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IN THIS ISSUE

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What quality managers are saying about JCAHO's new survey process

Newly surveyed assert survey process is tough but educational

Are you worried about your organization's ability to pass muster with the Shared Visions — New Pathways survey process from the Joint Commission on Accreditation of Healthcare Organizations? If so, it's the moment of truth.

Hospital Peer Review put the new process under the microscope by interviewing quality managers at four facilities surveyed in early 2004. By all accounts, you can expect enhanced education for frontline staff, but if you're betting on being able to fix problem areas on the spot before surveyors find them, think again.

That's because the new process is a true litmus test designed to identify areas in need of improvement, says **Mary M. Owen**, RN, MPA, director of outcomes case management at University of California, Irvine Medical Center in Orange.

"It is more collaborative and consultative and very thorough," she adds. "There is no way to hide or clean up things as you go, because the survey process moves much too rapidly through the organization."

In fact, surveyors will know a great deal about your trouble spots before they even walk in the door. "They arrived having read our priority focus process summary and were familiar with the priority focus areas and clinical service groups selected for the hospital," reports **Mary B. Bergerson**, resource specialist for performance improvement at St. Helena Hospital in Deer Park, CA.

"The new survey process will give the Joint Commission a more true picture of what really happens in the hospital," adds **Jane Gordon**, RHIT, director of quality at Harford Memorial Hospital in Havre de Grace, MD. "There was no opportunity to put on a show for the surveyors."

Here are reports from four facilities surveyed in early 2004:

✔ **Expect less interaction between surveyors and medical staff.**

The medical staff interview has been removed from the schedule, says **Lynne Adams**, CPHQ, director of quality at Upper Chesapeake Medical Center in Bel Air, MD. "There was no schedule for which patients or which units the surveyors would go to or when they would go," she explains.

As a result, the community practice physicians were mostly unavailable when surveyors arrived on the unit. In the few instances when a physician was available, the surveyor didn't ask to speak with him or her, Adams adds.

Since the chiefs of the emergency department (ED) and operating room (OR) are full-time staff, they were present, and the surveyor did interview them. However, the chiefs of other departments including medicine, surgery, obstetrics, and pediatrics are practicing physicians, so without an agenda, it was unreasonable to expect them to be available for four consecutive days, she says.

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Editorial Questions

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✔ **There isn't always an off-shift survey.**

"We were surprised that there was no evening or night-time survey during our four days," says Adams. "One of the surveyors let us know that the requirement for an off-shift survey is now based on what is found during the daytime survey activities."

✔ **Surveyors took an educational approach.**

Several times, surveyors clarified that they were giving consultative information and weren't stating findings, and they went on to give advice for improving compliance, Bergerson says. For example, surveyors made suggestions to the medical staff for improvements in the peer review and proctoring processes.

The surveyors were very good about educating staff when they found anything that could be done better on the unit, Gordon says. "They were approachable and did a good job of making the team members feel at ease," she adds.

For instance, when the physician surveyor reviewed procedures for moderate sedation, he immediately suggested a better way to prompt care providers to give patients pre-sedation assessment. "He had seen this format at another hospital, and it made sense for us," Gordon says. "The change was made and approved at the next medical executive committee meeting."

Similarly, when the surveyor noticed a couple of dirty vents at University of California, Irvine, he suggested that this probably was caused by recent fires in the area and suggested a system for more frequent cleaning of the vents, Owen reports.

✔ **Patient and systems tracers worked as expected.**

The Joint Commission's Priority Focus and Tracer Methodology video (part of the Shared Visions — New Pathways video information series) does an excellent job of outlining what to expect, according to Adams. "The video very closely resembled our survey process," she says.

Here are the steps that occurred for each patient tracer:

- The surveyors identified the type of patient they wanted to see by diagnosis and length of stay, and a patient was selected from the daily census.
- At each unit, the surveyor was introduced, taken to the patient's nurse, and given the chart to review. The surveyor interviewed the nurse and usually asked to speak to someone from the different disciplines who had worked with the patient, such as a

physical therapist or dietitian.

- If the patient had been on more than one unit, the surveyors traced back through those units, going to a unit as many times as they felt necessary. "For example, the three surveyors visited the intensive care unit seven times in four days — at one point, all three surveyors at once." Adams says.

✔ **Unit staff were asked direct questions.**

Surveyors asked very pointed questions of unit staff, in sharp contrast to previous surveys, when organizational leaders answered the vast majority of questions, says Gordon. "They asked the same questions on every unit they surveyed, so they truly saw whether our answers reflected the hospital policies and practices and weren't just rehearsed answers."

Staff clearly could see the value of the survey process because they were so closely involved, Gordon says. "There has been much more discussion among the team members after the survey than I have ever seen before," she adds.

Although frontline staff weren't used to being the focus, they were asked in a way that wasn't intimidating to explain various care processes, Adams notes.

Staff were able to speak in terms they were familiar with, and it was the surveyor's job to determine whether the standards were met. "Team members didn't have to recite the Joint Commission lingo, but the surveyors listened to the process in the context of whether or not it met the intent of the standards," she says.

For instance, instead of asking staff about "core measures" specifically, surveyors asked them to "tell me what you're doing to improve the care of your patients with congestive heart failure."

The tracer process places the focus on frontline staff and the consistency of various patient care processes, Bergerson says. "Since safety and quality of care are the primary areas of concern for caregivers as well, they were very engaged in and supportive of the new survey process," she says.

After arriving at each unit, surveyors reviewed the medical record, noted the patient's flow through the organization, and checked for timely placement of information such as history and physical, laboratory results, and consultation reports.

"The surveyor then asked for the nurse or clinician who had primary responsibility for taking care of the patient," Bergerson says. "This staff member was asked to summarize the patient's history and plan of care."

Numerous questions were asked about processes such as medication administration, patient identification, infection control, coordination of care between disciplines, competency, taking verbal orders, data regarding medication variances, and other quality initiatives. "Occasionally, the surveyor asked to see the staff members' competencies, license, or other certifications during the interview process," Bergerson says.

✔ **Surveyors compared notes.**

At the end of each day, surveyors checked with one another, looking for any problems with compliance, flaws in process design, or inconsistencies in existing processes. Any areas of concern were investigated through additional patient tracers, review of closed medical records and personnel files, policy and procedure clarification, scheduled interview sessions, and systems tracers.

After performing a few tracers, surveyors wanted an in-depth look at patient education at discharge, especially as it related to patient safety at home. "The surveyors requested several closed medical records, asking for patients who were admitted at specific dates and times," adds Bergerson. "Although they did not say why they wanted the medical records, it became apparent. Fortunately, they found what they were looking for," she continues.

