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Work with infection control staff to study and prevent sentinel events

More infections should be sentinel events, JCAHO says

With the Joint Commission on Accreditation of Healthcare Organizations' recent emphasis on investigating nosocomial infections as sentinel events, now is the time to start planning how you will coordinate a root-cause analysis with your organization's infection control professionals. There may be crucial differences in how quality improvement and infection control conduct such investigations, and it is better to plan your response before a sentinel event occurs.

Quality improvement and peer review professionals typically take the lead when it comes to accreditation and complying with standards promulgated by the Joint Commission, but that group's recent announcement about nosocomial infections indicates a need for interdepartmental cooperation, says **Barbara Soule**, RN, MPA, CIC, an infection control consultant in Olympia, WA, and president of the Association for Professionals in Infection Control and Epidemiology in Washington, DC. This partnership may be a little different from what quality improvement professionals are used to because, unlike many other departments, infection control already has its own system for investigating serious problems. Though the two departments must work cooperatively, the task won't be as simple as taking your expertise to infection control practitioners and instructing them in how to conduct a root-cause analysis, she says. Moreover, that kind of instruction won't even be necessary.

"The methods of investigation we've always used are not that different from a root-cause analysis, and we've used them for years," Soule says. "The root-cause analysis is structured a little differently, but looking at all the various factors and how they affect outcome is pretty traditional for our work."

Communication will be a priority now that the Joint Commission has made clear it is looking for more investigation of nosocomial infections, Soule says. The Joint Commission recently announced that serious nosocomial infections should be considered sentinel events and thoroughly investigated, a position that could lead to a significant increase in the number of sentinel events for many providers.

Paul Schyve, MD, Joint Commission senior vice president, said, "If a patient dies in a hospital or has a permanent disability as a result of a nosocomial infection, the hospital really should think about that as a sentinel event and treat it and evaluate as such. When the outcome is that serious, it is not the same as saying, 'Let's add these [infections] up and look for trends and patterns.' It is, in fact, a sentinel event."

The most recent *Sentinel Event Alert* from the Joint Commission states that "Despite the small number of infection-related sentinel event cases reported to the Joint Commission, the number of patients acquiring infections in the health care setting, as well as the number of patient deaths due to an acquired infection, remains high." Only 10 infection-related reports have been reviewed under the sentinel event policy since its implementation in 1996, the Joint Commission says.

In addition to urging more reporting of infections, the Joint Commission urges health care providers to take these steps:

- Revise orientation and training processes and competency assessments.
- Revise equipment-cleaning processes.
- Revise hand-washing procedures.
- Switch to single-use IV flush vials.
- Add waterless hand rubs.
- Define supervisory expectations.
- Revise critical care privileging and intensive care unit admission criteria.
- Conduct inservices and team trainings.
- Institute tracking systems.

Your efforts to comply with the Joint Commission directive and investigate more nosocomial infections will be more successful if you first approach infection control professionals by acknowledging that they already are on the ball, even if their work hasn't resulted in many sentinel events reported. There is some resentment among infection control practitioners who think the Joint Commission implied that they should start investigating infections, as if they weren't already doing that, says **Carol Elder**, infection control practitioner at Mount Carmel West in Columbus, OH.

"I think a lot of infection control practitioners will respond that we've always done what they want us to do. They call it a root-cause analysis; we call it an epidemiological investigation," she says. "They're just calling it something different. If I see two or three patients with an infection that's unusual, or maybe they had the same procedure, I don't sit back and wait until we declare it a sentinel event to do a root-cause analysis. I'm already out there investigating it."

Infection control practitioners will not need a step-by-step explanation of how to investigate nosocomial infections, but they may need to be briefed on the particular manner in which the Joint Commission expects the investigation to occur. The differences may be more semantic than substantive, Soule says.

"It might be that infection control professionals need to learn the new process that you use with sentinel events, and the terminology expected by the Joint Commission might be new to them," she says. "It also can be helpful to go over the documents required by the Joint Commission."

How much you need to educate infection control professionals about the sentinel event process might depend on how much they have been

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involved already. Some organizations already include infection control as a regular part of sentinel event investigations, so Soule says the only needed change might be giving the infection control practitioner a bigger role in some instances. When investigating a nosocomial infection as a potential sentinel event, it might be appropriate to have the infection control representative lead the team.

"If you have a situation in which your quality improvement professionals and infection control professionals have not worked together before on sentinel events and root-cause analyses, this would be a good time to educate each other about how that process works. You might want to do it before an event occurs, but not necessarily," she says. "There can be 'just-in-time' training, and a lot of people think that is the most effective. That takes place when you have a potential sentinel event and you get in a room with the team and go over the expectations for the Joint Commission."

Elder says she has met with her hospital's quality improvement department to discuss the new Joint Commission directive, and she recommends that as a starting point for other providers.

Communication between the two departments will be key to satisfying the Joint Commission without getting in the way of the work already done in infection control, she says. Remember that many infection control departments consist of just one person, so additional paperwork and reporting systems can get in the way of an already heavy work load. Above all, she cautions providers not to implement a system that will hobble infection control's standard investigation process by waiting for a sentinel event declaration.

"We already investigate faster than if we had to go through a reporting process and then get an official order to investigate the problem," Elder says. "There's a risk of delaying investigations if you implement some sort of bureaucracy for reporting that delays what we already do, which is to go ahead and investigate as soon as we have reason to."

