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White House's latest quality initiative: Panacea or new ring of red tape?

It might ease reporting burden but miss consumers' real concerns

If "try and try again" is the key to useful, cost-effective quality measures, then we have another cause for optimism in President Clinton's recently announced initiative to measure and report health care quality.

Launched on the recommendations of the president's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, the effort includes both public and private sector components.

The public sector Advisory Council on Health Care Quality will set national clinical aims — for instance, reducing medication errors by a certain percentage within two years. The council also will develop strategies to achieve the national goals. The composition of the advisory council still is on the drawing boards.

The private sector Forum for Health Care Quality Measurement and Reporting will implement comprehensive and standardized health care quality measurements. Its second charge is to ensure widespread availability of quality reports to consumers, providers, purchasers, and others. Serving on the forum will be representatives of private and public health plan purchasers, consumers, and providers.

Executive Summary

- President Clinton has launched a public/private-sector quality initiative charged with designing national goals for clinical quality improvement, creating better quality reports for consumers, and lightening reporting burdens for providers.
- Some speculate the initiative is just another political move or that the dominant presence of purchasers could overshadow consumers' interests. Others believe it foreshadows advancing federal controls over private-sector health care. Still others say this project is not directed toward the real interests of consumers.
- The initiative's goal of reducing duplicate and inconsequential reporting is regarded as an urgent priority.
- The three leading accreditors — AMAP, JCAHO, and NCQA — have various degrees of involvement in the effort.

Work will commence sometime next year, says **Richard Sorian** of the U.S. Department of Health and Human Services in Washington, DC. Sorian served as deputy director of the commission until it completed its work last March.

The forum's objectives promise a little something to everyone:

• for providers, lighter reporting burdens by elimination of duplicate and inconsequential reports;

• for consumers and purchasers, a common yardstick to compare health plans, hospitals, long-term care, and physicians.

Experts still aren't sure, however, whether those objectives will be met. **Don Berwick**, MD, who is founder of the Institute for Healthcare Improvement (IHI) in Boston, expresses cautious optimism.

A member of the original quality commission, Berwick observes, "We hope the forum's work will reduce the burden of JCAHO [Joint Commission on Accreditation of Healthcare Organizations] and NCQA's [National Committee for Quality Assurance] reporting. In theory it could, but nobody knows how it will play out. It could be politicized, but it has a very real chance of doing some good."

Less hopeful is **Patrice Spath**, health care quality and resource management consultant with Brown-Spath & Associates of Forest Grove, OR. She foresees problems if private-sector employers were to dominate the forum. "One wonders if their needs and interests are consistent with consumers'," Spath says. "As payers for health care services, employers might have a different idea of how to measure quality.

"There's a public uproar right now around being able to pick your own doctor," she notes. "But I doubt if payers would place high priority on this because it might raise premiums $100 a month."

There's resounding agreement about one facet of the forum's mission — easing providers' reporting burdens. For example, Berwick says, "Some insurance plans now have as many as 900 data elements they're reporting to different bodies. And not all the data elements are especially useful."

Sandra Schmoll, MBA, manager of information services with The Alliance, a Denver-based purchaser of health benefits for small businesses, says she'd like the forum to consolidate quality measures to help conserve health care resources. It's nothing to see insurance companies with whole departments devoted to turning out HEDIS reports for NCQA, she notes. "I would not want to see the forum add to the paperwork in this industry."

Indeed, we probably have 20 different ways to measure immunizations, notes Sorian. "We need to eliminate those and agree on one. That will free up resources to move on to other important measures that we haven't even touched yet, like measuring care for chronic or disabling conditions." For example, arthritis treatments need attention, he explains.

Does effort presage tighter federal controls?

A partnership like the forum certainly stirs conjecture about advancing governmental presence into private health care. "This seems a portent of more federal control," Schmoll says. "Let's say a plan does not meet some criteria set by the forum. Will it incur some type of sanction?" she asks. "But we can't tell until we know how they are going to use the data."

Sorian says the forum's evolution could parallel that of the NCQA's HEDIS compliance. Right now, forum participation is voluntary and open to all, even government health care purchasers, he notes. As with NCQA, forum membership will imply agreement that the participating organization will base health service purchasing decisions on the standards to be set by the forum. For openers, he explains, compliance with the forum's measures and reporting criteria probably will be voluntary.

Will the forum gradually solidify this voluntary compliance into accreditation or certification

as NCQA has through its health plan accreditation? How would that improve health care quality for Americans? Only time will tell.