✔ **Less time was spent on documentation review.**

The new tracer methodology focuses on delivery of patient care instead of retrospective review of documentation, Bergerson explains.

"The emphasis is on processes which ensure patient safety and quality outcomes, as opposed to the review of written documentation," she says.

Surveyors requested an operating room log, emergency department log, cath lab log, and current census with diagnoses for their morning planning session, Owen reports. "Additionally, the only time we had to pull retrospective records was with respect to narcotic logs and wastage documentation, and that was very limited," she says.

The request for documents was onerous in the past and typically required a minimum of two weeks of preparation to get all the necessary binders together, Owen says. "This time, there really was no preliminary request for documents other than the statement of conditions. It's much simpler than in the old days."

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How will Medicare data affect your next survey?

Find out how you compare to other organizations

Since surveyors from the Joint Commission on Accreditation of Healthcare Organizations will come to your organization armed with detailed information on how you compare to other facilities, why not be proactive and do your own comparative analysis?

This is a smart move, since it sheds light on how your organization measures up *before* your survey, according to **Patti Muller Smith**, RN, EdD, a consultant for Shawnee, OK-based Administrative Consulting Services. Smith works with hospitals on performance improvement and regulatory compliance.

Data from the Centers for Medicare and Medicaid Services' Medicare Provider Analysis and Review (Medpar) database will be one of the elements used by the Joint Commission to determine your priority focus areas and clinical service groups, says **Carrie Gross**, manager of the Joint Commission's division of accreditation systems integration.

The Medpar data will be risk adjusted by Salt Lake City-based 3M Health Information Systems, the Joint Commission's vendor, according to Gross. "The risk-adjustment process considers a patient's age, comorbidities, and illness severity level," she explains.

Different adjustment factors are used to create the expected rate of performance, including the underlying case mix and illness severity levels derived from regrouping the cases with 3M's All Payer Refined Diagnosis Related Grouper (APR DRG).

According to Gross, the following data elements will be reviewed: volume, length of stay, mortality rate, complication rate, case mix index, full-time employee over adjusted occupied bed, and Medicare utilization rate.

Medpar data files provide information for 100% of Medicare beneficiaries using hospital inpatient services as well as covered services in other settings, Smith notes. The data are provided by state and then by DRG and include total charges, covered charges, Medicare reimbursement, total days, number of discharges, and average total days.

One of your biggest challenges as a quality manager is to provide information that directs a specific course of action, Smith says. She points to the Joint Commission's performance improvement standards requiring that a valid outside data source be used, in addition to your organization's internal data-gathering systems.

That gives you the opportunity to compare the internally generated data with data from other organizations and evaluate the effectiveness and efficiency of your organization as it provides health care to your service population, Smith says. "Rather then just generating and reporting data, the Joint Commission is moving toward developing information on which decisions can be made," she says.

Priority focus areas are processes, systems, and structures in your health care organization that significantly affect the quality and safety of care, Smith explains. In light of this, you should be concerned with three key questions, she says: Is the care provided appropriate? Is the care provided effective? Is the care provided efficient?

Medpar is one data source that can answer these questions by painting a picture of what goes on in your organization, Smith says.

"It serves to demonstrate how you measure up in comparison to other like organizations," she explains. "This comparison helps quality managers target areas for further assessment and possible improvement."

Analyzing Medpar data can help you focus

performance improvement activities toward the processes, systems, and structures that would cause delays in discharge or higher-than-expected costs, Smith says. "More than anything, it encourages the quality manager to ask 'why?'"

To do your own comparative analysis before a survey, first collect data from internal sources regarding average charges and average cost. Then compare this to the Medpar data, Smith advises. "If there is a discrepancy or significant difference in the numbers, the quality manager begins to ask questions," she says. "What is it that we, as an organization, do that is different from these other organizations that creates this difference?"

For example, if the covered charges are far less than your billed charges, you'll need to determine if the current practice in your hospital is to order unnecessary tests for a given diagnosis. Or it may be that patients have a longer length of stay because laboratory data are not made available in a timely manner to initiate treatment, or there may be an unreasonable lag time between ordering diagnostic tests or medications and when the order is acted upon, Smith says.

To take into account the unique patient population your organization serves, it is beneficial to identify your top DRGs and then compare Medpar data to your internal data, she recommends.

"These data should be readily available from cost accounting and medical records," she says. "You may have to hunt for the data, but once it is located, it allows the quality manager to provide information rather than numbers."

In essence, your comparison will raise questions, and further investigation will provide more information on which decisions can be made, Smith explains. Performance improvement is intended to be a continuous process that provides ongoing improvement in services to patients, she stresses.

"It is not just a matter of collecting data in books, reporting the numbers at meetings, and having documentation to show surveyors," she says. "It is intended to examine current practices and processes to see if they can be done in a different, more effective manner."

"It helps determine that the organization is providing the right amount of care in the right setting for a reasonable cost and still achieving safe, quality health care," Smith notes.

For instance, effective discharge planning can reduce potentially avoidable days spent in the acute care setting, she suggests. Chart reviews examining this process can identify valuable information to give clues as to why the length of stay for a particular DRG is greater than expected.

"Is discharge planning initiated during the admission process, or is it crisis managed when the physician writes the order?" Smith asks. "If the order is written on a Friday, is there something that prevents the patient from being discharged late on Friday and results in a two-day longer stay?"

If costs for a particular DRG are higher than expected, drilling down in the Medpar data will give insight on where ancillary services have higher-than-expected costs associated with caring for patients with this diagnosis, Smith notes.

"Reviewing the charts of patients assigned to this DRG can help identify why costs in your hospital are higher than expected," she says.

"The next step is for a performance improvement team to conduct further investigation and identify areas for improvement," Smith adds.

Check out these web sites for risk-adjusted Medpar data

To do your own comparative analysis to prepare for Joint Commission surveys, you'll need to obtain risk-adjusted Medpar data, says **Patti Muller Smith**, RN, EdD, a consultant for Shawnee, OK-based Administrative Consulting Services.