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RCA of transplant case reveals lack of redundancy

Redundant validation put in place

A root-cause analysis points to a lack of redundancy as the critical failure that allowed organs to be transplanted into a patient with the wrong blood type, according to information from Duke University in Durham, NC, the site of a recent notorious sentinel event. The public immediately wondered how such a tragic mistake could occur, but quality improvement professionals knew the root cause had to be more than a surgeon's mistake. Duke launched a root-cause analysis immediately and reports that a lack of redundant steps for confirming blood type and other compatibility factors in the hospital's organ transplant process contributed to the death of Jesica Santillan, 17.

Separate news releases from Duke and the organ donor bank described the series of events this way: When the heart and lungs became available, Carolina Donor Services found two potential recipients, and both were at Duke. Both had blood type A, the same as the organs. They contacted a Duke surgeon on call for adult heart transplantations. When he realized the first organ-matched Duke patient was a child, he referred the call to James Jaggers, MD, the surgeon in charge of pediatric heart transplants. Carolina Donor Services maintains that it gave Jaggers all the necessary information about the organ, including blood type.

Jaggers told Carolina Donor Services that the child suggested was not medically ready for the transplant, but according to a Duke statement, "He inquired as to whether the heart and lungs might be available for Jesica Santillan." Since the original offer was for only a heart, and Santillan needed lungs also, the donor bank caller had to check on the availability of lungs before giving Jaggers an answer.

Santillan was not the second potential recipient that the donor service had identified at Duke. The second potential donor with Type A blood was not discussed with Jaggers because the patient was an adult, and Jaggers handled pediatric transplants. Jaggers says he inquired about Santillan receiving the organs because she needed the transplant so badly, and he was hoping the organs were a match. Santillan had O-positive blood.

Jaggers gave Santillan's name to Carolina Donor Services and thought it would look up pertinent

information on the national list of patients awaiting transplants, says **Jeff Molter**, spokesman for Duke University Hospital. The donor bank proceeded on the assumption that Jaggers knew the organ blood type was A. Jaggers thought the bank would confirm compatibility through its database before getting back to him with an answer.

The donor bank contacted the physician of the second patient it had identified at Duke, but the organs were not a size match for that patient. The bank then called Jaggers back regarding Santillan. The donor bank confirmed that the lungs also were available, which Jaggers took as a confirmation that organs were a match in every way because he had thought they were checking their database for the match. The transplant was put in motion despite the blood type mismatch.

Carolina Donor Services said the organs arrived with paperwork and labels that clearly indicated the blood type. Duke said the blood type match was not confirmed at that point because the team thought all compatibility had been checked already. A statement from Duke said, "Jaggers does not recall blood-type matching being discussed with CDS, but does recall the discussion including the donor's height, weight, organ function, and cause of death. Dr. Jaggers assumed that they wouldn't have called back and released the organs if they weren't a match. This was a wrong assumption on his part."

Hospital Peer Review obtained a copy of a letter from **William J. Fulkerson**, MD, vice president and chief executive officer at Duke University Hospital, to Deanna Sampson, director of policy compliance at the United Network for Organ Sharing in Richmond, VA, which oversees the organ transplant system. In the letter, Fulkerson wrote, "We have concluded that human error occurred at several points in the organ placement process that had no structured redundancy. The critical failure was absence of positive confirmation of ABO compatibility of the donor organs and the identified recipient patient."

The letter continued, "Duke University Hospital has conducted a thorough root-cause analysis of the event and the organ procurement process followed in the pediatric thoracic transplant program. During that review, the lack of redundancy was recognized as a weakness. Validation of the ABO compatibility and other key data elements regarding the donor and recipient will now be performed by: the transplant surgeon, the transplant coordinator, and the procuring surgeon. The transplant surgeon will actively confirm the donor and recipient key data elements verbally. During the notification call to the transplant surgeon, the donor key data elements will be communicated. These data elements will be compared to the information in the transplant program's database to confirm blood type compatibility, size compatibility, and if there are issues regarding anti-HLA antibodies.

"An additional verification will be accomplished via telephone contact with the organ procurement organization placement coordinator by the transplant coordinator." In addition to the redundant validation put in place, Duke University Hospital is evaluating the information technology supporting access to recipient information. Technology improvements may result, the letter stated.

Ralph Snyderman, MD, chancellor for health affairs at Duke University and president and CEO of Duke University Health System, released a statement: "The response to the tragedy, however, was a true test of our institution. When the surgeon, Dr. Jim Jaggers, understood the problem of the mismatch, he immediately assumed responsibility for his role, informed the family, and placed the patient on the priority list for a second heart-lung transplant. He signaled the problem to the institution, which immediately initiated a sentinel review process and instituted corrective actions to prevent such mishaps in the future."

Santillan's initial transplant operation took place Feb. 7. A second heart-lung transplant procedure, using blood group-compatible organs, was conducted Feb. 20. Santillan died two days later.

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Hospital achieves 90% compliance with pathways

JCAHO awards hospital with Codman

Clinical pathways often are hailed as a premier quality improvement tool, but they also are seen as pie-in-the-sky solutions because they don't do any good if clinicians don't actually use them after all the fanfare of introducing them. Compliance can be the weak point in implementing even

one clinical pathway, but a pediatric hospital in San Diego has proved that you can get an astounding compliance rate even when introducing dozens of pathways.

Children's Hospital and Health Center in San Diego has implemented more than 60 clinical pathways in the past eight years and boasts a 90% compliance rate. Data show that the pathways have improved quality of care while significantly decreasing costs, says **Paul Kurtin**, MD, vice president for clinical innovation and director of the Center for Child Health Outcomes, the department that develops and implements the pathways. He says the hospital's experience holds lessons for any organization introducing clinical pathways, whether you're introducing one or 100.