Brian Schilling, NCQA spokesman, explains the accreditors' move as a sign of their intention to be at the forefront of any effort in this country to rationalize quality measures.

Meanwhile, notes Sorian, AMAP has official representation on the forum. While JCAHO and NCQA do not have official forum representatives, some members of the body have close ties with both organizations, he reports. He reads their participation as a sign of readiness to "give up their less-valuable measures and incorporate more-valuable new ones."

How will the forum's work help consumers as they decide on insurance plan X, Y, or Z? In theory, Berwick explains, the forum's objective is to show consumers how health plans measure up to national quality criteria. That information should enable them to choose a health plan on the basis of its quality.

But Spath is pessimistic about the public's use of quality ratings for much of anything. "I am not sure whether the public will use quality information that tells them they need to drive an extra hundred miles to see a doctor who gets a better rating than their own. Consumers are really clamoring more for access to health care than for quality ratings." **(For an eye-opening corroboration of Spath's comments, see story, at right.)** ■

SOURCES

For more on health care quality measurement, contact:

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For progress reports on the Forum for Health Care Quality Measurement and Reporting or the Advisory Council on Health Care Quality, or for a free copy of the final report of the Presidents Advisory Commission on Consumer Protection and Quality in the Health Care Industry, contact:

Consumer Bill of Rights, Box 2429, Columbia, MD 21045-1429. Telephone: (800) 732-8200. World Wide Web: http://www.hcquality commission.gov.

How many patients really use quality report cards?

In 1996, a group of Pennsylvania researchers tested the popular assumption that if we compile report cards, patients will read them. The study[1] centered on awareness of, interest in, and barriers to the use of Pennsylvania's *Consumer Guide to Coronary Artery Bypass Graft* (CABG) *Surgery*.

Published since 1992, the guide features risk-adjusted mortality ratings of all cardiac surgeons and hospitals in the state. The Pennsylvania Health Care Cost Containment Council compiles the material and disseminates it to hospitals, surgeons, public libraries, business groups, legislators, and the media. Individuals receive free copies upon request.

The study involved a sample of 474 patients who had undergone CABG surgery during the previous year. Investigators explored awareness, knowledge, use, and barriers to use of the guide. Here are the highlights of their findings:

1. Awareness, knowledge, and use of consumer guide.

- 12% were aware prior to surgery.
- 4% knew their hospital's ratings.
- 2% knew their surgeon's or surgical group's ratings.
- 1% reported that the surgeon's or surgical group's rating influenced their choice of same.

2. Declared interest in obtaining consumer guide.

- 28% not at all interested.
- 22% somewhat interested.
- 33% very interested.

3. Willingness to change surgeons based on ratings.

- 16% don't know.
- 11% definitely would not change.
- 31% definitely would change.

4. Patient-reported barriers to use of performance ratings.

- 38% had less than three days between decision to operate and surgery.
- 33% had no other hospital within a reasonable distance.

- 88% cited hospital proximity as "somewhat" or "very important" to the choice.
- 43% remained in same hospital between the decision to operate and the operation.

The investigators comment that lack of awareness and use of the guide could stem from the fact that referring physicians are a prime source of information about the quality of surgical specialists. Other surveys reveal that Americans rely more on reports from relatives and friends than reports from objective sources.[2]

The researchers concede that one limitation of the study is its focus on a consumer information source seen by so few of the subjects. Even so, they note, "We found formidable evidence that public reporting of mortality outcomes in Pennsylvania has had virtually no direct impact on patients' selection of hospitals or surgeons."

References

1. Schneider EO, Epstein AM. Use of public performance reports: A survey of patients undergoing cardiac surgery. *JAMA* 1998; 279:1,638-1,642.

2. Robinson S, Brodie M. Understanding the quality challenge for health consumers: The Kaiser / AHCPR survey. *Jt Comm J Qual Improv* 1997; 29:239-244. ■

Nurses revamp IV therapy: One stick lasts months

PICCs cut complications, costs of therapies

Needles. Patients dread them, yet hundreds owe their lives to the medications they deliver. So you can imagine the excitement at Lehigh Valley Hospital (LVH) in Allentown, PA, when staff learned about an intravenous (IV) therapy device that stays in place for months instead of three to five days as with older methods.

The new device, a peripherally inserted central catheter (PICC), frees people to go home and resume normal activities. One woman actually received intermittent cancer chemotherapy for two years from one PICC insertion. PICCs also can deliver antibiotics, antivirals, and nutritional therapies.

