers has been of a practical nature, with the main goal being that limited health care resources be mobilized for a large number of victims. While that remains a concern, Wise says the New York experience illustrated the need for more information-sharing among providers during the disaster and afterward.

"One of the things that completely overwhelmed the hospitals in New York was that there was no central place for names of the people admitted or the several thousand who died," he says. "So you had all these people going from hospital to hospital to hospital looking for their husband, or mother, or daughter. We hope not to see that again."

Wise praises the overall preparation of hospitals in the New York City area, saying it was nearly impossible for anyone to anticipate a disaster of the type and magnitude that struck on Sept. 11. But now it's not so hard to imagine that type of disaster happening again, so providers must learn from the experience and plan accordingly, he says. A centralized databank for the community, with all local providers inputting information and consolidating it, would greatly improve the community's response, Wise says.

The other issues cited in the new requirement also deal with sharing information among providers — elements of your command structure, contact information for key people, and resources that could be pooled or shared. Sharing that kind of information may sound easy at first, but Wise cautions that you could run into problems once you try to do it. Handing over information may not be easy, especially in communities where providers are in strong competition with each other.

## *COMING IN FUTURE MONTHS*

- Hospital is model for emergency planning
- Sharing information with competitors
- What to do after the surveyor leaves
- M&M info: How to get the most out of it
- Learning from sentinel events

"Part of the problem is that hospitals are in tough shape financially, a very competitive environment, and most see the hospital down the road as a major competitor," he says. "In some places, it will require a culture change to sit down and work together. I think that they will embrace it in spirit, but clearly the issue is in the details. How do they take something that is philosophically well within their mission and make that happen within a highly competitive business environment?"

Wise suggests that the best strategy might be to work within existing structures such as local hospital councils or state hospital associations.

**Joel Mattison**, MD, physician adviser in the department of utilization management and quality assurance at St. Joseph's Hospital in Tampa, FL, agrees with that strategy. Most communities already have some local committee that helps coordinate disaster response among health care providers, so they are the natural choice for coordinating the newly required information exchange.

However, Mattison cautions *HPR* readers not to underestimate the obstacles they might encounter when trying to comply with the new Joint Commission directive. Sharing information often will prove more difficult than cooperating in patient care, he says. It is unlikely that hospital administrators or clinicians will be able to just pick up the phone, call a competitor across town, and work out a shared computer database, for instance.

"Even if no one is looking for an excuse for avoiding this, you'll run into a lot of practical problems," he says. "Will your different information systems be able to mesh? Will there be fear of commercial espionage? No one ever admits that they fear that, but everyone does."

Confidentiality will be another major concern. Can one hospital share information with other facilities, or with a community database, without violating patient confidentiality? And Mattison anticipates that hospitals might have to upgrade their data collection systems, "so that you have computer terminals everywhere. If you're going to get this information in the system quickly, you can't wait for data entry at the end of the day."

## *Plan solo effort and cooperation at same time*

Wise says the Joint Commission saw another lesson emerge from the Sept. 11 attacks, something the organization has seen at countless other disasters of various types. No matter how well your hospital has planned to cooperate with other providers during a disaster, you'll probably be on your own for a while. That means your emergency management plan must take both scenarios into account.

"We've heard and learned that at the time of the emergency, the hospital has to assume it is going to be on its own for the first 72 hours," Wise says. "So you have to plan for all this cooperation, but you may be isolated at first. In New York, the police shut down streets, communication was disrupted, and the city lost its emergency operations center, so coordination by the city was severely hampered. You have this very interesting problem where the hospital has to say, 'I'm going to be on my own and need to be capable of sustaining our services for that time.' But you still need to plan for the cooperation that is so important afterward."

## *Expect challenges and hard work*

Wise acknowledges that hospitals and other health care providers may find this new requirement challenging. If you don't, he says, either your community has a truly superior system in place already or you're underestimating what the Joint Commission expects. The required work — setting up a central community database, for example — can be expensive, so the Joint Commission is working closely with federal officials to find funds. Some of the money allocated by Congress after the terrorist attacks might be made available to health care providers for this type of improvement, he says.

Hospitals will be challenged to comply with the new Joint Commission directive, but the work will be easier if administrators remember why they're doing it, Mattison says.

"Those people wandering around New York looking for people, that's the kind of thing that will make hospitals cooperate when other things wouldn't. We all remember seeing that, and we don't want it in our community," he says. "That will motivate even those people who usually don't cooperate very well."

*(Editor's note: For more information on preparing for terrorism and other disasters, see the Joint Commission's publication* Perspectives. *The December 2001 issue is a special report on emergency management and contains a wealth of useful information. The issue is available on-line for free at www.jcrinc.com/subscribers/perspectives.)* ■

# QI project: Get babies home fast, yield savings

Cutting length of stay is a goal at most hospitals, but neonates usually are not a target because they are seen as too delicate and no one wants to risk sending a sick newborn home too soon. At a North Carolina hospital, however, the quality improvement staff found that an aggressive approach can benefit both patient and hospital alike, with little increased risk.

Carolinas Medical Center in Charlotte, NC, already was seeing great success in its use of a low birth weight clinical path that standardized the care of many neonates, reducing the length of stay by 46% over several years. But because North Carolina ranks high in the percentage of babies with low birth weight and in infant mortality, there still was plenty of room to improve, says **Martha Whitecotton**, RNC, MSN, vice president and chief nurse executive at the hospital. She previously worked as a nurse in the hospital's neonatal intensive care unit.

"We started hearing about other hospitals discharging babies at a much lower weight, so we looked at that as a way to further lower our length of stay," she says. "One process that we had to put in place was a whole new process of thermoregulation. We thought we were holding these babies too long, not moving them from the bassinet to the open crib, not challenging them early enough."

The hospital started working on a program called "There's No Place Like Home" that could accelerate the babies' progress and send them home earlier. Not only would the hospital benefit, but the neonates and the families would benefit from limiting the expense and the stress of a hospital stay. In nearly all cases, a baby will develop better at home as long as certain needs are met, Whitecotton says. But for low birth weight babies and others with serious problems, the challenge was how to meet those needs without keeping the baby in the hospital for weeks or months.

"They needed home care if we were going to send them home any earlier. We previously had some home visits for discharged babies, but there weren't a lot of home care nurses who were comfortable caring for premature babies," she says. "And the clinicians weren't interested in discharging them sooner because they thought they would just end up back in the hospital. So we decided to cross-train our neonatal nurses to be neonatal home care nurses."

## *Nurses take NICU care to the baby's home*

Deciding it was easier to train neonatal nurses in home care than vice versa, the hospital trained five nurses in the particular concerns of home care, including documentation and other regulatory issues that were different from their usual work. The original idea was for each baby to be cared for at home by the same nurse who cared for him or her in the hospital, but that proved unfeasible. Instead, the five neonatal nurses split up the home care workload. Two of them do only home care for neonates, and the other three split their time between inpatient care and home care.

"The two nurses who do it full time were burning out in their positions before we started this program, and now they're loving their work again," Whitecotton says. "So in addition to all the other benefits, we see it as great for staff retention."