"Data are key to making clinical pathways work. When you have the right data, you can show that they're the right way to treat patients, and the physicians will comply when they see that their patients benefit." Children's is the first pediatric hospital to win the Codman Award from the Joint Commission on Accreditation of Healthcare Organizations, which recognizes outstanding quality improvement projects.

Clinical pathways are nothing new, of course, having been around since the mid-1980s. While they initially were dismissed by some clinicians as cookbook medicine, pathways are gaining acceptance as more data prove their effectiveness. Kurtin says the Children's experience shows that a careful implementation, keeping in mind the objections that sometimes get in the way of compliance, can make all the difference.

The benefits of clinical pathways are hard to ignore. In addition to decreased costs and improved quality, The hospital's president and CEO **Blair L. Sadler** says they provide effective, consistent training for new pediatric residents and interns, nurses, clinical technicians, and other support staff. Each Children's pathway is developed in collaboration with physicians, nurses, and other clinical and hospital staff, including respiratory therapists, social workers, and dietitians. "Pathways provide irrefutable evidence that quality care can be measured. And we know they lead to the safest, most effective treatment for kids."

Kurtin says research indicates there can be as much as a 15-year lag between when best practices in medicine are identified and when they are put into everyday use. While the national average of physicians who comply with pathways is between 15% and 20%, physicians at Children's are 90% compliant, he says.

"It's easy to make claims of quality care; it's much harder to prove it," Sadler says. "Pathways provide irrefutable evidence that quality care can be measured. And we know they lead to the safest, most effective treatment for kids."

The effort to implement clinical pathways began 10 years ago, spurred in part by the growing financial pressure from managed care. There also was a growing call for accountability and data on outcomes. Kurtin was hired to head the Center for Health Outcomes, and he says the experience at Children's offers lessons any hospital can use in implementing pathways:

Lesson 1: Actively engage the physicians in implementing the pathways.

"Nursing-led projects hadn't been successful," Kurtin says. "We wanted to devise a program that made sense with how physicians think and practice." The first step was getting physicians to acknowledge that there were different levels of care, with great variations in how the same patients were treated. Data on outcomes and treatment patterns helped show physicians that most of the variation was unnecessary and driven by physician practice and habit rather than patient need. Simply saying that wasn't enough, because every physician sincerely thinks his or her treatment choices are justified by the particulars of the individual patient. Data make all the difference, he says. "When a physician stands up and says, 'I've been practicing for 20 years and don't need a clinical pathway,' I'll ask what his outcome has been over that time. They never have an answer because individual physicians don't have outcomes data. But I can show our outcomes with this pathway, and they know they'd be happy to have that kind of outcomes record with their name on it."

Lesson 2: Use a team that includes everyone involved in the patient's care, not just one group such as nurses or physicians.

Children's adopted a systems approach to implementing pathways, not leaving it to nonphysicians to develop and then expecting physicians to follow them, and not relying only on physicians to develop pathways that would be used by nonphysicians as well. Instead, the hospital includes a wide range of professionals included in patient care — nurses, dietitians, social workers, surgeons, and many others. The team is selected anew for each clinical pathway slated for development, putting together a team that is especially familiar with that issue.

Lesson 3: Start with the most common, obvious needs.

The first clinical pathway addressed asthma care, and it didn't take long for the physicians and others on the pathways team to determine that there was a lot of room for improvement. Clinical organizations had developed asthma guidelines that nearly everyone agreed were valid, but Children's wasn't following them, and neither was hardly any other hospital in the country.

Lesson 4: Don't make the pathways mandatory.

The asthma project revealed strategies that would be carried forward to many other clinical pathways. For starters, Kurtin and the clinicians involved made it clear that the pathways were not mandatory — seemingly a contradiction to the effort to achieve the highest compliance possible. But they knew that physicians would rebel at being required to practice medicine exactly as prescribed in the pathways. Instead, they wanted to bring the physicians on board willingly.

"Nothing interferes with what the physician thinks is best for the patient," Kurtin says. "But we got the support of key physicians who believed in the pathways and promoted them. We got about a 20% compliance rate at first, which is typical."

Lesson 5: Do make the pathways the default treatment plan.

Once the data started building and clinicians saw that those following the pathways had better outcomes, the compliance rate grew steadily over the next eight years. Soon, Kurtin went to the department of pediatrics and asked that the clinical pathway be made the default care plan for asthma, so it automatically is followed unless the physician specifies otherwise. "Before that, the physician had to take action to put the child on the pathway; and at 3 a.m., that often didn't happen."

Though the pathways still are not mandatory, that change greatly increased compliance. Now the hospital sees a 98% compliance rate with the asthma pathway. Kurtin explains that the hospital doesn't even want 100% compliance because there always will be legitimate outliers who need to deviate from the pathway.

The hospital's asthma pathway has reduced a child's average length of stay in the hospital from 2.2 to 1.6 days and cut the average cost of care in half, from nearly $1,800 to $900. In addition, asthma patients have needed fewer in-hospital respiratory treatments, says **John Bastian**, MD, director of allergy/immunology at Children's.

"Pathways help us provide the best evidence-based care for all patients with a given disease," he says. "They form the framework for our dedicated staff to provide excellent one-child-at-a-time care."

Lesson 6: Streamline the pathways to make them more usable.

Over time, Children's developed more than 60 pathways and continues to take on more projects. At first, the pathways teams took about nine months to develop each one, but now that process has been pared down to only one month. The format for the pathways was pared down from a very detailed, multipage document that looked almost like a nursing care plan, laid out day by day, to a series of algorithms on one side of one page. "That format also works better because that's the way physicians think: If this, then do that," Kurtin says.

Lesson 7: Don't waste time debating what already is proven in the literature.