Application at bedside

PICCs are flexible, IV-access tubes of silicone or polymer, 20 to 24 inches long. The catheter goes into one of the large veins of the upper arm and advances into a larger vein near the heart. Unlike older IV devices, PICC insertion is not an operative procedure. In fact, LVH nurses do them at the bedside.

Compare that to invasive subclavian (beneath the clavicle) insertions performed by physicians. Sites had to be changed every five days due to venous irritation from the caustic medications. The other alternative, a Hickman catheter, involves surgical insertion into the chest wall. In either case, the complication rates were high.

Costs of maintaining the older devices also are high. While they have to be changed every four days after the patient goes home, the PICC only requires a weekly dressing change. That alone saves $812 per patient in home care costs. **(For comparative insertion costs, see table, "Estimated Cost of Insertion of Catheters," p. 126.)**

Nurses recognize trend before it starts

When the LVH nurses saw their first PICC patient five years ago, they knew more were on the way, recalls **Mary Agnes Fox**, RN, MSN administrator of patient care services. So they wasted no time developing a protocol to take care of them. Fox and colleagues sold the project to the administration and medical staff as an initial policy "for care of the occasional patient with a PICC," she says.

Foreseeing the overlap between subacute and home care, they recognized that success depended on building seamless communications between the bedside and home care providers and an interdisciplinary nursing team.

True to the nurses' intuition, PICC volume rose to 120 insertions in six months following the first patient's admission. Today, the monthly average is 100. To Fox's knowledge, the LVH team is the only one in the Lehigh Valley, a region 50 miles northwest of Philadelphia. **(See graph, "Number of PICC Insertions," for quarterly rates of PICC insertions since 1994, p. 126.)**

In the absence of readily accessible role models, the LVH nurses mapped their own way using patients' perceptions and needs as a guiding

(Continued on page 127)

SUMMARIZATION OF JUSTIFICATIONS AND COST BENEFITS*

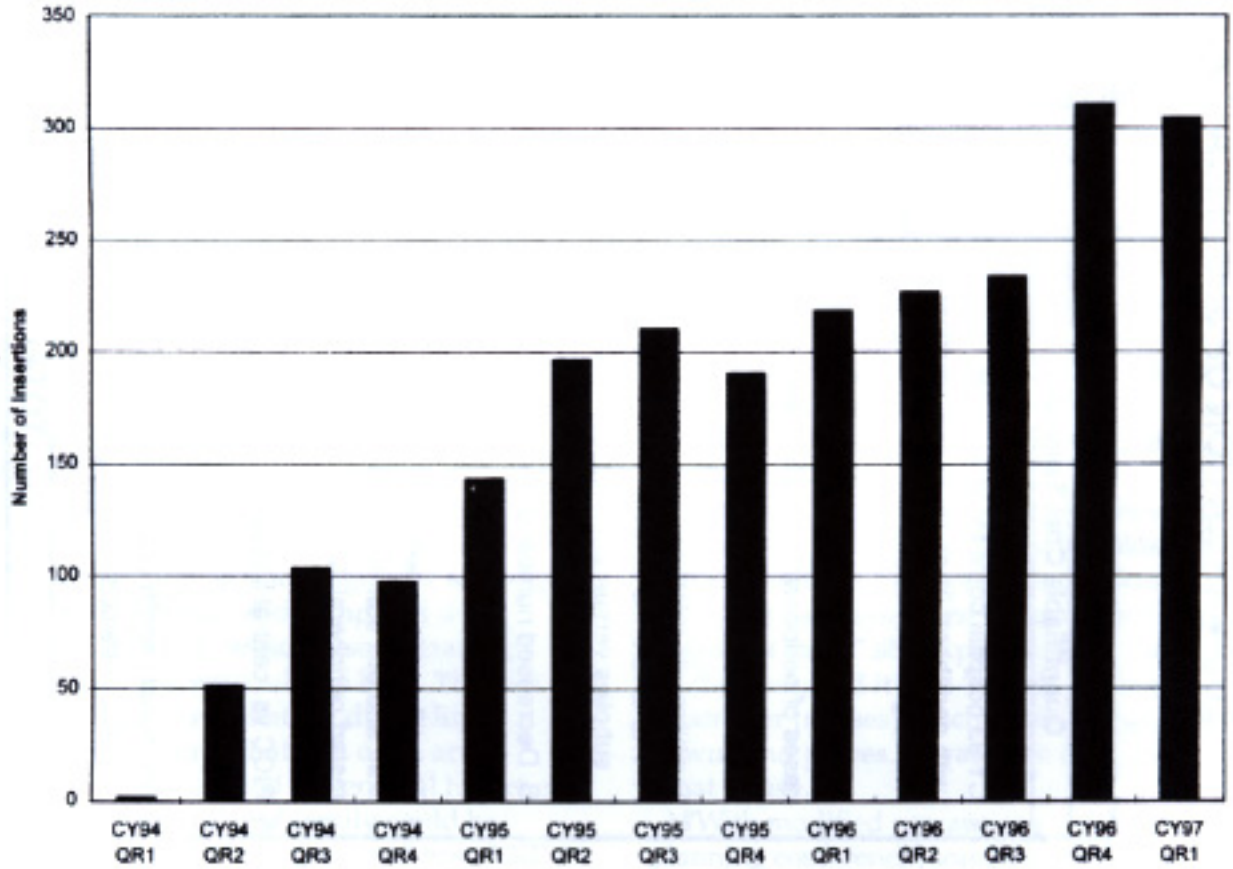
JUSTIFICATIONS AND COST BENEFITS		
Quantifiable Cost Savings		**Non-Quantifiable Justifications and Savings**
1. CY'93 hospital costs for 20 patients with peripheral IV phlebitis and infections with significant sequelae:	**$100,000**	1. Improved patient satisfaction.
2. Hospital costs for 1,825 uncomplicated cases of peripheral IV phlebitis and infections.	**53,895**	2. Reduction in risk management and liability costs.
3. Supply costs related to:		3. Decreased central line insertion complications due to increased utilization of PICC's
A. The difference between use of stock supplies versus stock kits for initial peripheral IV insertions:	**7,644**	4. Earlier patients discharges due to timely initiation of patient and family home IV therapy teaching.
B. Decreased number of reattempts after failed insertions:	**10,731**	5. Timely IV insertions and associated initiation of fluid and medication therapies.
4. The difference between PICC team staff and unit staff time to start and restart peripheral IV's:	**50,041**	6. Improved physician satisfaction.
5. PICC vs. central line (subclavian) insertions:	**59,428**	
6. Additional Length of Stay for Hickman vs. PICC insertion:	**90,720**	
TOTAL	**$372,459**	