The program started in 1996 and took a full two years of preparation. After the nurses were trained in home care for neonates, the hospital still had to choose participants carefully. Babies previously were discharged at a minimum of 5 lbs., but the goal in the new program was to discharge them at 4 lbs. to 4.5 lbs. That goal wouldn't be realistic for all premature babies, however. For the early discharge to work, the parents had to be eager, motivated, and highly involved in the patient's care. The baby had to be stable, able to maintain its body temperature, and gain weight at home.

About 250 babies have been discharged in the program so far, and the resulting data have been analyzed for the first 135. Those first babies were discharged an average of 15 days sooner than their hospitalized counterparts, and they actually gained more weight at home — about 35 g per day at home vs. 20 g per day in the hospital. The faster weight gain is a good indicator of overall health improvement, Whitecotton says, and most likely the result of more attention and a better overall environment at home.

## *Investment pays off for babies and hospital*

The readmission rates were the most impressive sign of success. Carolinas already had a significantly lower readmission rate for premature babies than the industry average, but the rate fell even lower when the babies were sent home

early. The early discharge babies were readmitted at an average rate of 0.74%, compared to 0.89% in the hospitalized group.

There was no doubt that the first year of the program brought great benefits to the babies, but then some number crunching revealed benefits to the hospital as well. For the first 135 babies, the charges for home care totaled $81,000 but the charges avoided in the hospital were $3.5 million, based on expected 15 days of stay for each baby.

Start-up costs for the program were about $38,000. Top administrators at Carolinas supported the program from the beginning, Whitecotton says, and it helped that the start-up costs were relatively low. The hospital did have to hire additional neonatal nurses because of the increased workload.

### *Program wins award from Joint Commission*

**Suzanne Freeman,** president of Carolinas Medical Center, says the investment paid off for both the babies and the hospital. The program was successful largely because of the cooperative effort from the parents, clinicians, and administrators.

"Many people worked very hard to make this program successful, especially the parents of low birth-weight babies who meet the challenge to learn about home care and the special needs of their little ones," Freeman says. "I'm also proud of the neonatal intensive care nursery staff, the medical staff, and the home care nurses who worked together to make this successful from the clinical perspective."

Such good results did not go unnoticed by the Joint Commission on Accreditation of Healthcare Organizations. "There's No Place Like Home" was the 2001 recipient of the Joint Commission's Ernest A. Codman Award in the home care category. The Codman Award recognizes excellence in the use of outcomes measurement to achieve health care quality improvement. In announcing the award, **Dennis O'Leary**, MD, Joint Commission president, said the accomplishments of Carolinas Medical Center "underscore the productive innovations that can be achieved by measuring and using outcomes to improve patient care processes."

### *Benefits take time to build*

The program has had unexpected challenges and benefits. When the babies first started going home early, parents complained that they couldn't find local pharmacies to provide some of the special prescription drugs the babies needed. So Carolinas started a pharmacy outreach in which hospital pharmacists showed local drugstore pharmacists how to prepare some of the needed medications. Community physicians came to respect the program enough that they did not require as many visits as they normally did to monitor a neonates's development.

"They knew a qualified nurse was coming and would weigh the baby and would look for any signs of a problem, so they allowed the parents to visit the doctor a little less often," she says. "That was a big thing to the parents, because it can be quite an operation to load up the baby in the car, take the other kids with them, and go to the doctor for that checkup."

Another unexpected benefit was that managed care groups looked favorably on Carolinas for discharging the babies quickly and safely, so much so that 10 have approved the hospital for out-of-contract neonatal care.

The Carolinas experience shows that even challenging patients can be the subject of an aggressive quality improvement project, Whitecotton says. With the program's initial success, the hospital plans to proceed by expanding it to families that might not have been considered good risks before, such as single teenage mothers.

For peer review professionals who want to implement a similar quality improvement program, patience is a virtue, she adds.

"It was a full two-year process to get ready, and I don't think we could have hurried that. You can't rush it or you'll make mistakes along the way," she says. "The results showed us that all the time we took in putting it together was worthwhile. My first advice is to be patient." ■

## Hospitals should still use *Sentinel Event Alerts*

Much to the relief of many peer review professionals, the Joint Commission on Accreditation of Healthcare Organizations is backing off a plan to require that providers respond to its *Sentinel Event Alerts* in ways that could be assessed by a surveyor. But you still need to pay attention to the alerts, and formal scoring is not ruled out for the future.

The original plan was for the Joint

Commission's *Sentinel Event Alerts* to be used in calculating the hospital's patient safety management score. The *Sentinel Event Alerts* are published periodically by the Joint Commission and bring attention to the type of dangers involved in a particular type of sentinel event, plus the lessons learned by the health care providers. Joint Commission officials wanted the alerts to be used as criteria for determining how well a hospital has addressed patient safety — each alert was to be considered a lesson on that topic and then accredited hospitals would have to put those lessons to use.

**Ken Shull**, FACHE, president of the South Carolina Hospital Association in West Columbia, tells *Hospital Peer Review* that there was considerable resistance among providers who thought they would be unable to prove they had utilized the *Sentinel Event Alerts* in a short time. Shull chairs the Joint Commission's Accreditation Process Improvement Implementation Task Force.

### *Joint Commission issues moratorium*

In response to that criticism, the Joint Commission recently announced "a moratorium on the scoring of health care organizations with *Sentinel Event Alert* recommendations." The notice from the Joint Commission makes clear, however, that providers should continue making use of the alerts, even though formal scoring has been put on hold.

**Janet McIntyre**, Joint Commission spokeswoman, says surveyors still will look for evidence that providers are using the alerts, and she says the moratorium could be lifted if the Joint Commission develops a satisfactory scoring system.

"Current standards require organizations to review all *Sentinel Event Alert* recommendations, determine their applicability to their organization's services, and, where applicable, implement the recommendations or reasonable alternatives within 90 days of publication in *Joint Commission Perspectives*," according to the Joint Commission statement.

"Although the implementation of recommendations will not be scored during the moratorium, surveyors will assess, for consultative purposes, the organization's knowledge of *Sentinel Event Alert* recommendations and how the organization plans to implement these recommendations." ■

## ORYX option can reduce duplication of data

The Joint Commission on Accreditation of Healthcare Organizations has announced a new option that can help long-term care organizations reduce duplicative data collection requirements and even the costs of complying with ORYX.

Under a new plan just recently developed by the organization, an Internet-based reporting system will allow long-term care organizations to self-report to the Joint Commission the aggregate quality indicator data from the Minimum Data Set (MDS) mandated by the federal Centers for Medicare & Medicaid Services.

This will permit these organizations to use the same data to satisfy both government and Joint Commission performance data report requirements, says **Marianna Kern Grachek**, MSN, RN, CNHA, executive director of Long Term Care and Assisted Living Accreditation Programs at the Joint Commission.

Long-term care organizations that are satisfied with their current approach to meeting ORYX requirements may continue working with a Joint Commission-accepted performance measurement system without any disruption, Grachek says.