The development process also speeded up when the teams started doing the literature review before consulting the involved physicians. The first meeting used to consist of deciding what papers to look at, but now the first meeting involves a few members presenting a summary of what the literature shows and what care standards are recommended in the literature. Team members receive a packet of information that summarizes the research before the entire team meets for the first time. "We can say the literature agrees on these six steps, but there's no agreement on these three steps, so how do we want to handle them at Children's?" Kurtin says. "That way, we avoid wasting time agreeing on what's already established in the literature."

Lesson 8: Find an enthusiastic proponent who can promote the pathway to peers.

Every clinical pathway has a physician champion who promotes its use. This person usually isn't a physician with great authority such as a department chairman but is a senior physician who is well respected in that field. That ensures the other physicians can follow the champion's lead without feeling that they're being ordered to.

When choosing targets for any new clinical pathways, Children's goes after the usual suspects — high volume, high risk, and high cost. Now that the pathways are accepted readily in the hospital, physicians often approach Kurtin with new ideas. The first priorities for pathways were the most common illnesses, but now the hospital is willing to target issues that may affect only 25 patients per year. The hospital also is broadening the scope of its pathways to include specific procedures, such as high-tech procedures in the intensive care unit, to make sure the procedure is done correctly. The

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Hospital's award-winning plan for prescription drugs

Some $150,000 in free meds provided each year

A social work professional at a 100-bed hospital in Indiana is getting free medications for patients who can't afford them with a program she says could be a model for health care organizations across the country.

Using an Internet program called IndiCare (www.indicare.com), which provides access to pharmaceutical companies that offer free drugs to needy patients, **Jaris Hammond**, ACSW, LCSW, social services coordinator for Hancock Memorial Hospital and Health Services in Greenfield, IN, oversaw the distribution of at least $148,500 in free medications in 2002.

She estimates the figure would be closer to $200,000 if she were able to track patients who refill their own prescriptions using cards issued by some of the drug companies.

Program recognized for innovation

In 2001, the program received the Eleanor Clark Award for Most Innovative Program from the Philadelphia-based Society for Social Work Leadership in Health Care.

"It can be duplicated without much effort," Hammond says. "That's exactly why it won the award. If everybody in the country could do this, there would be no need for Medicare to pick up the cost of prescription medication."

Before the IndiCare program began, Hancock was spending about $10,000 a year to purchase medications for some 50 needy patients through its medical assistance program (MAP), she explains. Under that program, the hospital and more than 40 physicians from a variety of specialties write off the medical care they provide to patients who meet the guidelines of the federal food stamp program.

"We decided three years ago that maybe it was time to try something else" to address the need for funding for prescription drugs, Hammond says.

Assistance programs continue to grow

A Hancock pharmacist who had heard about IndiCare requested a demonstration of the program, and the hospital eventually paid $3,000 a year to tap into it, she adds.

"[The pharmacist] did a trial with three or four patients, and then, when she left after three or four months, the program fell into my lap." In the last few months of 2000, when the program started, about $18,000 worth of drugs were distributed, she says. For 2001, the figure was about $109,000.

IndiCare is one of seven financial assistance programs she oversees, Hammond notes. She also serves as the sole social worker for the emergency department, outpatients, obstetrics, and same-day surgery. She also handles the referrals for drug and alcohol programs, as well as for domestic violence, adult protective services and child abuse cases. "I'm the 'go-to' person for our transition [discharge] planners."

That means, Hammond explains, that she would be unable to run the IndiCare program without "two wonderful volunteers." She soon

will have a third, she adds. "We also have social work interns and a two-days-a-week secretary who is awesome."

"What we do is go on-line, access what medications are being offered by specific pharmaceutical companies, get the forms, and fill out what's required for their format," she says. "It could be last year's tax statement or, in the case of one who went into [extreme] detail, the patient's electric bills."

Patients don't qualify for the coverage if they are eligible for any other prescription drug coverage, including federal, state, or private insurance, Hammond notes.

Most of the drug companies offer nongeneric medication through the program, she says. "If there's a generic [substitute] for it, they won't give it to you for free."

Patients with asthma or chronic lung disease or who need blood-pressure medication for hypertension "are great candidates for IndiCare," Hammond says.

After her office completes the IndiCare application for a patient, she explains, there is "a paper shuffle back and forth with the physicians' lounge" to obtain authorization for the drugs. "[Physicians] sign off on the application, put it in our box, and we mail it in. Most of the medications are delivered to the physicians' offices."

Keeping patients in the program

Her office tracks each case, making sure the medicine gets to the right people, and then reapplies, setting the process in motion again, adds Hammond. "The pharmaceutical companies usually send a three-months' supply, so after two months, we reapply."

"Many people have been on the program for three years," she says, "and a lot of them don't have any insurance at all. Sometimes, their medicine costs $1,000 a month."

Frequently, patients can afford to pay their physician but don't have the money for their medications, Hammond notes.

"In many cases, [getting the free drugs] prevents them from being hospitalized." This is particularly true for diabetics, many of whom the program helps to obtain free insulin from one pharmaceutical company and free test strips from another, she adds. "Sometimes, I have someone come to my door from the Medicare office and say, 'I've applied for Medicare, but I've been off my meds for two weeks.'"

In addition to the IndiCare program, patients can get help from a private fund called HELPS that is used to buy medications "in a pinch," Hammond says. That fund comes into play "if somebody's in the emergency department [ED], for example, who needs antibiotics for a bad infection or for wound care."

Despite its relatively small size, Hancock Memorial Hospital and Health Services provides a wide range of services, she notes, including hospice care, cardiac catheterizations, a geriatric psychiatric unit, and a rehabilitation unit.