*All dollar amounts are for one complete year. *Source:* Lehigh Valley Hospital, Allentown, PA.

ESTIMATED COST OF INSERTION OF CATHETERS

COST ITEMS	PICC	SUBCLAVIAN	HICKMAN
Physician	None	230	700
Catheter	72	64	156
Supplies	21	21	56-303
Chest X-ray	95	95	95-118
Fluoroscopy	0	0	81
Coagulation Study	47	47	47
Anesthesia	0	0	761
Operating Room	0	0	741
Recovery Room	0	0	217
TOTAL	**235**	**457**	**2,637-3,124**

NUMBER OF PICC INSERTIONS*



***33 of these patients were under the age of 18**

CY= Calendar Year; QR= Quarter

Source for both charts: Lehigh Valley Hospital, Allentown, PA.

(Continued from page 124)

principle. Patients' feedback indicated a desire for a comfortable, durable, and reliable IV system.

The PICC team grew from its original 1.8 full-time equivalents (FTEs) to the present 2.8 FTEs, costing $141,055 a year. Quantifiable cost savings of the project are $372,459 a year. **(For a breakdown of the savings, see chart, "Summarization of Justifications and Cost Benefits," p. 125.)**

Fox credits the team's success to the following factors:

• Clinical training with built-in continuous quality improvement.

At first, key nursing staff received training sessions in PICC procedures so they could provide clinical support and instruction to staff nurses and troubleshoot problems. However, maintaining competency was difficult due to sporadic clinical exposure. Now PICC team members themselves provide case-by-case bedside teaching of staff nurses at the time of insertion. The four team members can handle almost any type of clinical situation because they come from backgrounds in emergency, medical/surgical, and home infusion care. In addition to on-site consultation for insertions, the team is on call 12 hours every day.

• Standardized PICC care policies and procedures across care continuum.

The PICC team hosts quarterly inservices for about 30 Lehigh Valley Home Care nurses. Topics include troubleshooting, catheter maintenance, and redressing. A smaller core group of home care nurses receives insertion training. The team also teaches catheter insertion and maintenance techniques to nurses from long-term care institutions and other hospitals in the area.