The new option was created in response to concerns expressed by accredited organizations and an August 2001 survey that found that this option and current reporting provisions would satisfy more than 70% of respondents.

The new options will preserve the widely recognized need to collect and transmit performance data while affording flexibility to long-term care organizations, she says. The charges for exercising the MDS data option — estimated at $550 annually — will be rolled into the triennial survey for accredited organizations.

A transition period of one year will be required for the Joint Commission to build the necessary infrastructure to receive self-reported data via the Internet. During this time, the organization will consider ORYX participation exemptions on an ad hoc basis to provide immediate relief to overburdened long-term care organizations. Such exemptions will require that long-term care organizations share MDS data reports with surveyors during onsite surveys and make those 2002 reports available to the Joint Commission via the Internet in 2003. ■

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# Office CM program draws praise from physicians

*Program helped decrease inappropriate admissions*

A medical office case management program that began in July at Sutter Health Central in Sacramento, CA, is drawing praise from initially reluctant physicians and offering veteran case managers a new and particularly enriching caregiving opportunity.

"I really find great value in this position," says **Bernadette Damper**, RN, BSN, A-CCC, a medical office case manager for Sutter Physicians Alliance who has been a nurse for 26 years and a case manager for the past nine. "This is the most useful I have ever felt."

One of the physicians with whom she works recently told Damper that he and his colleagues at first couldn't understand why a case manager was needed in their office. Now, Damper adds, the physician says, "We'd love you to be here five days a week all year."

Damper's assessment of the program is that it has provided "the missing link" for other Sutter initiatives, such as the chronic care program and the case management expertise provided in the hospital and in skilled nursing facilities.

"It has really enhanced communication with the rest of the continuum of care team," Damper says. "If the case manager in the hospital is having difficulty persuading a patient who needs more care than can be given at home, [the case manager] can call me, who might know the family better, and we can collaborate. If a patient is not doing well at home, and [the caregiver] sees that something needs to be addressed but can't count on the patient to communicate that, [the caregiver] can call me."

"I can be there during the physician visit."

When there is a change in the patient's medication regimen, Damper notes, she can inform the caregiver, as well as alert Sutter's chronic care team, which can meet with the patient at home to provide additional information.

The medical office case management program began as a way to add value to physicians' participation in the Sutter Physicians Alliance, says **Jan Van der Mei**, RN, continuum case management director for Sutter Health Central. In view of the resistance that some physicians have to being in a managed care organization, she notes, "we felt it was important to be aligned with the physicians to support them."

## *Survey physicians' opinions*

Before starting the program, Van der Mei says, Sutter Health sent physicians a survey to gauge their opinions on such issues as whether it was easy to place a patient directly into a skilled nursing facility or to manage the care of patients who make frequent visits to the emergency department (ED).

The results of the survey indicated that physicians believed there was room for improvement in several areas. For example, 85% disagreed with the statement that management of patients who frequent the ED is easy, and 77% disagreed with this statement: "I do not have to spend a great deal of time with

certain complicated patients who primarily have social issues." **(See survey results, p. 9.)**

At the program's six-month point, Van der Mei adds, another survey will be done to see if the case management initiative has made a measurable difference.

## *Program objectives*

The following strategic objectives were established for the program:

• **Increase patient satisfaction.**

Sutter Health already has distributed some patient satisfaction surveys, and the responses have been positive, she says. The survey process, however, is a "work in progress," Van der Mei notes. "Sometimes the case manager talks to the patient, sometimes to the caregiver, so finding the right person to survey has been a challenge."

It also is difficult at times for the patient to connect one of the various professionals she or he dealt with to the case manager referred to in the survey, Van der Mei adds. "They may have one or two contacts with the case manager. We're trying to improve the process of helping patients know who the survey is about."

• **Decrease primary care physician (PCP) visits per 1,000 patients by actively assisting with complicated cases.**

The idea, Van der Mei notes, is that patient issues more social than medical in nature could be handled by the case manager, eliminating the need for some physician visits.

• **Enable closed practices to open to new members.**

"We've had a huge problem with closed practices," she says. "I'm not sure if we can impact that, but one of the hopes is that by helping manage complicated cases, [the case management program] will decrease the caseload to the point that some closed practices could be reopened."

• **Avoid inappropriate admissions.**

When a caregiver comes into the office and says, "I can't deal with Mom anymore," there may be a tendency for the physician to admit the patient to a hospital because he or she doesn't know what else to do. A case manager can help in such situations by, for example, arranging a nursing home placement, Van der Mei adds.

• **Decrease the volume of ED visits.**

"Some patients use the ED as a physician's office," she says. "Case managers can work with the physicians to develop a contract or a care plan for the patient, which the case manager can help implement or support."

## *'Contract' promotes compliance*

Sutter Health issues a report that identifies patients who are noncompliant, meaning they repeatedly disregard physician instructions regarding medications or other issues, Van der Mei explains. That might mean, for example, habitually going to the ED to get more migraine medication at the last minute, rather than getting the drug through the physician's office, she says.

Although such action is rarely taken, patients who abuse the system can be disenrolled from the physician practice and from the managed care group, Van der Mei adds.

The patients that physicians initially thought to refer to their new case managers were those with mental health issues, she points out, and the fit was a good one.

"Most of the managed care contracts have mental health 'carved out,' and it is difficult to find who your HMO mental health providers are," Van der Mei says. "The patients were not able to get care, when you're severely depressed, you don't feel like making 10 calls [to find the appropriate provider]." The office case managers, she adds, were able to help navigate the HMO carve-outs and get the proper care for those patients.

Although physicians initially were skeptical about the case management program, Damper says, they now recognize that it can make a positive difference in their patients' outcomes. Her own interactions with patients and caregivers have ranged from helping decipher the changes in copays for Medicare HMOs to taking a proactive approach to nursing home placement.

Some medications that formerly were covered by Medicare are no longer covered, Damper points out, and some are covered but with different copays than before. She has helped find solutions for patients who were noncompliant because of financial concerns regarding their medications.

"With some patients, we need to find out if we can substitute a medication," Damper says. In other cases, she says, "we get in touch with the drug company representative and see if there is a [financial assistance] program they can go on." Many drug companies will supply free

*Continued on page 10*

**Sutter Health**
**Central Case**
**Management**

## PCP Pre-Program Survey
## Total Results – SIP, SMG, SWMG

| PLEASE ANSWER THE FOLLOWING: | Agree | Not Sure | Disagree | N/A or No Answer |
|---|---|---|---|---|
| The ability to place a patient directly into a Skilled Nursing Facility is easy. | 22% | 9% | 63% | 6% |
| The ability to obtain home health, infusion therapy or durable medical equipment for my patients is easy. | 26% | 9% | 65% | 0% |
| Management of my patients who frequent the ED is easy. | 6% | 3% | 85% | 6% |
| I do not have to spend a great deal of time with certain complicated patients who primarily have social issues. | 17% | 6% | 77% | 0% |
| I do not have many non-compliant patients. | 9% | 14% | 71% | 6% |
| My patients receive adequate education and support. | 20% | 9% | 71% | 0% |
| Linkages to the SNF team for admissions and follow-up care post discharge are easy. | 9% | 9% | 19% | 63% |
| Linkages to the Hospitalist team for admissions and follow-up care post discharge are easy. | 26% | 8% | 40% | 26% |
| It is easy to refer patients to the following Sutter programs and community resources: | | | | |
| SMF Diabetes Education | 34% | 9% | 57% | 0% |
| Sutter Chronic Care Program | 34% | 26% | 37% | 3% |
| CHF disease management | 21% | 38% | 35% | 6% |

*Source:* Sutter Health Central, Sacramento, CA.

medication to a patient if it's been determined the person needs a specific drug and can't afford to buy it, Damper adds.