"These data can be obtained from a variety of commercial sources or may be bundled into services already provided such as billing audits," she explains. Here is a partial listing of vendors offering risk-adjusted data:

- **Administrative Consultant Services**, 678 Kickapoo Spur, P.O. Box 3368, Shawnee, OK 74802. Phone: (405) 878-0118. Fax: (405) 878-0411. Web site: www.acsteam.net.
- **Centers for Medicare & Medicaid Services** has risk-adjusted data on its web site: cms.hhs.gov. The site offers downloads of Medicare data sets at no cost, often in PC-ready formats. Click on "Statistics and Data."
- **Health Grades Inc.**, 44 Union Blvd., Suite 600, Lakewood, CO 80228. Phone: (303) 716-0041. E-mail: customerservice@healthgrades.com. Web site: www.healthgrades.com.
- **Solucient**, 1800 Sherman Avenue, Evanston, IL 60201. Phone: (800) 366-7526. E-mail: provider info@solucient.com. Web site: www.solucient.com. ■

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Simple methods improve hand-washing compliance

One idea: Change location of hand-wash stations

It's no secret that compliance with hand hygiene is a key element in reducing the rate of hospital-acquired infections. Yet changing physician behavior often is easier said than done.

"Just posting signs or sending letters from the chief of staff or infection control officer will not cause much change in physician behavior or change the culture, even though all recognize the need," says **Frederick P. Meyerhoefer**, MD, principal of the Canton, OH-based Meyerhoefer Organization, a consulting firm that specializes in compliance with Joint Commission on Accreditation of Healthcare Organizations standards.

Even if your organization's infection control officer makes regular presentations to physicians about nosocomial infections and hand washing, you still have the problem of how to monitor compliance, he says. "Because of the multiple areas where hand washing should occur, it is very difficult to objectively monitor a process where compliance is subjectively decided by the individual."

A recent study suggests that physicians don't wash their hands enough between patient encounters. Researchers placed identical liquid soap dispensers next to sinks in a primary care surgical unit in the United Kingdom, and recorded the levels of soap the clinicians used at the end of the year. Nurses were found to wash their hands significantly more often than physicians.[1]

To increase physician compliance, try these effective strategies:

- **Change the location of hand-wash stations.**

Often, the physical setup for hand washing is badly arranged, according to Meyerhoefer, who adds that sinks and other supplies may be inconveniently located in relation to patient rooms.

"The new CDC [Centers for Disease Control and Prevention] hand hygiene recommendations addressing alcohol-based hand rubs now allow hand-wash stations to be placed nearer the need," he adds.

Sinks are no longer required because the hand rub takes the place of soap and water, Meyerhoefer explains. Still, there are regulations stating how and where stations can be placed and the amount of hand rub that can be stored on a unit.

"The regulations still apply, primarily because of the slight potential for explosion," he explains. "Any hospital has to check into that before doing any installation."

When physicians fail to wash their hands, it isn't always deliberate — they may be pressured by time constraints or forget because of poorly located sinks, he underscores. "The process has to be structured to easily facilitate physician compliance."

- **Educate patients**.

Include information about hand washing in patient education materials, with the goal of making patients aware of that expectation for all physicians, health care workers, and others who come into contact with the patient, Meyerhoefer recommends. "If physicians and others realize that their actions will be noted by patients, this will also serve as a goad for individual compliance," he says.

Patients can be strong advocates for this type of change, says Meyerhoefer. "Patients are sensitized to infections, with concerns about new viruses and antibiotic-resistant organisms being trumpeted in the press," he says. "Note all the cleaning products in the supermarkets touting their antibacterial prowess." He gives the example of one elderly woman attaching a sticker saying, "Have you washed your hands?" to her patient gown.

To develop patient handouts, Meyerhoefer suggests using the CDC hand hygiene recommendations and the revised JCAHO infection control standards, which become effective January 2005.

Armed with this knowledge, patients will realize that they have the right to ask their physicians whether they have washed their hands before performing an examination, adds Meyerhoefer.

"What argument can any health care professional make that hand washing is not the correct

(Continued on page 55)

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Successful CM program gets JCAHO approval

Database demonstrated processes were in place

With a care coordination program in place that has dramatically reduced acute care and emergency department (ED) utilization by the chronic frail elderly while enhancing patients' quality of life, Sutter Health Sacramento (CA) Sierra Region (SHSSR) was looking for a way to take the program to yet a higher level, says **Jan Van der Mei**, RN, care management director.

The Sutter Care Coordination Program (SCCP) — profiled in its early stages in the April 2001 issue of *Discharge Planning Advisor* — assisted more than 3,000 patients in 2003, she notes.

A list of outcomes for the report period from June 2002 to June 2003 includes a cost of $598.61 per member per month less for SCCP patients than for the baseline group, while ED costs for SCCP participants were 40.7% less and acute inpatient costs were 52.6% less. After subtracting program costs, Van der Mei adds, there was an annual saving to SHSSR of $935,000.

At an American Case Management Association (ACMA) conference in early 2003, Van der Mei heard about the Disease Specific Care (DSC) certification offered by the Joint Commission on Accreditation of Healthcare Organizations.

In June 2003, she and SHSSR's manager for disease management and care coordination supervisor attended a Joint Commission conference on how to be certified.

By November 2003, the health care organization had attained certification for the Sutter Heart Failure Telemanagement Program, the Sutter Anticoagulation Program, and the Sutter Asthma Management Program, as well as for its care coordination program.

"When we decide to do something, we want to get it done," Van der Mei said with a laugh when asked about the short time frame. "We wanted to accomplish this in 2003."

What the Joint Commission certification reflects, notes **Cheryl Phillips**, MD, medical director of the Sutter Medical Group, an association of physicians that is aligned with SHSSR, is the recognition that care coordination and case management are critical elements of patient care.

"For the first time, we recognize case management as having some of the elements present in disease management — especially the structure of evidence-based models," she says. "Part of the criticism of case management in the past has been that its effectiveness is dependent on whether you have a good case manager.

"Now, there is some evidence-based structure so the case manager is not winging it every time with every problem," Phillips adds.

A structured process

The algorithms and decision trees Van der Mei has developed, she notes, illustrate that "care coordination is not just doing nice things for people but a fairly structured process that can be replicated."

Certification of SHSSR's care coordination program represented a first for the Joint Commission process, which previously had focused only on programs with clear, easily demonstrable guidelines, Van der Mei points out.

"To be certified, you need to show you've based your program on evidence-based guidelines. That's easy to do with heart failure and with asthma and anticoagulant programs, because [the guidelines] are out there," she adds.

"But a program dealing with the chronic frail elderly," Van der Mei explains, "is not disease-specific. Most patients have at least three or four chronic diseases and a couple of comorbidities, so we weren't sure how we would be able to show them that our program is based on evidence-based guidelines."

As part of that effort, Van der Mei provided JCAHO with information on problems the program had identified as common to the care of the frail elderly and the accompanying interventions taken by SCCP.

With some problems — advance care planning, abuse and domestic violence, AIDS/HIV, and Alzheimer's disease, for example — established evidence-based guidelines do exist, Van der Mei notes. For bereavement, however, or inadequate caregiving support, such established guidelines were not available, she adds.