• Support from administrative and medical staff.

Approval of top management lent credibility to the initiative, and that helped the nurses gather key players. Represented on the original planning group were the infection control department, physicians, pharmacy, radiology, and materials management.

• Sensitivity to patients' needs for information and support.

To ensure the best care outcomes, a PICC team nurse screens IV patients, identifying those whose health status and family or community support make a PICC home-maintenance plan feasible.

For likely candidates, the nurse contacts the patient's insurance plan, infusion pharmacies, and the home care agency that will be involved. Patient and family teaching begins at the bedside on the day of insertion. The team wrote a detailed booklet, titled *Home Advisor*, illustrating the step-by-step procedures for home management.

The hallmark of this project is its rapidity in moving people back to their familiar surroundings, where they heal best. "Patients are happy to go home after a short hospital stay, and this is not an operative procedure. They like that," says Fox. By other measures, the project is equally laudable:

1. Medical staff satisfaction.

The PICC team averages 4.42 points out of a possible 5, compared to 3.95 for 30 other LVH clinical cost centers.

2. Cost benefits.

Length of stay savings for PICC patients over other IV procedures: $90,720.

3. Clinical outcomes.

The infection rate is 0.3%, or seven infections for 2,282 insertions; 90% to 95% of the PICCs remain in place until conclusion of therapy.

4. Overall performance excellence award.

The PICC team won the prestigious 1997 Quality Valley, USA Team Award, in Lehigh Valley's all-industries competition. ■

SOURCES

For more on designing PICC teams and patient care guidelines, contact:

Mary Agnes Fox, Patient Care Services, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556. Telephone: (610) 861-2500. Fax: (610) 402-1674.

For clinical details, see:

Driscoll M, Buckenmyer C, Spirk M, et al. Inserting and maintaining peripherally inserted central catheters. *MEDSURG Nursing* 1997; 6:350-358.

For the IV nursing standards of practice revised January 1998, contact:

Intravenous Nursing Society, Fresh Pond Square, 10 Fawcett St., Cambridge, MA 02138. Telephone: membership services, (800) 694-0298. World Wide Web: http://www.ins1.org. Cost: $40 for nonmembers, $10 for members. The Web site details the guidelines, but they are not downloadable.

How feasible are new SHEA guidelines on VRE?

More freedom of movement allowed

The Society for Healthcare Epidemiology of America (SHEA) has released a position paper on vancomycin-resistant enterococci (VRE) in long-term care facilities.[1] Infection control practitioners say while new information on VRE in long-term care is welcome, they still must modify the SHEA recommendations, as well as guidelines from the Hospital Infection Control Practices Advisory Committee, to make them practical for use in long-term care facilities.[2]

Patti G. Grota, RN, MSN, CIC, CPHQ, infection control practitioner (ICP) for the South Texas Veterans Healthcare System's geriatrics and extended care programs in San Antonio, says she and other ICPs implemented a modified version of the Centers for Disease Control and Prevention's contact precautions in 1995.[3]

> ***"You have to consider the quality of life of these patients. The person who is too restricted wouldn't be able to even dine with other people. There's too much of a leper mentality with people who have resistant organisms."***

"In the old days, when patients were on contact precautions, we put them in their rooms and shut the door," she explains. "We restricted visitors and only sent patients to diagnostic testing. We looked at that model and compared it to what we need in rehab, which is socialization, and tried to see how we could do both. The two things we changed were that we didn't limit movement to the degree that you do in acute-care settings, and we looked at personal hygiene and whether the patient and family could be taught about washing their hands and how VRE is transmitted."

Grota and her colleagues performed a study on the prevalence of VRE and multidrug-resistant *Klebsiella pneumoniae* in the VA nursing home care unit, or extended care therapy center (ECTC). The study indicated that the prevalence of VRE was 2.8% (three of 109 patients had stool colonization) in the ECTC. A similar study for multidrug-resistant *K. pneumoniae* indicated its prevalence in 1996 was 12.2% (five of 41 patients were colonized).

"That [prevalence] was pretty low, but it was our wake-up call to VRE in our long-term care setting," says Grota.

To help implement rehabilitation goals and socialization among patients, the ICPs modified the CDC Guidelines for Isolation Precautions in Hospitals to allow freedom of patient movement, says Grota, including allowing some patients to perform their own personal hygiene measures. **(See sample modifications, p. 131.)** For example, one wheelchair-bound patient who has difficulty with personal hygiene but likes to move about the facility has his wheelchair cleaned by a light-duty nurse throughout the day; that helps avoid any incidences of possible cross-contamination. The nurse also washes his hands every four hours.