In other cases, she says, a complicated drug regimen needs to be simplified or explained. That could involve a referral to Sutter's education program for diabetics, for example.

The goal with nursing home placements, Damper notes, is to encourage physicians to refer patients to her when the patient appears to get weaker with each visit, or when the caregiver looks haggard and is not coping as well as before.

"I like to get involved as early as possible so the family and the patient have more choices," she says. The patient may be eligible for long-term MediCal coverage, Damper explains, but because of the waiting period required might have to go in as a private-pay patient if the placement is done at the last minute.

Arranging a placement when the patient can wait at home for a couple of weeks also makes it more likely that a geographically convenient location can be arranged, she says.

Having a case manager involved can prevent a patient who may need only temporary placement in a nursing home from being admitted and "forgotten," Damper points out. "I had a patient with rheumatoid arthritis who couldn't walk to the bathroom because of the amount of pain she was experiencing. The caregiver couldn't manage her."

The patient was admitted to a nursing home, she says, but with the purpose of working on pain control and mobility. "With some adjustments we were able to make, she is now on a pain control regimen that works," Damper adds.

"I was able to keep abreast of her condition, so she was able to get in and out and be back home with her family for the holidays," she says.

Medical office case managers can play a key role in addressing end-of-life issues before a patient is in the ED being put on life support, she notes. "If a patient is losing the ability to take oral nourishment, we can address what the person's wishes are, so when the time comes, things aren't done that he or she didn't want done."

Before assuming her position, Damper says, she had been a medical/surgical case manager for Sutter, performing utilization management of both bed days and resources.

She also had discharge planning responsibilities. Asked to compare her previous job with her current one, she notes that while her mission is much the same, the way it is perceived is vastly different.

"One of the purposes of my being [in the medical office] is to ensure that the patient is treated in the most efficient location, at the appropriate place at the most appropriate time, Damper points out. "We still have utilization on our minds."

But unlike hospital case managers and discharge planners, she's no longer the "firing point" of families who think a patient is being released too soon and physicians who think they're not getting to make decisions, she says.

"I'm basically doing the same thing," Damper adds, "but because it's a noncrisis situation, what I'm doing is perceived better."

*[For more information on Sutter's medical office case management program, contact:*

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# CAQH announces plan for credentialing system

Pledging to ease physician paperwork, The Coalition for Affordable Quality Healthcare (CAQH) in Washington, DC, announced plans to launch a credentialing application system that it says will be dramatically simpler than existing systems and reduce paperwork for health care providers, health plans and hospitals.

CAQH is a nonprofit coalition of health care organizations founded by 26 of the nation's largest health plans and insurers covering more than 110 million Americans. **H. Edward Hanway**, chairman and CEO of CIGNA and chairman of CAQH, says the CAQH system will gather and store detailed data from more than 600,000 providers nationwide. These electronic records will be available anytime to authorized health plans and hospitals without requiring cumbersome paperwork and delays.

This initiative, to be launched in the spring of 2002, is the first phase of CAQH's broad multi-year plan to simplify not only the credentialing process, but also other administrative processes in the health care industry, says **Jay Gellert**, president and chief executive officer, Health Net, and chair of the Administrative Simplification Committee for CAQH.

"One of the most time-consuming tasks facing providers and payers is the paperwork associated with credentialing," Gellert says. "As part of our ongoing commitment to improving the health care experience, CAQH is reducing administrative hassles for providers across the country, giving them more time to focus on what's important: their patients."

A typical provider contracts with 10 to 20 health care organizations, each of which requires the provider to complete an extensive credentialing application. Using the CAQH system, each provider will submit a single application to one central database to meet the needs of all of the health plans and hospitals participating in the CAQH effort.

Providers may easily update their information on-line or via fax anytime, and will confirm once each quarter that the data on file are complete and accurate. During the course of the roll out, CAQH will invite health plans, hospitals, and related organizations nationwide to utilize these data to maximize the benefits of the system for the entire health care industry.

Organizations are not required to join CAQH to subscribe to the CAQH credentialing data system. Previous efforts to create a shared system for credentialing data have been limited to individual states, have appealed only to part of the health care industry, or simply lacked the technology available today.

**Marjorie O'Malley**, senior vice president for CIGNA and chair of CAQH's Credentialing and Provider Directory Work Group, says the CAQH system is designed to support the entire health care industry.

"CAQH is not a business; it is a not-for-profit coalition that enjoys the support of 26 of the nation's largest health plans and key trade associations," O'Malley says. "CAQH continues to gather input from organizations representing health care providers, health plans, hospitals, and even state legislatures to ensure that this system will meet the industry's needs. Each organization will continue to make its own credentialing decisions, but we will reduce the cost and hassle of managing up-to-date provider data."

CAQH development teams have agreed on a common set of required data and have incorporated state-adopted application forms where appropriate to provide a universal solution for providers and organizations nationwide.

Beginning in the summer of 2002, the system will become available to providers nationwide. ■

# Health plans report quality improvements

The National Committee for Quality Assurance (NCQA) reports that its fifth annual State of Managed Care Quality shows significant gains in all key areas of care and service from health plans for the second year in a row.

The report is based on an analysis of health plan performance data reported to NCQA for use in Quality Compass 2001, NCQA's database of managed care quality information. The 372 health plan products submitting data to the 2001 edition of Quality Compass cover more than 63 million people, says NCQA President **Margaret E. O'Kane**.

"For two years in a row, we've seen that participating health plans are getting better; the

rest of health care is still a real question mark," she says. "Further improvement is going to depend on collaboration and measurement at all levels of the health care system."

### *Continued success in care and service*

For the second year in a row, reporting plans registered across-the-board gains in all key areas of care and service. In particular, health plans are demonstrating increased success in delivering services aimed at controlling or preventing disease. Among reporting plans, the average rate of patients receiving a cholesterol screening after a cardiovascular event such as a heart attack rose from 69% in 1999 to 74% in 2000.

O'Kane says that is an important improvement because adequate cholesterol screenings, as part of a complete cholesterol reduction program, can help reduce morbidity and mortality from a heart attack or stroke by as much as 40%.

In addition, the rate at which diabetic members of reporting plans received an annual retinal exam increased from 45% to 48%. Retinal exams can lead to better management of the disease, thus preventing such complications as blindness and amputations, notes **Gregg Meyer**, MD, MSc, director of the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality.