What impressed the JCAHO reviewer, Van der Mei believes, is that SCCP had guidelines for most of the problems and that the processes used are detailed in a comprehensive database that SCCP makes available to the physicians with whom it works.

"[The database] is part of the physician's medical record," she points out. "We're linked to the physicians, so they know what we're doing with their patients. We've built in the care plan, the problems identified by the physician, nurse, or social worker, and the interventions. That, as well as meeting the other standards, is how they were able to certify us.

"What's unique about our programs," Van der Mei goes on to explain, "is that we are able to incorporate all of the interventions that we do in care coordination into our disease-specific programs. The case managers collaborate, so if someone is in the heart failure program, we not only manage those signs and symptoms, but if there are other issues — like the patient is not compliant, can't afford meals, or has other psychosocial problems — the care coordination

A quick view of JCAHO's DSC certification

The Disease-Specific Care (DSC) certification offered by the Joint Commission on Accreditation of Healthcare Organizations is designed to evaluate disease management and chronic care services provided by hospitals, health plans, disease management service companies, and other care delivery settings.

The evaluation and resulting certification decision is based on an assessment of these components:

- compliance with consensus-based national standards;
- effective use of established clinical practice guidelines to manage and optimize care;
- an organized approach to performance measurement and improvement activities.

Disease-specific care services that successfully demonstrate compliance in all three areas are awarded certification for a one-year period.

After the first year, a one-year extension can be granted, contingent on the submission of an acceptable assessment by the organization of continued compliance with standards and evidence of performance measurement and improvement activities.

The first year, the off-site plus on-site evaluation covers standards compliance, clinical practice guidelines, and demonstrated performance measurement and improvement activities.

The second year, there is an off-site review of submitted descriptive material by the reviewer that covers updated guidelines information, assessment of standards compliance, and again, demonstrated performance measurement and improvement activities.

Thereafter, an on-site review must be conducted every two years to maintain certification.

In developing the DSC certification, the Joint Commission attests, it received guidance from 25 health care organizations representing hospitals, health plans, disease management organizations, integrated delivery systems, and primary health care providers, who reviewed the draft program model, program tools, and standards.

Nine sites pilot tested the program, and a 21-member Certification Advisory Committee provided advice on the draft program model, standards, and performance measurement requirements. The committee included, among others, representatives from the National Chronic Care Consortium, the Disease Management Association of America, and the Disease Management Purchasing Consortium.

The Joint Commission publishes a list of the certified DSC programs on its web site.

(For more information, go to the organization's web site at www.jcaho.org.) ■

team can address those issues as well."

She points out, for example, that patients in the heart failure program have 68% fewer admissions for any reason — not just heart-related problems — than a group of like patients who are not in a care coordination program.

Reevaluating processes, outcomes

Part of the value of the JCAHO certification process, Van der Mei says, was the accompanying growth and learning that took place. "We knew we would benefit by meeting the standards of another body and evaluating the things we were doing. It made us look at all of our processes and say, 'Do we have a policy to support these?'"

One of the biggest challenges for SCCP — which uses a nurse/social worker model — was looking at how its program supports patient self-management, which is an integral part of the Joint Commission's philosophy, she says.

"It's important to [JCAHO] that patients are involved in the plan of care," Van der Mei adds. "Our social workers are good at doing that, at saying [to the patient], 'Which goal do you want to work on first?'"

A different perspective on outcomes

But while social workers are better at working with patients to identify their goals, she notes, nurses tend to provide more direction and to base it on what they believe are the most urgent medical conditions.

Going through the Joint Commission certification, Van der Mei says, "helped us get the nurses to be more cognizant of being less directive and more soliciting of patients' willingness to make changes."

Another benefit, she points out, was the opportunity to take a different perspective on program outcomes. While Sutter has always had outcomes that reflect both quality and utilization, she notes, it did not necessarily have the measurements to fully document its emphasis on quality.

The Joint Commission was not interested particularly in utilization standards, which addressed such results as the amount of money saved because patient visits to the ED were reduced, Van der Mei says.

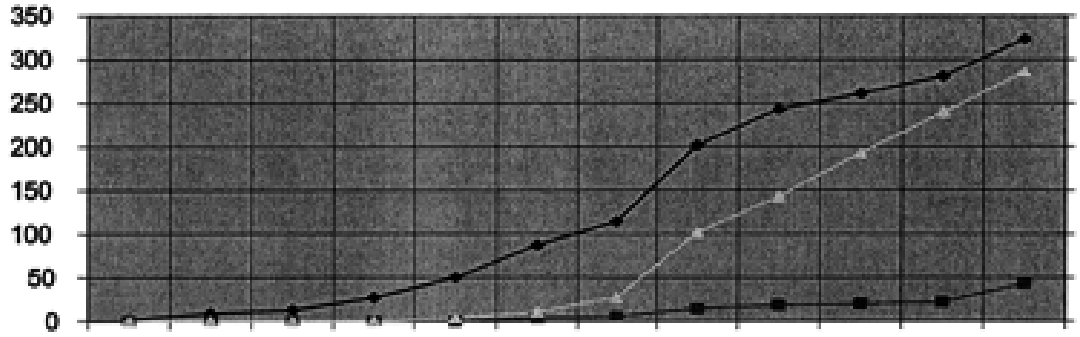
It was more focused on other outcomes, "which we did have, but we had to come up with some additional measurements," she adds.

For example, SCCP patients are given an initial assessment, but the program wasn't measuring exactly when the assessment was done, Van der Mei explains.

"Was it in the first month?" Similarly, the program already did advance care planning with patients, she adds, but as a result of its Joint Commission process, identified that it would measure whether that discussion took place within 90 days.

"For our disease-specific programs, we do a lot

SHSSR Care Coordination Program — Medication Payment Assistance



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Denied	0	0	0	0	0	3	5	15	18	20	21	47
Pending	0	0	0	0	3	11	27	102	143	192	240	269
# of Medications Requested	2	9	13	26	53	99	147	319	404	472	542	654
# Patients assisted	1	6	9	17	29	49	70	139	178	213	247	299

Source: Sutter Health, Sacramento (CA) Sierra Region.

of patient education around heart failure, asthma, and the consequences of being on anticoagulant drugs," Van der Mei continues. "We want to make sure that education happened within a certain time frame, so we had policies for that, but we weren't measuring when it took place. We found we weren't documenting it as well as we should, that nurses weren't indicating in the database [that they had done patient education].

"We know we have the policies and procedures in place," she says, "but until you do the measurement, you don't realize you have a problem. So [the certification process] helped us identify that we had a documentation problem."