"He's actually in a room with three other patients who have no invasive lines and are fairly bedridden, and we've not had any cross-transmission to them," Grota notes.

No more 'old ways'

A follow-up study in 1997 indicated that the prevalence of VRE was 3.8% (three of 79 patients), which was a slight increase from 1995. The prevalence of multidrug-resistant *K. pneumoniae* was 1.3% (one in 79 patients), which was a significant decrease from 1996. There was no cross-transmission of either organism identified.

Modifying contact precautions is in some ways more difficult than following older disease-specific isolation precautions, says Grota.

"In the old days, nurses didn't have to make judgment calls," she explains. "You put a sign on the door, and it said 'enteric precautions.' Whenever [nurses] touched stool, they wore gowns and gloves. It was very direct about what to use.

"With modified precautions, it takes treatment-planning conferences sometimes for us to figure out what to do with a particular patient. There's more judgment involved. Does the patient have diarrhea? Is he colonized or infected? Does he have good hand and nail hygiene? The nurse has to make a more specific assessment about how the organism could be transmitted."

James F. Marx, RN, MS, CIC, an infection control and epidemiology consultant in San Diego, says that although the SHEA position paper makes good recommendations regarding issues such as patient and family education on VRE, some recommendations are not as applicable as they could be for long-term care facilities.

"I found the position paper to be too academic and not practical enough," he says.

Disinfection, cleaning ignored

In particular, Marx says although VRE is an organism found in stool, the SHEA statement doesn't address the specifics of stool management in VRE patients. But he says he would have liked to have seen recommendations on issues such as cleaning and disinfection of bedpans and rectal thermometers. He also says many nursing homes use cloth diapers because they are less expensive, but that disposable diapers appear to pose less of a contamination risk to the environment. **(See related story, p. 130.)**

"What I recommend is disposable diapers," Marx notes. "If they don't have disposable diapers, then what they need to have is a place to put the cloth diaper immediately after they remove it from the person so they don't set it down on the bed or the floor. They should have a plastic bag there to put it into, and some facilities require that they rinse [cloth diapers] before they go to the laundry."

Interaction still important

He also says the SHEA statement doesn't really address what to do with VRE patients during activities such as dining. As long as patients have good personal hygiene, they should be able to join other residents for some activities.

"You have to consider the quality of life of these patients," Marx says. "The person who is too restricted wouldn't be able to even dine with other people. There's too much of a leper mentality with people who have resistant organisms."

But **Richard Garibaldi**, MD, hospital epidemiologist at the University of Connecticut Health Center in Farmington and co-chair of the SHEA long-term care committee, says a private room is clearly preferable in some situations.

"With VRE, it's very tricky, because most people are colonized because of gastrointestinal tract involvement," he says. "That's where the colonization usually is. And one of the problems is that the environment gets contaminated fairly easily. Then people who come into the environment, be they visitors or health care workers, are likely to be passive carriers of the organism from one patient to another. If you have patients with diarrheal disease or who are unable to take care of their own personal hygienic needs, those are the people you should really emphasize to put in a single room. People who are attentive to cleanliness, you're better able to put them in semiprivate rooms, because the likelihood of transmission is at least decreased."

Grota says although VRE isn't as pathogenic as some other resistant organisms — especially in the nursing home setting — it still is important to follow contact precautions in patients who are colonized with it.

> ***"My concern is that if we don't practice with VRE, then when we get other organisms that are very difficult, we may get outbreaks."***

"My concern is that if we don't practice with VRE, then when we get other organisms that are very difficult, we may get outbreaks," she says. "It may be intermediate *Staph aureus* resistance, but we need a practice round with our staff. If they don't take caution with this, then we may get another drug-resistant organism . . . and then we're going to get many patients with morbidity and mortality."

(Editor's note: Marx maintains a Web site on infection control at www.broadstreetsolutions.com. In addition, the California Association of Infection Control Practitioners' Coordinating Council maintains a Web site that includes antibiotic resistance guidelines at www.cacc.net.)

References

1. Society for Healthcare Epidemiology of America Committee on Long-Term Care. Vancomycin-resistant enterococci in long-term care facilities. *Infect Control Hosp Epidemiol* 1998; 19:521-525.