"Improvements in health care are often measured a percentage point at a time as best practices are adopted," Meyer says. "But this year, we're seeing something different: more rapid gains in plan performance, which have been prompted by NCQA's efforts."

### *High vs. low quality health care*

To help quantify the economic impact of these quality improvements, Meyer says the NCQA soon will release an economic model that will allow employers to calculate the financial benefits of selecting high quality versus low quality health care. Based on the improvement in seven key Health Plan Employer Data and Information Set (HEDIS) measures over the past several years, U.S. employers will enjoy an annual productivity dividend of 8 million sick days avoided and $1.4 billion in improved productivity and avoided sick wages saved this year.

The degree of variation among plans continues to close, as plans that have performed poorly in the past again have registered impressive gains. For plans performing in the 10th percentile, the average rate of cholesterol screenings jumped 10 percentage points, from 53% in 1999 to 63% in 2000, while 90th percentile averages increased from 83% to 85%. The 10th percentile average for childhood varicella (chicken pox) immunizations showed a similar increase, from 50% to 58%, helping to spur an increase in the overall average, which rose from 64% in 1999 to 71% in 2000.

Among the health plans reporting impressive results and strong improvement in their HEDIS measures this year were Anthem Blue Cross/Blue Shield plans. **Sam Nussbaum**, MD, executive vice president and chief medical officer of Anthem Blue Cross/Blue Shield, says the HEDIS results are a good indicator of how hard a plan is working to improve quality.

"When you watch a health plan's HEDIS results increase from year to year, that plan has done a good job of developing a collaborative relationship with its physicians and members," Nussbaum says. "Health plans that work with their physicians, hospitals, and members can raise the bar dramatically on quality."

### *Gains in new areas are key*

O'Kane says another key finding is that plans recorded their highest performance gains in newer measures, such as cholesterol control rates and controlling high blood pressure, evidence that plans that engage in measurement and reporting are devoting greater attention and resources to important areas of care.

Rates for cholesterol control rose from 45% in 1999 to 53% in 2000, and average rates for controlling high blood pressure jumped 13 percentage points in 2000, from 39% to 52%. Health plans made similar progress in diabetes care. For instance, the average rate of diabetics screened for LDL (low-density lipoprotein) cholesterol increased from 69% in 1999 to 77% in 2000.

An interesting finding in the face of the ongoing debate on a Patients' Bill of Rights is that average rates for key indicators of member satisfaction also are rising. The percentage of members who rated their health plan 8, 9, or 10 out of 10 increased from 57% in 1999 to 59% in 2000. Members demonstrated a similar increase in satisfaction with customer service, as 67% said they did not encounter problems in obtaining plan information, getting help, or completing paperwork (up from 65% in 1999). ■

# CHSRA indicators deemed a success

The Center for Health Systems Research and Analysis (CHSRA) indicators are being called a success after nearly a decade of use, and the developers say the development process should be a model for the creation of other quality indicators. The CHSRA indicators were developed in the 1990s as part of a project for the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services) by the University of Wisconsin-Madison (UW-Madison) to assess nursing home care quality.

The university's assessment calls the indicators a success in helping measure quality for more than two million residents living in the nation's 17,000-plus nursing homes. All of those nursing homes and others in about a dozen countries worldwide apply the quality indicators. The CHSRA indicators essentially are mechanisms that state and federal inspectors, accreditation agencies, and nursing homes themselves use to target areas of nursing home care that need review for improvement, says **David Zimmerman**, CHSRA director and UW-Madison adjunct professor of industrial engineering.

The 24 indicators cover 12 areas of care: accidents, behavioral and emotional patterns, clinical management, cognitive patterns, elimination and incontinence, infection control, nutrition and eating, physical functioning, psychotropic drug use, quality of life, sensory functioning, and skin care. The data they generate are based on facilities' mandatory quarterly assessments of each resident, called the Minimum Data Set (MDS). For example, under the "clinical management" quality indicator, an excessive number of residents who received nine or more different medications during the most recent assessment period would raise a red flag.

"Just being on nine or more medications doesn't necessarily mean that you've got a bad drug policy," Zimmerman says. Instead, the indicator might mean that the nursing home should be aware that the chances are higher for such residents to experience adverse reactions, which, if not identified and acted on quickly, might require hospitalization.

When the project first began, CHSRA staff identified nearly 200 indicators based on nursing home data in five states. To determine whether the indicators were valid measures of quality, CHSRA staff then sent clinical teams into nursing homes in four states to assess care and compare the results to what the indicators predicted. Later, to accommodate a new version of the MDS, the project team reduced the number of indicators to its current 24.

Now the Centers for Medicare & Medicaid Services is using the indicators as the basis for a second-generation set of quality mechanisms that would apply not only to nursing homes, but also to other settings, such as post-acute care. Zimmerman is consulting for the project. ■


# Credential your allied health professionals

By **Patrice Spath**, RHIT
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The medical staff credentialing process serves several purposes. First, the process helps in setting standards for the practice of patient care within the institution to ensure quality patient care. Well-drafted credentialing policies and procedures also can reduce potential legal problems. In years past, only fully licensed physicians were credentialed and privileged through the medical staff. However in recent years a new group of practitioners has emerged — allied health professionals (AHPs). These practitioners are nonphysician health care workers. They may be classified as either independent or dependent practitioners.

An independent practitioner may provide patient care in accordance with state licensure laws and with medical staff oversight, exercise their own judgment, and assume a considerable level of responsibility for patient care. Dependent practitioners only provide patient care under the direct supervision of a sponsoring physician. AHPs may be employed by a physician member of the medical staff or may be independent practitioners with a member of the medical staff serving as their sponsoring physician. These individuals also may be hospital employees.

Regardless of who the AHP reports to, it is important for the hospital to ensure that patients

are protected from any unreasonable risk of harm. While some AHPs, by law, must have a supervising physician onsite or available by phone, these nonphysician practitioners make many autonomous medical decisions in everyday practice. Because they provide clinical services and generally exercise a high level of responsibility for patients' medical care, many hospitals find it prudent to formally credential and recredential AHPs.

The standards of the Joint Commission on Accreditation of Healthcare Organizations do not prohibit hospitals from appointing AHPs to the medical staff and/or credentialing and privileging them. Many hospitals have a special category for these practitioners. The credentialing process does not have to be exactly the same as that used for physicians, although it is important that the process for credentialing AHPs be consistent among the various disciplines. For example, advanced nurse practitioners should be credentialed in the same manner as physician assistants. Credentialing for AHPs includes a process for validating the background and assessing the qualifications of each health care professional. The process should be an objective evaluation of a person's current licensure, training or experience, competence, and ability to perform the services or procedures requested.

All people applying for AHP privileges should be required to complete an application and delineation of privilege form. The application should be accompanied by a letter from their sponsoring physician, proof of current licensure, registration, or certification, and proof of professional liability insurance coverage. Primary source verification must be obtained prior to the application being presented to the credentials committee, executive committee, and governing board for final approval. Be sure to get the applicant's written permission to obtain information from other facilities and to conduct police and/or credit checks if required.