Staff supportive of process

Her staff were actively involved in looking at the different JCAHO standards and determining whether the program met them, and if so, how to show that compliance, Van der Mei notes.

"Sometimes, they were worded a little different, so we'd have to think about it and say, 'Oh, yeah, we're doing that — we're just not calling it that.'"

She says the SCCP nurses and social workers understood that obtaining the JCAHO certification "helped us move to the next stage of our development and would provide us with a standard we could say — [to insurance companies, for example] — that we meet."

The fact that Sutter's care management programs are part of a hospital system that goes through JCAHO's accreditation process makes disease-specific certification a little easier than for, say, a disease management company that might be seeking certification, Van der Mei points out.

"In fact," she says, "JCAHO gives organizations a discount if they're part of a hospital system that's accredited." And, Van der Mei adds, the care management program was able to adapt the hospital system's sentinel event policy to meet the JCAHO requirement for disease-specific programs. "There are some other [hospital system policies] that just needed to be tweaked," she notes.

[For more information on Sutter's care management programs, contact:

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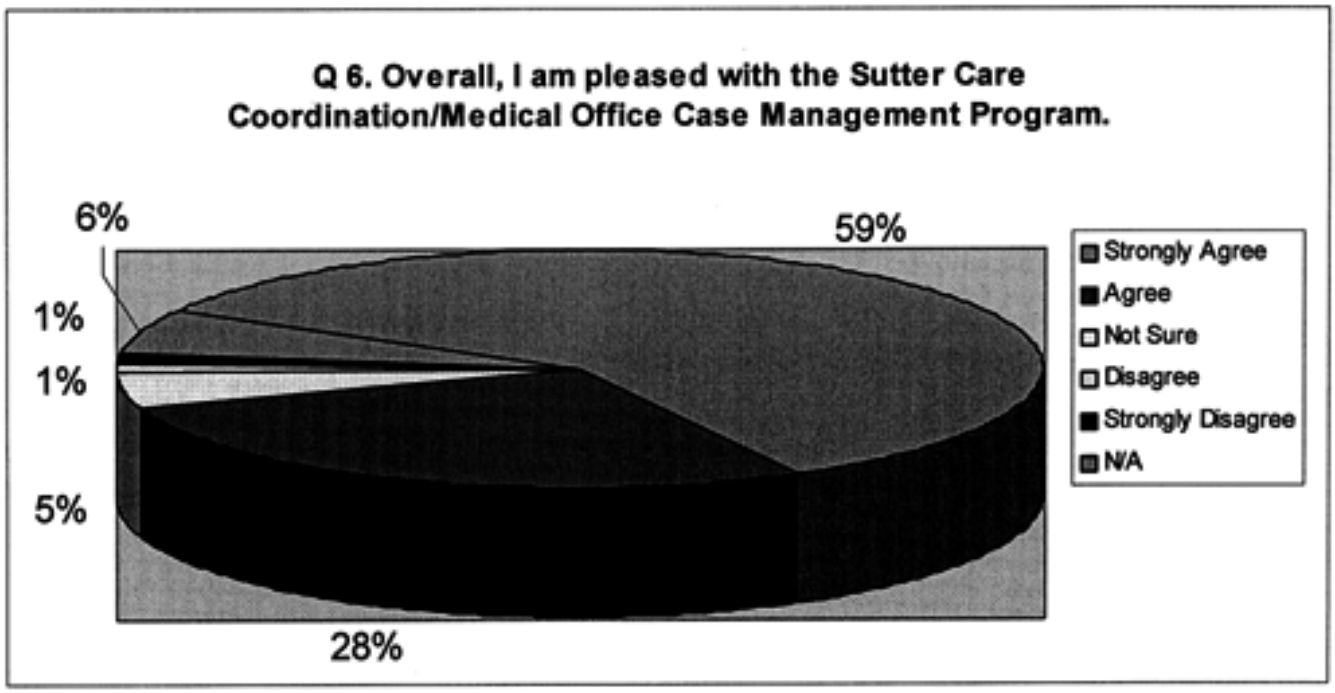
SHSSR Care Coordination Program



Source: Sutter Health, Sacramento (CA) Sierra Region.

(Continued from page 50)

and necessary thing to do?" he asks. "More and more, this type of information will be available to the public as part of the increasing release of a hospital's quality data."

- **Allow patients to see hand washing.**

Consider placing sinks or hand washing stations at the entrance to each patient room to allow patients to observe hand washing, suggests Meyerhoefer.

At Swedish Medical Center in Seattle, dispensers are placed directly in patient rooms, reports **Nancy J. Auer**, MD, FACEP, the facility's vice president for medical affairs. "We make it easy for them, by making bottles and dispensers of alcohol gel readily available for their use," she says. "Patients do like to see physicians wash their hands when they come into a room. It gives them extra comfort that the physician is concerned about their health."

- **Ask peers to observe physicians with poor compliance**.

Physicians are strongly influenced by their peers, and you should use this as leverage to ensure compliance, advises **Linda L. Dickey**, RN, MPH, CIC, infection control practitioner at University of California — Irvine Medical Center in Orange. "When a physician is noted by a staff member not to have good hand hygiene compliance, we confidentially ask a respected peer or superior to observe and provide direct feedback."

Staff are encouraged to remind other health care workers about hand hygiene if a breach in infection control practice is noted. "This is a cultural norm we reinforce when we talk informally to staff or physicians, provide inservices, or present data," she says. "We emphasize this should not be viewed as a correction of behavior as much as a helpful reminder — a reminder that not only helps keep the patient safer, but also the health care worker."

If blatant or repetitive breaches in infection control practices are noted, staff are encouraged to notify infection control so corrective action can be taken. "If an individual calls us with a report of a lack of hand hygiene compliance, their report is kept confidential," Dickey notes.

Health care workers should be able to freely express concerns peer-to-peer, she stresses.

"We must get over the idea of blame in health care if we speak to each other about a behavior that isn't up to par. We must keep in mind two things: Infection control practice protects both the patient and the health care worker, and we need to treat patients as we would want to be treated," Dickey adds

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- ***Frederick P. Meyerhoefer**, MD, The Meyerhoefer Organization, 1261 White Stone Circle N.E., Canton, OH 44721. Phone: (330) 966-6717. E-mail: Meyerorg@aol.com.]*

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1. Stone A. Audit of soap usage by a primary care team. *BMJ* 2003; 327:1,453-1,454.

2. Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. Guideline for Hand Hygiene in Health-Care Settings. *MMWR* 2002; 151(RR16); 1-44. ■

Can you prevent harmful staff from getting hired?