Part of her job, Hammond explains, is helping some of the patients who make use of those services through the seven financial assistance programs she oversees. In addition to IndiCare and MAP, she says, those programs include:

- **Senior Health Insurance Information Program (SHIIP)**, a volunteer program that keeps patients updated on changes in long-term care insurance and Medicare and Medicaid regulations, and provides counseling for those who need it.
- **Women Helping Women**, which Hammond calls "an awesome answer to women who need mammograms and can't afford them. We have a fundraising dinner once a year and made close to $20,000 with this year's dinner." She adds that the program, which gets a great deal of physician support, "could be modeled by anybody."
- **Breast and Cervical Cancer Program**, a state-funded initiative for which Hammond provides the social work component. "We hired a two-days-a-week person to coordinate that program," she says.
- **Financial Write-off Applications.** "Our little office does at least 200 applications a year for people who don't qualify for MAP, but really can't afford to pay their bill," Hammond explains.

This would include someone who "just came to the ED and had a $300 to $400 bill. We take a snapshot of their financial situation and ask for last year's tax return and [documentation of] the last three months of income. On the basis of that information, we write off all or part of the bill. Physicians tend to write off what we write off."

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Redirect indigent funds for prescription drugs

Hospital spends $1 to provide $16 in medication

W.A. Foote Memorial Hospital in Jackson, MI, has dramatically increased the bang for its prescription drug buck by forming a medication assistance program (MAP) in conjunction with several community agencies, says **Beth A. Smith**, RN, MSN, MBA, director of case management.

Rechanneling funds it originally contributed to a United Way-sponsored operation run by Catholic Social Services (CSS), the hospital developed an in-house program that is providing some $16 in free medications to the needy for every dollar spent, adds Smith, who serves as liaison between the new program and the community.

Old program had limited funds

Previously, she explains, the hospital had contributed $60,000 annually to the CSS program, which also received $50,000 a year from United Way. "They could service about 100 patients a month and would normally run out of money by the middle of the month."

Under that system, the agency gave vouchers to patients after a cursory financial screening, and the patients went to a pharmacy to purchase their medications, Smith notes. "They paid retail price, so [the program] couldn't service that many people."

Another problem was that there was no case management of the program, which was run by a clerical employee, she says.

"One person needed treatment for a toe fungus, and the physician prescribed medicine that costs $200. There are other, less-expensive treatments," Smith explains.

Because the CSS program focused on serving as many people as possible, patients received funding for their medications intermittently, maybe once or twice a year, Smith notes.

That meant there was no provision for those who were on, for example, long-term heart medication, she adds.

Meanwhile, officials at the hospital, which is part of Foote Health System, had been batting around the idea of starting its own indigent prescription drug program, she says. "The issue was funding."

An organization called the Emergency Needs Coalition, which looks at shelter, heating and health care needs in the community, asked a group of agencies to get together and address the prescription drug issue, Smith adds.

After some discussion and initial resistance from those administering the CSS program, the coalition agreed to let Foote take the $60,000 it was contributing to the United Way and use it to fund its own program, she says. "The community felt we could serve more people."

With its own pharmacists overseeing the program as part of their jobs, the hospital uses the funds to pay an annual $4,500 licensing fee for the computer software program Indicare and to hire two pharmacy technicians [1.4 full-time equivalents (FTEs)], who do the processing that the IndiCare computer program requires, she notes.

Approximately $12,000 a year goes to pay for medications that cannot be obtained from pharmaceutical indigent programs or from samples contributed by the drug companies and by physician offices, she says. Those medications are dispensed at cost in the case of brand-name products, or for a $5 copay for generics, Smith adds.

Prescriptions given are 10 times greater

While CSS was able to provide 100 patients a month with about 222 prescriptions, the Foote program provides about 450 patients with a total of 2,300 prescriptions, she adds.

Other results are not as easily measured but are very real, Smith notes. "All of the community agencies have noticed a decrease in the requests for medications, a lessening of the burden."

In addition, she says, the hospital has been able to discharge patients earlier because of the availability of home intravenous infusions provided through the program.

"We have received numerous letters from the patients and their families in appreciation of this program," Smith wrote in an application proposing MAP for a national award. "In many cases, it helped relieve what had become a desperate financial situation."

There are plans for expansion, she notes. "We are looking at adding one or two FTEs. The bang for the buck is so incredible. Our pharmacists do this along with their normal job, so we're hoping to add [funding for some] pharmacist hours."

In addition, Smith says, the Emergency Needs Coalition is asking for funds from United Way to replicate parts of the program at the Center for Family Health, a federally qualified health center that serves Medicaid patients and the uninsured.

[For more information, contact:

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Partnership gets drugs for needy patients

Discharges are more efficient, staff less frustrated

Obtaining prescription drugs for patients who can't afford them has been a problem for Athens (GA) Regional Medical Center for the 18 years that **Beverly A. Baker**, CRC, CCM, has been with the hospital, she says.

"With the rising cost of medication, this problem had only gotten worse," adds Baker, who is director of social work services. "My staff were spending hours each week looking and begging for medications for patients. The physicians had even gotten to the point where they would refuse to discharge a patient until medications were obtained.

"We were looking at how many discharges were being delayed while we looked for resources," she says. "With hospitals going into bed [availability] crunches, turning over rooms was an issue."

The situation changed dramatically for the better about a year and a half ago, she explains, when the hospital established a medication assistance program (MAP) that works in conjunction with local charitable agencies.

When a patient is being discharged and needs help paying for prescriptions the physician has written, the hospital picks up the cost for the first 30 days, Baker explains, and then refers the patient to a community agency with which the hospital has partnered.