You'll want to query the National Practitioner Data Bank to determine if the AHP has had any reported adverse actions. But remember, hospitals and other health care entities are not required to report adverse actions related to AHPs. For this reason, the databank may not be the best source of information about nonphysicians.

The patient care responsibilities of allied health professionals should be clearly defined. This definition may take the form of specified clinical privileges or a detailed description of the patient care duties they are allowed to perform. The basic education requirements, minimal amount of formal training needed, and scope of practice should be defined for each AHP category. People who are required by law to practice under a sponsoring physician (for example, physician assistants or advanced nurse practitioners) should have a written agreement with that physician as well as jointly agreed upon protocols.

To develop a list of privileges for an AHP, ask sponsoring physicians to provide the medical staff credentials committee with a list of common duties AHPs are qualified to perform. Also, find out what professional associations recommend as the scope of practice for AHPs. Even if a person has a current credential, that does not mean privileges automatically are granted for all

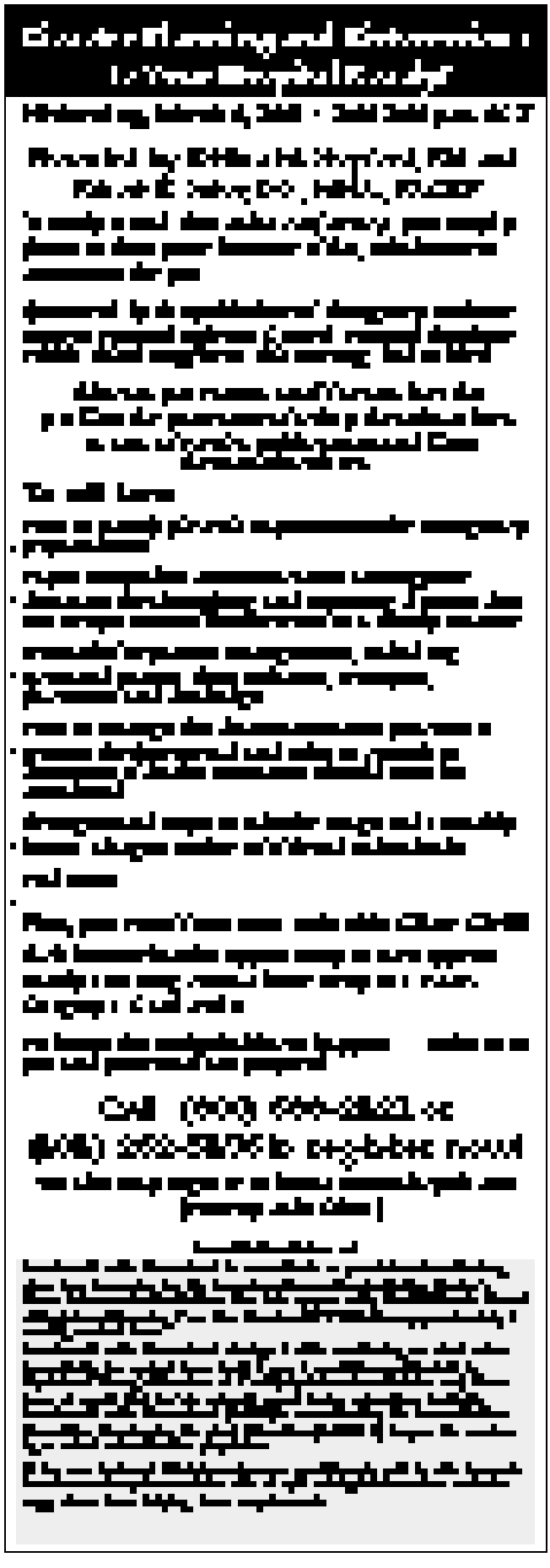
## CE questions

1. Following the September 2001 terrorist attacks in New York City and Washington, DC, the Joint Commission on Accreditation of Healthcare Organizations added a new clause to the intent section of which accreditation standard?
   A. EC.1.4
   B. LD.1.6
   C. IM.7.3
   D. PE.1.7

2. List the approximate startup cost of the "There's No Place Like Home" program at Carolinas Medical Center in Charlotte, NC.
   A. $15,000
   B. $38,000
   C. $159,000
   D. $351,000

3. According to the National Committee for Quality Assurance's fifth annual State of Managed Care Quality report, the rate at which diabetic members of reporting health plans received an annual retinal exam increased from 45% to what percent?
   A. 73%
   B. 62%
   C. 48%
   D. The rate did not increase.

4. Currently, how many Centers for Health System Research and Analysis quality indicators are there?
   A. 2
   B. 6
   C. 16
   D. 24



requested procedures. Just like licensed physicians, AHPs should be asked to provide evidence of the number of procedures previously performed and outcome data.

Also, check out your state hospital licensing laws. These laws vary from state to state and they dictate what types of practitioners may be members of the organized medical staff. The practitioner's license or registration will define the exact limits of his or her activities. The scope of an AHP's license is the starting point for your hospital to define the scope of patient care permitted.

However, AHPs are not automatically entitled to provide all services for which they may be licensed. The governing body, with input from the medical staff, ultimately is responsible for the approval of delineated clinical privileges,

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## Editorial Questions

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whether or not the AHP is a member of the medical staff. For example, what a physician assistant does in a physician's private office may be entirely different than the duties he or she is allowed to perform in a hospital.

Independent health professionals should be reappointed in the same manner as other practitioners who have been granted clinical privileges, i.e. reappointment application, evaluation of current clinical competence, and peer review recommendation. Dependent practitioners without clinical privileges usually are evaluated through a process similar to an employee evaluation. An AHP working under the direct supervision of a physician should have his or her work evaluated through the same quality monitoring process as the physician.

It is becoming much more common for hospitals to collect quality data on allied health professionals, whereas in the past many did not distinguish the AHP's quality measures from those of the supervising physician. This separate identification can be accomplished fairly simply with either a unique identifier number for the AHP or by adding a modifier code to the supervising physician's number.

The AHP's personal track record of performance within your hospital should be evaluated during the reappointment process. To assess current competence when considering reappointment, the credentials committee can consider information such as the following:

- clinical activity;
- medication usage;
- findings of departmental monitoring and evaluation activities;
- risk management data;
- resource management data;
- data on timeliness of medical record completion;
- complaints against the professional;
- morbidity and mortality statistics;
- outcomes of procedures performed.

The true purpose of credentialing is for the benefit of our patients. Credentialing is your hospital's most direct means of ensuring that patients receive quality care. It influences care quality by ensuring that patients receive care only from qualified practitioners. Although credentialing requires time and resources, the alternative is far worse — an adverse event or outcome for the patient and liability exposure for your facility. Effective nonphysician credentialing helps protect patients and the organization. ■



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- 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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BIOTERRORISM WATCH

*Preparing for and responding to biological, chemical and nuclear disasters*

# Flu or anthrax? First inhalational cases yield clues for clinicians to make the critical call

*Use case history, blood work, X-rays, rapid tests*

There is a postal worker in your emergency department (ED) with flulike symptoms.