Experts recommend anonymous reporting

(Editor's note: This is the second article in a two-part series on preventing employees from harming patients intentionally. This month, we'll give step-by-step instructions to prevent problem employees from being hired and tips to encourage staff to report concerns. Last month, we covered how to track deaths and improve communication with human resources.)

If a nurse, who had left a previous facility under suspicion of murdering several patients, applied for a hard-to-fill night shift at your organization do you think she'd be hired? Would it be possible for a technician to intentionally harm patients at your hospital over a period of years, with absolutely no action taken?

If you find yourself shaking your head in disbelief, consider the much-publicized killer nurses and physicians who eluded detection at many

facilities, and you may feel differently. So what steps should be taken to ensure problem practitioners don't fall through the cracks — and how can you prevent them from getting hired in the first place? Here are suggestions:

- **Encourage staff to report suspicions.**

As a quality manager, you need to draw upon the observations of staff throughout the facility, and encourage gut instincts to be reported, says **Kathleen Catalano**, director of regulatory compliance at Provider HealthNet Services in Addison, TX.

"In most instances, the quality manager learns of things only after the fact," she adds. "Education of the nursing staff is key, with a periodic review of what types of behavior to look out for, to avoid this scenario."

After a sentinel event occurs, a literature search is required in addition to a thorough internal investigation, Catalano notes. "Search the literature on this subject and glean from that the behaviors that fall into this type of scenario," she recommends.

For example, a red flag might be an individual who prefers to work with little help or interruption. "Most nurses want help and accept it gratefully. That's a clue," says Catalano.

In general, nursing staff should share their suspicions with quality, risk, and human resources, she urges. "It is extremely important, in spite of everyone's workload, that nonpatient care managers get out of their offices and know the staff working on the units, so that they aren't intimidated about discussing possible suspicious behavior with them," Catalano says.

Similarly, the lines of communication must remain open between quality managers, human resources, and risk management, says **Kathryn Baikie**, the facility's director of human resources. "Employees must feel they are able to confide in human resources professionals so that they can feel safe to blow the whistle on their co-worker if they see problems or issues, without fear of retaliation," she stresses.

- **Follow all steps in a process.**

Catalano points to the case of a physician who is believed to have killed more than 60 patients over a two-decade period.

"All of the things that should have been done were somehow missed," she says. "Even when processes were in place, they were not necessarily followed."

The scenario shows that if procedures aren't followed to the letter, a harmful practitioner could slip through the cracks, Catalano warns. "Even if something that didn't seem quite right showed up in the file, [the physician] would talk his way out of it," she says. "He was a master at this. The physicians decided there was no need to investigate further — he's a physician, and we'll take his word for it."

For this reason, Catalano strongly advises that each step in any process be followed, such as credentialing and privileging processes. "Disaster can lie right around the corner when you skip steps to save time," she says.

- **Have an anonymous reporting system.**

It's a serious mistake to pin blame on the trend toward a nonpunitive patient safety environment, according to Catalano. "If the patient safety environment were punitive, you would never see anything reported by those in the trenches, because they would be afraid of losing their jobs. I can't say that I blame them," she says.

There have been problems galore with punitive medication quality programs, Catalano adds. "I don't believe blame can be placed on any one thing," she says. "Placing blame on no one and actually reviewing the entire process is the way to go."

For this reason, an anonymous reporting system is key, Catalano points out. "Staff often don't want to rat on a colleague," she says. "With that in mind, put your anonymous compliance or patient safety hotline to work and be certain that retaliation does not occur when something is reported."

Still, the only way retaliation will no longer occur is if the facility enforces the nonretaliation policy that probably already is in place, says Catalano, who adds that this has to occur "from the top down. If even one person is found to be retaliating against someone for telling what they perceive to be the truth, that individual should be terminated or whatever the policy states."

The best system to use is a hotline allowing staff to report their concerns anonymously, she recommends. "The hotline must be outsourced and not a number called in-house. There must be safeguards in place for keeping the anonymity of the person. And there must be a system allowing the person making the call to check back and see what is being done regarding the reported issue."

The facility uses National Hotline Services, which gives the caller a number and a date to call back. "If action is taken, that action is reported back to the hotline, and they pass it on to the person if they choose to call back with their special number," Catalano says. "This works extremely well."

For instance, if a staff member calls to report the use of the wrong code for a certain procedure, an investigation would be initiated (including chart audits and a review of current law to see if changes had occurred and when the changes went into effect), and findings would be documented.

"If we found that coders had coded incorrectly, the hospital for which we were coding would be notified in writing with a complete breakdown of our findings," Catalano says. "They could, based on internal policy, notify the regional fiduciary intermediary. The results would be reported to the corporate compliance committee and on up the chain till it reached the board."

Education would be provided, and monitoring would be done to ensure that the situation did not recur, she points out. "Generally, when a hotline first is initiated, the main problem is people calling in with lots of HR issues. But that passes."

- **Use a web-based information service to check disciplinary history of health care providers.**

"In my opinion, the National Practitioners Data Bank (www.npdb-hipdb.com) does not provide enough timely information, and that makes it difficult to rely on," Catalano explains.

Instead, the organization uses the Fraud and Abuse Control Information System (www.facis.com.), a web-based information service that allows subscribers to look up the sanction history of individuals associated with the health care field.

"This is valuable, because it makes you aware of sanctions by the local, state, and federal government and adverse actions taken by various agencies," Catalano notes. "We have notice of any action that has been taken against a person at a state, local, or federal level."

All new prospective employees are screened through FACIS to be certain that they are not on the Office of Inspector General's list of excluded individuals or entities, or the General Services Administration debarment list.

"If they were on either of these lists and we billed for services they rendered, we would be committing fraud," she adds.

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- ***FACIS** is a web-based information service that allows subscribers to look up the sanction history of individuals and entities associated with the health care field. Possible types of sanctions include exclusions, termination of license, suspension, revocation, probation, and debarments, etc. FACIS reports from approximately 800 state and federal sources. To subscribe, contact FACIS, 112 South West St., Suite 300, Alexandria, VA 22314. Phone: (800) 718-5753 or (703) 683-3453. Fax: (703) 836-5256. E-mail: facis@facis.com. Web: www.facis.com.*
- ***The Compliance & Ethics Hotline** is a toll-free number your employees can call 24 hours a day, 365 days a year to speak anonymously with a hotline specialist trained to receive reports of perceived misconduct or wrongful behavior. For more information, contact: National Hotline Services, 620 Kenmore Ave., Suite B, Fredericksburg, VA 22401. Phone: (877) 267-1930. Fax: (540) 368-1411. E-mail: nhsmail@hotlines.com.]* ■

THE QUALITY - CO$T CONNECTION

Are your customers also partners in PI initiatives?