That agency assists the patient in applying for the Pharmaceutical Companies Indigent Drug Assistance Program, she adds. "We also do this on readmissions when different medications are required."

Because of the possibility for abuse, the hospital does not pay for pain medications, Baker says, but she notes that for cancer patients, there are other community resources that will cover those drugs. Patients qualify for MAP if their income is below 100% of the federal poverty guidelines and they have no other Medicaid or insurance benefit, she adds.

Once the hospital does its part, Baker says, the community agencies do the paperwork required to obtain the assistance from the pharmaceutical companies. Several agencies participate, including Catholic Social Services, a couple of free clinics, and a fund sponsored by the local newspaper, she explains.

Most patients who need prescription drug assistance, however, are referred to an association of area churches called "ARK," Baker explains, because the group has a program specifically for that purpose.

"If there are language barriers, we refer them to Catholic Social Services," she notes, "and if the person isn't going to meet the income guidelines of the pharmaceutical companies, we look for other agencies." Continued assistance from the hospital is not available if the patient does not follow up with the indigent drug assistance programs, Baker adds.

Although her department still is in the process of developing ways to measure the program's effectiveness, she says, indications are that lengths of stay and readmissions are being reduced.

"[Before], we were seeing instances of patients coming in, being discharged, and coming back in because they were not taking their medications. The reason they weren't taking them is because they weren't buying them," Baker says.

Meanwhile, her staff members are "feeling much more productive," she notes. "They spend their time doing more productive things than calling agencies trying to get money to cover the drugs."

[For more information, contact:

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(Continued from page 50)
pathways also include safety measures.

Lesson 9: Regularly consider the need to update pathways in response to new research.

"At least twice a year, we review the pathways for content. Is there a new drug or a new paper out now?" Kurtin says. "We also can do it ad hoc if the need arises. If a physician in charge of the pathway says there's a new drug out there and it needs to be included, we'll pull the team together and address that. We see them as living documents."

Children's recently studied its 100 sickest asthmatics, including one who had visited the emergency department (ED) 72 times in one year, and developed a pathway that includes the care of a specialist, home care, and intervention at school. That pathway lowered the hospital's cost of care for those patients by 82%, mostly by keeping them well and out of the ED.

Overall, the benefits have been tremendous over the past eight years, and Kurtin says they stem directly from the strategies that yielded the high compliance rate. The hospital has saved more than $5 million in direct variable costs, the costs that physicians can control, he says.

Lesson 10: Trumpet your achievements beyond your own organization.

Showing those cost savings to brokers and HMOs has helped increase the hospital's market share by 12% over the past eight years. The data show that patients do better at Children's at a lower cost, so insurers want their patients there. And the pathways have minimized admissions and length of stay so much that the hospital has not met its capacity as soon as it otherwise might have, Kurtin says.

Without the pathways, Children's probably would have reached its limits already. Using pathways also changed the way Children's nurses work with physicians in treating patients, says **Lesley Ann Carlson**, director of medical/surgical services. "Because pathways are approved in advance, they are reliable plans of care," she says.

"We know exactly how to start treatment from the minute a parent puts a child in our hands; there's no wasted time or energy in providing care."

Kurtin says the hospital is continuing to develop new pathways and now is considering using the system for other types of projects, such as improving patient flow. Teams now are working on pathways to ensure that every child in the intensive care unit truly needs to be there and is there for the shortest time necessary.

"In many cases, the child could be in a step-down unit but the physician just feels more comfortable with the patient in intensive care," he says. "There's very little evidence on this, so we're trying to build a consensus that the doctors can agree to. But we're sure that the pathways concept can work for more than strictly clinical treatment issues."

[For more information, contact:

- ***Children's Hospital and Health Center**, 3020 Children's Way, San Diego, CA 92123. Telephone: (858) 576-1700.]* ■

Reader Question

Spiritual assessment required in all settings

Question: Does the Joint Commission's standard on spiritual assessment apply only to behavioral health or to all health care settings? What are we expected to do in making this spiritual assessment?

Answer: The Joint Commission on Accreditation of Healthcare Organizations expects you to conduct a spiritual assessment of every patient in every health care setting, explains **Pat Staten**, RN, MS, associate director of standards interpretation. A different standard applies to each setting, but they all require essentially the same thing. The only exception is behavioral health, in which Standard PE.1.21.4 requires a more thorough assessment of a patient's spiritual outlook.

Exactly how you conduct the spiritual assessment is up to you, and it will vary from one setting to another, Staten says. The purpose of the assessment is to determine how a patient's religion or spiritual outlook might affect the care he or she receives. In the most typical inpatient setting, such as a patient admitted through the emergency department, the spiritual assessment should be conducted at the outset as part of the admission process, Staten says.

At a minimum, the spiritual assessment should determine the patient's religious denomination, beliefs, and what spiritual practices are important to the patient. Staten says the extent of the assessment will depend on the circumstances. For a patient admitted for a routine, low-risk procedure, it may be sufficient to inquire about his or

her religion and offer to have the appropriate clergyman stop by. The patient's response may dictate how much you need to explore further. A patient who says he is Catholic might be informed that there is a priest at the hospital who can be summoned, but a patient who says she is a Jehovah's Witness will require further discussion about how her beliefs will affect her medical care. The spiritual assessment also may indicate a need to provide a special diet or other unique concerns.

For a patient admitted to hospice or behavioral health, a more thorough assessment may be in order than in most other settings. The behavioral health setting requires a deeper assessment because so many aspects of treatment are tied to 12-step programs with religious components (a higher power and the need for prayer or meditation). A patient's religion or spiritual beliefs can have a profound impact on the effectiveness of such treatment, so the Joint Commission requires providers to assess that impact up front.