That once insignificant observation about occupation and illness now triggers a detailed algorithm created by the Centers for Disease Control and Prevention (CDC) in Atlanta. **(See algorithm, p. 2.)** Is it flu or inhalational anthrax? Whether a realistic question or not, it is what many of your incoming patients may be asking — particularly if another wave of anthrax scares coincides with a nasty influenza season. Many of the initial symptoms are similar, but investigators dealing with the first inhalational anthrax cases have gleaned out key indicators that will help clinicians make the call.

"It is important to take a careful history from the [patients] when they present," says **Julie Gerberding**, MD, acting deputy director of CDC's National Center for Infectious Diseases. "If the [patients are] mail handlers in a professional environment — where they're dealing with large amounts of mail that is not their own — then the index of suspicion should be raised and more testing should be done to be sure there aren't additional clues to suggest that it is not a common viral infection."

Using the first 10 cases of inhalational anthrax as a baseline patient profile, the CDC reports that the median age of the patients was 56 years (range: 43-73 years), and seven were men.[1]

The incubation period from the time of exposure to onset of symptoms when known (seven cases) was seven days (range: five to 11 days).

The initial illness in the patients included fever (nine) and / or sweats / chills (six). Severe fatigue or malaise was present in eight, and minimal or nonproductive cough in nine. One had blood-tinged sputum. Eight patients reported chest discomfort or pleuritic pain. Abdominal pain or nausea or vomiting occurred in five, and five reported chest heaviness. Other symptoms included shortness of breath (seven), headache (five), myalgias (four), and sore throat (two). The mortality rate was 40% for the 10 patients, much lower than historical data indicated. Indeed, one of the critical reasons to recognize inhalational anthrax early is that it is far more treatable than originally thought.

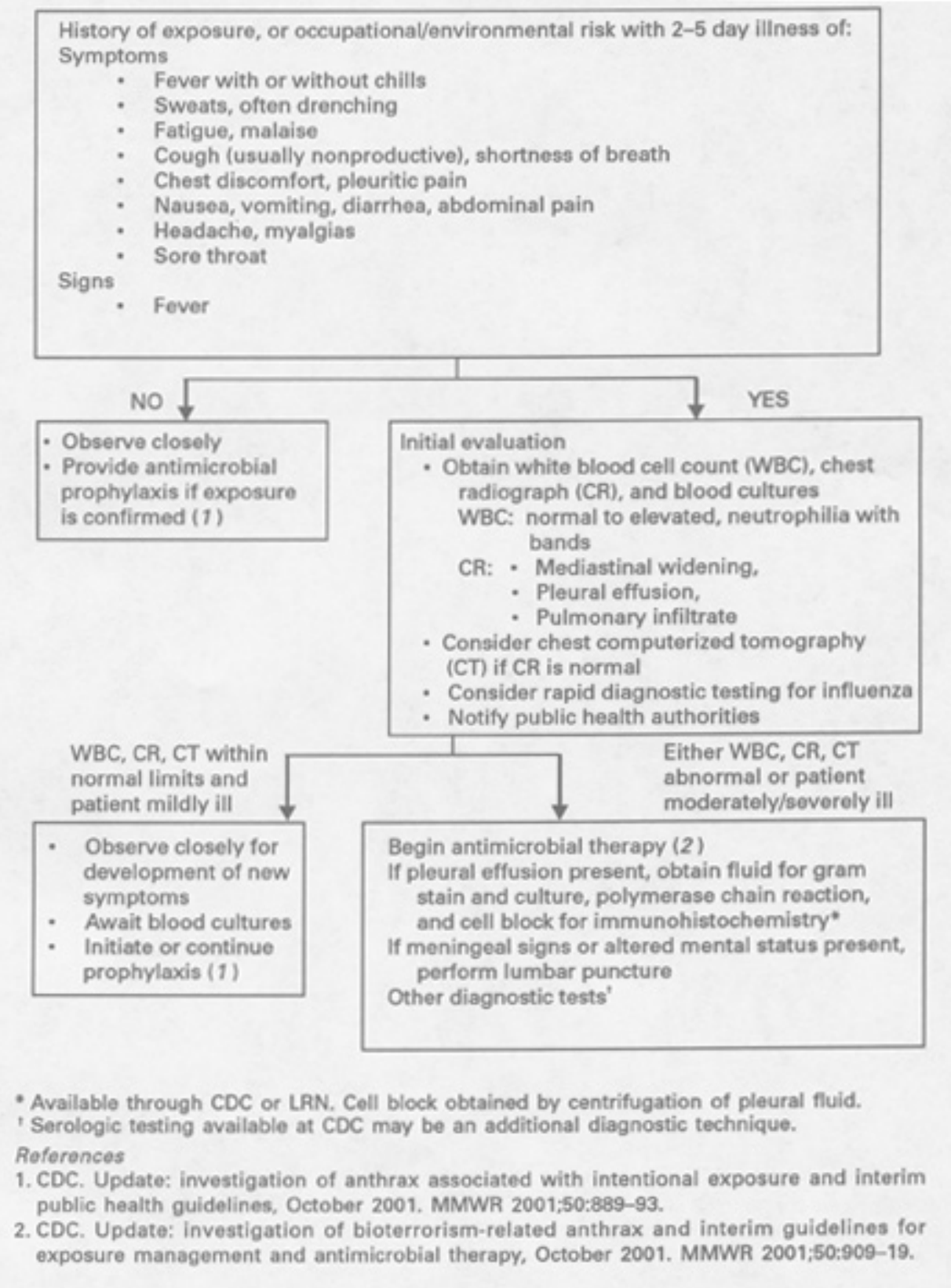
The CDC gathered comparative data on the symptoms and signs of anthrax and influenza, finding, for example, that only 20% of the anthrax patients reported sore throat.[2] Flu sufferers report a sore throat in 64% to 84% of cases. Likewise, 80% of the anthrax cases reported symptoms of nausea and vomiting. That symptom is reported in only 12% of flu cases. Shortness of breath appears to be another key distinguishing symptom, affecting 80% of the anthrax patients but seen in only 6% of flu patients.

"One of the other clues that we are noticing is that the patients with inhalation anthrax actually do not have nasal congestion or a runny nose,"

*(Continued on page 3)*

This supplement was prepared by Gary Evans, editor of *Hospital Infection Control*. Telephone: (706) 742-2515. E-mail: gary.evans@ahcpub.com.

# Clinical Evaluation of People with Possible Inhalational Anthrax




*Source:* Centers for Disease Control and Prevention. Update: Investigation of bioterrorism-related anthrax and interim guidelines for clinical evaluation of persons with possible anthrax. *MMWR* 2001; 50:945.

Gerberding says. "They don't have the symptoms of an upper-respiratory tract infection. They have a more systemic chest presentation, and that may be another distinguishing characteristic."

Another finding on initial blood work is that none of the inhalational anthrax patients had a low white blood cell count (WBC) or lymphocytosis when initially evaluated. Given that, CDC officials note that future suspect cases with low WBC counts may have viral infections such as influenza. Chest X-rays were abnormal in all patients, but in two an initial reading was interpreted as within normal limits. Mediastinal changes including mediastinal widening were noted in all eight patients who had CT scans. Mediastinal widening may be subtle, and careful review of the chest radiograph by a radiologist may be necessary, the CDC advises.