2. Hospital Infection Control Practices Advisory Committee. Recommendations for preventing the spread of vancomycin resistance. *Infect Control Hosp Epidemiol* 1995; 16:105-113.

3. Garner JS. Hospital Infection Control Practices Advisory Committee. Guidelines for isolation precautions in hospitals. *Infect Control Hosp Epidemiol* 1996; 17:53-80. ■

Stool management techniques prevent VRE

James F. Marx, RN, MS, CIC, an infection control consultant based in San Diego, makes these recommendations to long-term care facilities concerning stool management in patients with vancomycin-resistant enterococci (VRE):

• **Rectal thermometers:** Avoid the use of electronic rectal thermometers, if possible. Dedicate one electronic thermometer for rectal use only and ensure it is disinfected between uses. Outbreaks of VRE have been linked to probes. Use glass thermometers that have been cleaned and disinfected between uses or use a tympanic thermometer.

• **Cleaning the bedpan/commode:** Establish a regular cleaning schedule. The bedpan should be disinfected after each bowel movement.

• **Brief (diaper) use and disposal:** For disposable diapers, place them in plastic bags, not on the floor, bedstand, or bed. Dispose of plastic bags in regular waste containers. For reusable diapers, consider using disposables. If they are reused, rinse diapers only in an area designated for that purpose. Never rinse them in a semiprivate sink, toilet, or bathtub.

• **Incontinence management:** Initiate a bowel/bladder program according to facility policy. Use barriers (gloves and gowns) when appropriate. Hand washing after glove removal is required.

• **"Accidents" in the hallway:** Provide prompt cleanup with an appropriate disinfectant that is approved by the U.S. Environmental Protection Agency (EPA).

• **Behaviors that involve stool:** Treat them as inappropriate. Facilities may need to segregate residents by using a private room and restricting group activities and dining.

• **Bowel diversion:** Empty colostomy bags in the toilet. Do not rinse them in the sink. Bags should not be rinsed in semiprivate bathrooms.

• **Use of barriers:** Use according to standard precautions.

• **Selection of soap:** Use antibacterial soap in rooms with residents identified with enteric pathogens or poor hygiene.

• **Selection of disinfectant:** Use an EPA-approved disinfectant that is effective against VRE. *Clostridium difficile* may require stabilized chlorine solution.

• **Laundry and waste:** Contain stool and other body fluids in a plastic bag. Use red bags only if fluid blood is visible.

• **Room cleaning:** Routine cleaning procedures are adequate. Use recommended disinfectant.

• **Visitors:** Provide education about barrier protection to health care workers. Use barriers for direct care activities. Reinforce hand washing.

• **Rectal procedures and medications:** Single-use disposable gloves and hand washing after procedures are necessary.

• **Activities and dining:** Allow regular socialization and dining, provided the resident has good hygiene. ■

SHEA guidelines address education, surveillance

The recommendations of the Society of Hospital Epidemiology of America (SHEA) regarding reducing vancomycin-resistant enterococci (VRE) in long-term-care (LTC) facilities are summarized as follows: [1]

❑ Employee education about basic infection control and VRE is essential to any effort to control resistant organisms. Particular emphasis on the importance of colonization and the role of the environment is needed.

❑ Surveillance cultures of rectal swabs and wounds for VRE may be appropriate if an outbreak of infection appears to be under way. Otherwise, surveillance cultures are unlikely to be cost-effective and are not recommended.

❑ When a patient who is infected or colonized with VRE is transferred to an LTC facility from an acute-care facility, information on the VRE should be provided to the receiving institution.

❑ Recommendations for isolation in LTC for patients colonized or infected with VRE are:

• A private room should be given, if possible. If patients must share rooms, it is acceptable to place with another patient a VRE patient who is continent of stool, has no diarrhea, and doesn't have an open wound infected or colonized with VRE.

• Gloves are required before contact with colonized or infected patients, their secretions, or the inanimate environment in the room.

• Gowns are required if it is expected that the health care worker's clothing will have material contact with patients, the patients' secretions, or with environmental surfaces.

• Patients transport should be limited to situations required for medical care and precautions continued while patients are outside their rooms.

• Patient care equipment should be dedicated, if possible, to a single patient, or cleaned and disinfected between patients.

• Vancomycin use should be prudent, and regular monitoring of antibiotic use is appropriate in LTC facilities.