Staten cautions that simply asking about the person's religion is not sufficient to comply with the Joint Commission standards. Assessing a person's spirituality must go further.

"I don't know if people really understand well the difference between religion and spirituality," she says. "The spiritual assessment includes asking about a person's religious denomination, but it's more than that. Even if a patient says he or she doesn't belong to any particular religion, he or she may still have beliefs that affect the care you provide, beliefs that you should take into consideration. You should ask if the person has any personal beliefs about spirituality beyond just the denomination."

The Joint Commission provides these examples of questions that could be asked, but are not required, in a spiritual assessment:

- Who or what provides the patient with strength and hope?
- Does the patient use prayer in their life?
- How does the patient express their spirituality?
- How would the patient describe their philosophy of life?
- What type of spiritual/religious support does the patient desire?
- What is the name of the patient's clergy, ministers, chaplains, pastor, rabbi?
- What does suffering mean to the patient?
- What does dying mean to the patient?
- What are the patient's spiritual goals?
- Is there a role of church/synagogue in the patient's life?
- How does faith help the patient cope with illness?
- How does the patient keep going day after day?
- What helps the patient get through this health care experience?
- How has illness affected the patient and his/her family?

[For more information, contact:

- ***Pat Staten**, Associate Director of Standards Interpretation, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000.]* ■

Standards set for HIPAA privacy accreditation

URAC in Washington, DC, recently released a set of Health Insurance Portability and Accountability Act (HIPAA) Privacy Accreditation standards for public comment. When completed later this year, the new program is intended to help health care organizations display a commitment to fair information practices, and to demonstrate that they have taken the necessary steps to protect health information privacy in accordance with the HIPAA Privacy Rule, says **Garry Carneal**, URAC president and CEO; the organization also is known as the American Accreditation HealthCare Commission. "The purpose of this accreditation program is to verify that an organization has put in place the necessary infrastructure and implemented the necessary processes to comply with the HIPAA Privacy Rule," he says. "URAC supports fair information practices and recognizes the value that health information privacy adds to the health care process."

Among other benefits, URAC health information Privacy Accreditation will provide value to health care organizations by allowing internal verification of HIPAA privacy compliance efforts, providing a convenient source of industry best practices and certification by external reviewers; and assuring customers/patients that appropriate steps are being taken to protect health information.

"This accreditation program is designed to be relevant to all health care organizations expected to comply with the HIPAA Privacy Rule," Carneal says. "These include covered entities, business associates, and organizations that, while not legally subject to HIPAA, still wish to validate

their HIPAA compliance program. Since different organization types need to comply with certain HIPAA requirements, we intend to take a situational approach in determining which of the HIPAA Privacy Accreditation standards apply."

URAC HIPAA Privacy Accreditation will last for two years, at which time the accredited organization will submit a reaccreditation application and be reviewed by URAC before accreditation is granted for another two years.

[For more information, contact:

- ***URAC**, 1275 K St. N.W., Washington, DC 20005. Telephone: (202) 216-9010.]* ■

HHS adopts final security standards under HIPAA

Tommy G. Thompson, secretary of the Department of Health and Human Services (HHS), recently announced the adoption of final security standards for protecting individually identifiable health information when it is maintained or transmitted electronically. He also announced the adoption of modifications to a number of the electronic transactions and code sets adopted as national standards. Both final regulations are required as part of the administrative simplification provisions included in the Health Insurance Portability and Accountability Act of (HIPAA) 1996.

"Overall, these national standards required under HIPAA will make it easier and less costly for the health care industry to process health claims and handle other transactions while assuring patients that their information will remain secure and confidential," he said. "The security standards in particular will help safeguard confidential health information as the industry increasingly relies on computers for processing health care transactions."

Under the standards announced, health insurers, certain health care providers, and health care clearinghouses must establish procedures and mechanisms to protect the confidentiality, integrity, and availability of electronic protected health information. The rule requires covered entities to implement administrative, physical, and technical safeguards to protect electronic protected health information in their care. The security standards work in concert with the final privacy standards adopted by HHS last year and scheduled to take effect for most covered entities on April 14. The two sets of standards use many of the same terms and definitions to make it easier for covered entities to comply. Most covered entities will have two full years, until April 21, 2005, to comply with the security standards; small health plans will have an additional year to comply, as HIPAA requires.

In a separate final regulation, HHS adopted modifications to the transaction standards, which health plans, certain health care providers, and health care clearinghouses by law must use for electronic health care transactions. Covered entities must comply with these modified transaction standards by Oct. 16, 2003.

(Editor's note: For the complete text of both final rules go to: www.cms.hhs.gov/hipaa/hipaa2.) ■

Part 1 of 2

Using customer concerns to improve quality

By **Patrice Spath**, RHIT
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Forest Grove, OR

Service quality is a high priority for most health care organizations. Unfortunately, failures in service and, therefore, concerns are inevitable due to the number of variables and perceptions involved in health care delivery. Feedback and learning from concerns is a key ingredient for achieving service excellence. If concerns can be transformed into knowledge about customer expectations, they can become valuable learning opportunities. To exploit this information source, health care organizations must have a systematic concern management system that is integrated with other performance improvement activities.