Complementing the CDC's effort, are the observations of the few clinicians who have actually seen inhalational anthrax cases come into their hospital systems. Two inhalational anthrax cases, both of which survived, were admitted to the Inova Healthcare System in Fairfax, VA (near Washington, DC).

"Clinically, I think the history of the people who presented here is useful," says **Allan J. Morrison Jr.**, MD, MSc, FACP, health care epidemiologist for the Inova system. "They stutter-stepped toward their pulmonary symptoms. That had some mild symptoms and then they were sort of 'meta-stable.' They were not relentlessly progressing. Then they progressed with symptoms more aggressively. Whereas with influenza — in our experience — once you start to get sick, it just keeps on progressing with very high fevers, chills, muscle aches, and pains. As a consequence, we feel there should be a good way to differentiate the two."

Since anthrax is a realistic concern in the Washington, DC, area, what about the aforementioned scenario of symptomatic postal workers in the ED?

"We would take a very aggressive history, not only of occupation but physically where they have been," Morrison says. "If they are symptomatic and have been in or work around a 'hot zone' — a location from which anthrax has either been cultured environmentally or patients have come from there — we will err on the side of being very aggressive about working up anthrax. By that I mean chest X-rays, chemistry profile, [etc.]"

In addition, the hospital system pushed early flu vaccination programs for staff and the surrounding community. "We want to move toward herd immunity," he says. "We are also working with our local hospitals to make sure that they have access to the rapid influenza tests. So for diagnosis — for obvious reasons — it is very helpful to make that distinction early."

One such rapid test is ZstatFlu (ZymeTX Inc., Oklahoma City), which the company claims can yield a diagnosis of influenza A or B some 20 minutes after a throat swab. The test detects neuraminidase, an influenza viral enzyme. However, Gerberding cautions clinicians not to rely solely on such tests. Rather, they should use the results of tests in combination with the patient history and clinical presentation, she says.

"So it is a constellation of history, clinical findings, and laboratory tests," she says. "Hopefully, when we get these all together, we'll be able to at least reduce the anxiety among some people and help clinicians diagnose those patients who really do require the antibiotic treatment. What we don't want to have happen is for everybody coming in with the flu to get an antibiotic because that undermines a whole other set of public health issues relating to antimicrobial resistance and proper management of influenza."

## *Even the vaccinated can still have flu*

Complicating the issue is the fact that the flu vaccine efficacy can vary annually, but is usually 70% to 90% protective, says **Keiji Fukuda**, MD, a medical epidemiologist in the CDC influenza branch. Thus, depending on how well the vaccine matches the circulating strain, a certain portion of flu patients will tell clinicians they have been immunized. But in addition to vaccine breakthrough infections, there is a plethora of other viral and respiratory pathogens that will be creating similar symptoms, he says. In a somewhat sobering reminder — given that at this writing, the total anthrax cases remained in the double digits — Fukuda notes that a typical flu season will send 114,000 people to the hospital and 20,000 to their graves.

"There has been an awful lot of attention on the [anthrax] cases, but the bottom line is that there have been few cases, and these cases generally have occurred in a limited number of communities within a limited number of groups," he says. "And so the epidemiologic message is that anthrax really has not been diagnosed in most parts of the country, whereas we expect to see millions and millions of flu cases all over the place."

If facilities are faced with an onslaught of patients with respiratory illness there are several measures they can take, he notes. Those include:

- Reduce or eliminate elective surgery.
- Relax staff-to-patient ratios within the limits of your licensing agency.
- Emphasize immunizing staff so more staff are available.
- Identify ways to bring in extra staff to help out with the patients.
- Set up walk-in flu clinics to triage the patients.

### *Reference*

1. Centers for Disease Control and Prevention. Update: Investigation of bioterrorism-related anthrax and interim guidelines for clinical evaluation of persons with possible anthrax. *MMWR* 2001; 50:941-948.

2. Centers for Disease Control and Prevention. Consideration for distinguishing influenza-like illness from inhalational anthrax. *MMWR* 2001; 50:984-986. ■

# CDC moving quickly on smallpox front

*Immunizations, training, vaccine dilution studied*

Though officially stating it has no knowledge of any impending use of smallpox as a bioweapon, the Centers for Disease Control and Prevention (CDC) is scrambling with conspicuous speed to be ready for just such an event.

CDC workers from a variety of specialties are not only receiving smallpox vaccinations, they are being trained to give them to others using the old bifurcated needle scarification technique. And, even as creation of a new vaccine is fast-tracked, researchers are trying to determine if the current stockpile of 15.4 million doses can be expanded fivefold by simply diluting the vaccine.

Based on such actions, it is fair to say the agency is at least highly suspicious that the known stocks of smallpox virus are not safely ensconced in their official repositories in Russia and the United States.

"CDC is putting together a number of teams, which will probably total [more than] 100 employees, that could be quickly dispatched in a moment's notice to assist state and local health departments and frontline clinicians investigate suspect cases of smallpox," **Tom Skinner**, a spokesman for the CDC, tells *Bioterrorism Watch.*

"They are Epidemic Intelligence Service (EIS) officers, laboratorians, and others. Part of this includes vaccinating them against smallpox," he explains.

But while confirming that the CDC teams are being trained to administer the vaccine, Skinner would not specify who would be vaccinated following a smallpox bioterror event. "We have a smallpox readiness plan," he says. "Issues around vaccination are covered in that plan. That plan is being finalized. It is considered an operational plan. If we have a case tomorrow, it could be implemented. It covers who should be vaccinated and when."

The general consensus among bioterrorism experts is that those exposed would be vaccinated because the vaccine can prevent infection and possibly death even if given several days out. Likewise, health care workers and their family members would want vaccine if they were expected to care for the infected. Some aspect of quarantine would no doubt come into play because, unlike anthrax, it will be critical to separate the first smallpox cases and their contacts from the susceptible population.

Another aspect of CDC preparations includes the smallpox vaccine dilution study, which is being headed up by **Sharon E. Frey**, MD, associate professor of infectious diseases and immunology at Saint Louis University School of Medicine.

The vaccine, known as Dryvax, is no longer produced, but there are 15.4 million doses left. Frey and colleagues are looking at dilution studies that could maintain vaccine efficacy while increasing the available stock by millions of doses. In a study last year, Frey tried a one to 10 vaccine dilution, which would create a stockpile of more than 150 million doses. However, the resulting vaccine had only a 70% effective rate.

"The undiluted vaccine has about a 95% take rate," she tells *BW*. "It is not perfect, but we would like to be as close to that as we could be."

The new study will include a one to five dilution, which should show greater efficacy while increasing the stockpile to more than 75 million doses.

"We are looking at a 'take' rate for the vaccine, in other words how many people actually develop a typical lesion and whether they have a strong neutralizing antibody response to the vaccine," Frey says. "We know that the vaccine is still good. We actually titered the vaccine and it is very similar to its original titer," she adds. ■