Reference

1. Society for Healthcare Epidemiology of America Committee on Long-Term Care. Vancomycin-resistant enterococci in long-term-care facilities. *Infect Control Hosp Epidemiol* 1998; 19:521-525. ■

Elements of modified contact precautions

These are the contact precautions that were modified by infection control practitioners (ICPs) at the South Texas Veterans Healthcare System in San Antonio for use in its geriatrics and extended care programs to reduce the incidence of vancomycin-resistant enterococci (VRE) and other drug-resistant organisms:

• A private room or cohorting is preferred.

• If a private room or cohorting is not possible, VRE patients may be placed with patients not colonized with VRE under these specific conditions: no open, draining wounds; the noncolonized patient doesn't have invasive catheters and is not immunocompromised; the VRE resident doesn't have diarrhea; and both patients must have clean personal hygiene. The sharing of bathrooms is discouraged. A consult with an ICP is recommended.

• In addition to guidelines from the Centers for Disease Control and Prevention and the Society for Healthcare Epidemiology of America for hand washing and gloves, antimicrobial hand wash is recommended for both employees and VRE-colonized residents. Waterless alcohol foam soap is used after glove removal to enhance hand disinfection in areas where sinks are inaccessible.

• Wear gowns during direct care activities and when in contact with bedside equipment in patient rooms. Discard gowns before leaving patient rooms. Health care workers do not usually wear gowns when they are working around VRE residents outside of the patient's room.

• Do *not* limit patient activity. Activity and movement are dictated by the rehabilitation treatment plan. Only patients who are incontinent and not contained with an adult diaper, have diarrhea, or have open, draining colonized / infected VRE wounds are limited to their rooms.

• Address special resident issues such as dementia, wandering, or noncompliance through an ICP consult.

• If possible, dedicate equipment for single patient use, especially thermometers, wheelchairs, stretchers, and blood pressure cuffs. Rectal temperatures are not allowed. When dedicating equipment is not possible, disinfect it between patient use. Clean horizontal surfaces daily in the patient's room with disinfectant approved by the U.S. Environmental Protection Agency.

• Education is a high priority with families, residents, and health care workers; it should be ongoing and consistent. Resident and family education should address VRE transmission,

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personal cleanliness, hand washing, and environmental cleanliness for the facility and home when the patient is discharged. Health care worker education should focus on those issues as well as unique issues defined by the patient assessment related to VRE transmission risks. ■

Quick fixes for hospital utilization management

Clinical paths and case management solutions can take from three to 12 months to design and implement. While they're in the planning stages, though, you can apply any number of rapid measures for swift results. The key is to sensitize staff to the resource management elements of their own jobs, says **Patrice Spath**, health care quality and resource management consultant from Forest Grove, OR. An attitude that resource management should be the sole bailiwick of the utilization manager is a lose-lose proposition for your enterprise.

Spath urges subacute quality managers to share reimbursement data with people in every department. Lead discussions of the impact of clinical as well as nonclinical operations on surviving in a capitated or per-diem reimbursement market. To keep lengths of stay on target, educate physicians about the wide variety of out-of-hospital treatment options.

Other targets for quick-fixes include:

- Equipment not available the day ordered.
- Dietary service fails to deliver advanced-ordered diet.
- EKG/EEG not performed the same day as ordered.
- Drug or bowel prep not given as required by procedures.

For a free download of Spath's article, "Hospital Utilization Management 'Quick Fix' Solutions," visit Brown-Spath & Associates' Web site, http://www.brownspath.com, click on Original Articles. Or contact: Patrice Spath, P.O. Box 721, Forest Grove, OR 97116. Telephone: (503) 357-9185. E-mail: HC_Quality@msn.com. ▼

Health spending forecast: 24% rise by year 2000

In view of a recent prediction of upwardly mobile health spending, don't expect your cost-cutting pressures to lift any time soon. Milliman & Robertson, a Seattle-based consulting firm, forecasts that national health expenditures (NHE) will grow from the 1996 level of $1.035 trillion to $1.289 trillion by 2000.

John P. Cookson, a consulting actuary with the company, believes that NHE bottomed out in 1996, and we can look for moderate if uneven increases through the turn of the century. He attributes the upward movement to the delayed effect of the country's recently robust economic condition. Slightly higher inflation also was a factor.

Still, the report cites no reason to believe that NHE will return to earlier levels, which outstripped the economy's growth rates — unless the cost containment effect of managed care is only temporary.

However, one factor that could fuel expenditures might be the current backlash against managed care. Legislative changes resulting from the backlash just might weaken the managed care plans' ability to impose cost control measures. ■