Research suggests that relatively few dissatisfied patients and family members bother to report a concern. As a result, every concern received by the health care organization can provide insights into what might be a much larger problem. By evaluating the causes of concerns, the organization can reduce the number of concerns as well as improve satisfaction with services. Implementation of a formal concern management system requires some

(Continued on page 59)

Freeport Health Network Patient Concern Form

Date of concern: _____ Taken by: _____ Phone #: _____

Patient's name: _____ DOB: _____ DOS: _____
(Last, first, middle initial)

Location of service/department: _____ Cost center #: _____

Name of caller/relationship: _____ Acct. #/ medical rec. #: _____

Address: _____

Phone # (home): _____ (work): _____

Best time/times to call: _____

Attitude of caller: ☐ Upset ☐ Angry/loud ☐ Frustrated ☐ Calm ☐ Obnoxious

Description of concern: _____

_____

_____

_____

_____

_____

Patient/staff expectations: _____

Date concern referred: _____ Referred to: _____

**** CONCERN TO BE CLOSED IN SEVEN WORKING DAYS ****

Actions taken: _____

_____

_____

_____

_____

_____

Service recovery? ☐ Yes ☐ No

Type of service recovery: _____ Amount: _____

Date final contact made: _____

Final contact made by name & title: _____

Source: Freeport (IL) Health Network. Reprinted with permission.

additional expenditures on the front end. However, in the long run, such a system can reduce everyone's workload. By effectively dealing with individual concerns, systemic or recurring problems can be eliminated with a resulting decrease in future concerns. So even organizations with limited resources should have a systematic process for handling concerns. Using a system to manage concerns is more effective than providing ad hoc responses, which can lead to more serious concerns. A concern management system also allows you to feed information into the continuous improvement process, so that the organization can prevent similar future concerns.

An effective concern management system helps to develop an organizational culture of continual improvement as well as improving the organization's reputation, credibility, and image. When concerns are handled in a timely and professional manner, the organization will enjoy greater trust and satisfaction from patients and families. In addition, the information derived from concerns is a first-rate source for identifying customer needs.

Many health care organizations have a process for managing a serious grievance, but often the "minor" concerns get lost in the system. Thus, valuable information about customer satisfaction is not available to the organization. A good way to determine the types of concerns that should be managed is to ask, "Does this expression of dissatisfaction require that we take some sort of action to resolve the matter, other than providing routine services, information, or explanations?" A positive answer indicates that the concern represents a learning opportunity for the organization.

An effective concern management system involves five steps:

1. Document the concerns.
2. Organize the information for analysis.
3. Translate concerns into customer needs and expectations.
4. Analyze and determine a resolution.
5. Make use of the information.

The first step is to capture details about the concern. Freeport (IL) Health Network (FHN) has a well-defined, organizationwide process for handling patient, family, and visitor concerns. At FHN, a concern is defined as "any situation in which the employees or facility services did not meet or exceed the customer's expectation."

The concern may be a verbal or written expression of dissatisfaction, a dissatisfied comment, or a strongly suggested improvement.

When a patient or family member expresses a concern to an FHN employee, that staff member is expected to take steps to resolve the concern. Resolution begins with listening carefully to what the patient/family is saying and extending an apology for not meeting expectations. The concern process at FHN includes a service recovery component. The goal of service recovery is to address patient/family concerns to their satisfaction.

CE *questions*

13. According to JCAHO, how many infection-related reports has the organization reviewed under the sentinel event policy since 1996?
    A. 2
    B. 10
    C. 52
    D. 112
14. Which of the following is not a recommendation of the Joint Commission to help reduce patient infections?
    A. Revise equipment-cleaning procedures.
    B. Switch to the use of single-use IV flush vials.
    C. Discontinue the use of waterless hand rubs.
    D. Revise hand-washing procedures.
15. In the past eight years, how many clinical pathways have been implemented at Children's Hospital and Health Center in San Diego?
    A. 15
    B. 26
    C. 43
    D. More than 60
16. The required compliance date for the final security standards of HIPAA is identical to the required compliance date for HIPAA's transaction standards.
    A. true
    B. false

Answer Key: 13. B; 14. C; 15. D; 16. B

COMING IN FUTURE MONTHS

- Planning the year before triennial JCAHO visit
- Certificates of need may improve quality
- QI project lowers myocardial infarction mortality 36%
- When are blanket orders acceptable under JCAHO?
- Custom physician profiles aid recertification

Research has shown that customers who have had a service failure resolved quickly and properly are *more loyal* to a company than are customers who have never had a service failure. Service recovery means that FHN staff members are expected to take responsive actions to "recover" lost or dissatisfied customers and convert them into satisfied customers.

When a need for service recovery is identified, the staff member is encouraged to use the most effective and appropriate method possible. For example, if the concern is related to a delay in care, the patient or family may be offered a meal pass or small gift. Staff members can make billing adjustments for concerns related to billing errors, if appropriate. In some circumstances, the concern involves another facility or department. In these situations, the employee explains that the issue will be forwarded to the facility or department director within 24 hours for action and provides contact information to the patient/family. All efforts are made to resolve a concern at the lowest level possible. If necessary, the staff member may consult with the FHN customer service/patient safety officer. All concerns are expected to be resolved within seven days. The patient/family is notified of what was done to ensure customer expectations will be met in the future.

A patient concern form is completed for each concern. **(See form, p. 58.)** They are available to all employees in electronic or paper form. After the concern is resolved and actions implemented for preventing future problems, the form is forwarded to the customer service/patient safety officer. This person reviews all concerns and actions taken and uses the information to prepare summary reports for the network's quality coordinating council and the customer and market focus group. Concern patterns or trends also are communicated to the entire organization to raise awareness and improve care and services.

When patients or their families have a negative encounter with a health care provider, they are less likely to use that provider again, more likely to talk negatively about the provider, and more likely to switch to another provider. One way an organization can ensure repeat business is by developing a strong customer service program that includes service recovery and concern management as essential components. The first step of an effective concern management program, document concerns, is described in this column. The remaining four steps will be detailed in next month's *Quality/Co$t Connection* column. ■

CE objectives

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

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

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