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

Does your organization provide consumers and the community with opportunities to be involved in shaping your services and performance improvement initiatives? If the answer is "no" or "not very often," senior leaders and staff are missing out on valuable information. There is a growing recognition of the value of consumer and community input in redesigning the delivery of health care services.

To tap into this resource, health care organizations must learn how to effectively involve consumers and community members as agents of change. The term "consumer" refers to any users of health services or their families. The term

(Continued on page 59)

Consumer and Community Participation Self-Assessment

Part I: Organizational Level

Rating Scale: 5=Excellent 4=Very Good 3=Good 2=Fair 1=Poor

Criteria	Self-Rating
Consumer and community participation have been incorporated into the organization's vision, values, and any philosophical statements.	
The organization clearly has identified its consumers and community.	
The organization clearly has defined the purpose and mechanisms for involving consumers and community members at different levels.	
The organization involves consumers and community members in assessments of health service needs.	
The strategic directions of the organization respond to the needs expressed by consumers and community members.	
The leaders, champions, or staff members delegated with the responsibility for consumer participation clearly are defined and identifiable within the organization.	
The organization has key consumer policies in place, such as: • consumer rights and responsibilities • complaints • consumer access to information • consumer participation	
The organization has well-functioning mechanisms to ensure that consumers find out about: • their rights and responsibilities • how to make a complaint or commendation • accessing information • how they are to participate in decision making	
Staff education programs are in place to support the implementation and maintenance of consumer policies.	
Organizational resources have been allocated to support the incorporation of consumer and community input into strategic planning.	
Consumer participation is an element in everyone's job description.	
Consumer participation efforts and achievements are a component of employee performance management and staff recognition activities.	
Consumer and/or community input is a key part of organizational decision-making processes.	
The organization has methods for recognizing the contribution of consumers.	
Part II: Department Level	
The department has identified who its consumers are.	
The department have identified the purpose and mechanisms for involving consumers.	
The department has a plan for obtaining consumer feedback and participation.	
The organization's consumer policies are reinforced through the department's performance management system.	
Resources are allocated at a department level for enabling consumer feedback and participation.	
The department uses specific strategies to involve consumers in decision making about care processes and service improvement.	
Individual performance reviews include evaluation of the staff member's attitude toward and achievement of consumer participation in care processes and service improvement.	
Staff members attend education programs about consumer participation and consumer policies sponsored by the staff development department.	
The department has links and feedback mechanisms with other services/facilities outside the organization to ensure consumer satisfaction with continuity of care.	
Consumers routinely participate in the development and evaluation of the department's consumer education/information resources.	
The department has working relationships with key support/community groups associated with the consumers who routinely are served by the department.	
The department regularly reports its consumer participation activities and outcomes to staff.	
When consumer feedback indicates an improvement opportunity, appropriate staff members are held accountable for taking action.	

"community" refers to either a particular community group (e.g., culturally determined group, disease-oriented group, or an interest group), area where the hospital is located, or catchment area for the hospital. Consumer and community participation can be at different levels of your organization. High-level involvement includes activities such as strategic planning, policy development, and evaluation of care and services. Low-level involvement ranges from minor participation (information giving and information seeking) through more interactive participation (group or one-on-one interactions and partnerships).

The importance of consumer and community involvement is supported by the recommendations of several external groups, including the Joint Commission on Accreditation of Healthcare Organizations and the Baldrige National Quality Program in Gaithersburg, MD.[1] The leadership standards of the Joint Commission call for consideration of patient and family needs and expectations when planning for and designing services. In the chapter on ethics, rights, and responsibilities are standards related to involving patients in decisions about care, treatment, and services provided. The Baldrige Health Care Criteria for Performance Excellence address consumer and community involvement in the leadership category and the category Focus on Patients, Other Customers, and Markets.

The criteria encourage health care organizations to involve consumers and the community in strategic planning and have mechanisms to obtain feedback about key patient/customer requirements and expectations. This feedback, along with other information, is to be used by the organization's leaders to ensure current health services are adequate and to establish future business directions. Senior leaders in organizations striving for excellence view feedback and participation from consumers and the community as a vital component in performance improvement initiatives.

There is no one right way of enabling consumers and the community to participate in your organization's performance improvement initiatives. However, if the involvement is poorly planned and managed, the results will be less than optimal.

CE *questions*

13. Which is true of JCAHO's new survey process?
    A. Surveyors will interview all medical staff.
    B. All organizations will have an off-shift survey.
    C. More time will be spent on review of written documentation.
    D. Unit staff will be asked specific questions about care processes.
14. Which is accurate regarding surveyor visits to units during a patient tracer?
    A. Only one unit is visited per patient tracer.
    B. Each unit is visited a single time.
    C. Surveyors will return to a unit as many times as necessary.
    D. Units only are visited if problems are discovered during review of a patient's chart.
15. Which is true regarding use of Medicare claims data during JCAHO surveys?
    A. Medicare claims data will not be used to determine priority focus areas unless a previous problem was identified.
    B. Raw data will be used instead of risk-adjusted data.
    C. You can use Medicare claims data to identify areas in need of improvement.
    D. Quality managers should avoid doing your own comparative analysis before a survey.
16. Which is an effective way to encourage staff to report suspicions about harmful practitioners?
    A. using an anonymous reporting system with a hotline
    B. ending the practice of allowing anonymous reports
    C. requiring all reports to be made to a department head in person
    D. investigating a staff member's concerns only if several similar reports are made.

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

First, the organization must identify clearly its consumers and community members and define the purpose and mechanisms for involving them. For maximum benefit, consumer and community participation should be part of an overall management organizational strategy, rather than a series of ad hoc projects.

COMING IN FUTURE MONTHS

- Foolproof ways to be ready continuously for JCAHO
- Update on new stroke center certification
- What to do when things go wrong during a survey
- New technology to comply with patient safety goals
- Comply with JCAHO's peer-review requirements

On page 58 is an audit tool for evaluating the level of commitment to consumer and community participation in your organization. The questions range from those on management issues (Part I) to activities at the department level (Part II). Both parts could be completed by the quality manager through interviews with relevant senior leaders and managers and by reviewing documents. Another approach is for the quality manager to gather information for Part I of the tool and ask department managers to conduct their own self-assessment by answering Part II questions.

Once information is gathered, it can be analyzed and reported to the board, senior leadership team, managers, and staff. The results are a measure of the organization's commitment to and activity in consumer and community involvement. Use the information to identify organizational strengths, as well as gaps and limitations. Priorities should be established to develop an organizational approach to consumer and community participation.

Reference

1. Baldrige National Quality Program. *Health Care Criteria for Performance Excellence*. Gaithersburg, MD; 2004. Web site: www.quality.nist.gov. ■

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.

If you're not an *HPR* CE subscriber and would like to sign up, call customer service at (800) 688-2421. ■

PHARMACOLOGY WATCH

Estrogen Found to Not Affect Heart Disease, Breast Cancer

The NIH has halted the estrogen-alone wing of the Women's Health Initiative (WHI) a year before its scheduled end. The 11,000 postmenopausal women who have had a hysterectomy and were enrolled in the estrogen-alone trial recently received a letter informing them of the preliminary results of the study and asking them to stop their study medication. After nearly 7 years of follow-up it appears that estrogen alone does not affect the rates of heart disease or breast cancer (either positively or negatively), both key findings of the estrogen/progesterone wing of the study, which was halted in July 2002. The researchers did find, however, that estrogen alone led to a slightly higher incidence of stroke (8 per 10,000), similar to the rate found in the estrogen/progesterone wing. Estrogen alone was also found, however, to decrease the risk of hip fracture. The NIH statement also says that older women (65 and older) showed a trend toward increase risk of probable dementia or mild cognitive impairment with estrogen-alone treatment. All of the women in the study were taking Wyeth & Co.'s conjugated estrogen product, Premarin. The full results of the trial will be published in a major peer-reviewed journal in the next 2 months. The NIH statement concurs with the guidance from the FDA, which states that hormone use should be limited to treatment of moderate-to-severe menopausal symptoms, vulvovaginal atrophy, and prevention of osteoporosis (as a second-line drug). The NIH statement is available on its web site at www.nih.gov/news.

Antibiotics Associated With Cancer Risk

Is antibiotics use associated with an increased risk of breast cancer in women? The question, which was first raised decades ago, has been the subject of much debate, but now a new study suggests that the answer may be yes. Researchers looked at data from more than 10,000 female members of the Group Health Cooperative in Washington state and identified 2266 women with invasive breast cancer and 7953 randomly selected controls without breast cancer. The variable evaluated was cumulative days of antibiotic use over the study period from January 1993 to June 2001. Increasing cumulative days of antibiotic use was associated with increased risk of breast cancer. The categories were 0 days, 1-50, 51-100, 101-500, 501-1000, and > 1001 days. The odds ratios (95% CI) for breast cancer were, respectively, 1.00 (reference), 1.45 (1.24-1.69), 1.53 (1.28-1.83), 1.68 (1.42-2.00), 2.14 (1.60-2.88), and 2.07 (1.48-2.89) ($P < .001$ for trend). Increased risk was seen in all antibiotic classes, including women taking tetracycline or macrolides for treatment of acne or rosacea. After adjusting for age, length of enrollment, and use of postmenopausal hormones, the death rate from breast cancer also increased with cumulative days of antibiotic use. The authors conclude that use of antibiotics was associated with an increased risk of incidence of breast cancer and death from breast cancer; however, it cannot be determined

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from the study whether antibiotic use is causally related or whether the indication for use of antibiotics was the primary factor (*JAMA*. 2004; 291:827-835). The link between antibiotics for breast cancer is plausible since antibiotics affect intestinal microflora, thus affecting phytochemical metabolism in the gut. Phytochemicals are thought to play an inhibitory role in the carcinogenesis pathway. Antibiotics also affect immune and inflammatory responses, which may lead to mammary carcinogenesis. An accompanying editorial reviews the possible mechanisms of the antibiotic/breast cancer connection and suggests that this study provides more questions and answers but that further research is needed. In the mean time, antibiotic use in women should be scrutinized, especially when other treatment options are available (*JAMA*. 2004;291:880-881).

Topiramate Effective Against Migraine

Topiramate is an effective agent for migraine prevention, according to a new double-blind study of 483 migraine patients. The drug, which is approved for prevention of seizures, was used in maximal doses of 50, 100, or 200 mg for 18 weeks in patients aged 12-65, who had at least a 6-month history of migraine and averaged 3-12 migraines per month. Mean monthly migraine frequency decreased significantly in the 100-mg ($P = .008$) and 200-mg ($P \leq .001$) doses, and the benefit was seen within the first month of therapy. Migraine days and use of rescue medication were also significantly reduced in the 100-mg and 200-mg groups. Adverse events included paresthesia, fatigue, and nausea (*JAMA*. 2004;291:965-973). Johnson & Johnson has already received conditional approval from the FDA for topiramate for the indication of migraine prevention pending additional safety information.

Statin Therapy For Heart Failure

Statin therapy has been found to be beneficial for a number of chronic illnesses; now add 2 more to the list. Statins have been found to benefit patients with advanced ischemic and non-ischemic heart failure. Researchers from UCLA reviewed the records of 551 patients with systolic heart failure with ejection fractions of 40% or less. After risk adjustment, statin use was associated with improved survival without the necessity of urgent transplantation in both non-ischemic and ischemic heart failure patients (91% vs 72% [$P < .001$] and 81% vs 63% [$P < .001$], at 1-year follow-up, respectively) (*J Am Coll Cardiol*. 2004;43:642-648). A new, large, randomized trial shows statins may also reduce the risk of stroke. As part of the Heart Protection Study in the United Kingdom, 3280 adults with cerebrovascular disease and an additional 17,256 patients with other occlusive arterial disease or diabetes were randomized to simvastatin 40 mg per day or placebo. Over the 5-year treatment period, there was a significant 25% proportional reduction in the rate of first stroke (4.3% simvastatin vs 5.7% placebo; $P < .0001$). The entire benefit was found in reduction in ischemic stroke. There was no difference found in the rate of hemorrhagic stroke, either increase or decrease. Simvastatin also reduced the number of TIAs ($P = .02$) and requirement for carotid endarterectomy or angioplasty ($P = .0003$). Among patients with pre-existing cerebrovascular disease, there is no apparent reduction in the stroke rate, but there was a highly significant 20% reduction in the rate of any vascular event ($P = .001$). Interestingly, benefit was seen in all levels of LDL, even in patients with LDL levels less than 116 mg/dL. The authors conclude that statin therapy reduces the risk of ischemic stroke by one-quarter to one-third in these at-risk patients (*Lancet*. 2004;363:757-767).

FDA Actions

The consumer watchdog group Public Citizen is calling for the FDA to ban AstraZeneca's new statin, rosuvastatin (Crestor), because of the risk of myositis and rhabdomyolysis. The drug, which was introduced to the American market in September, has been associated with 7 cases of rhabdomyolysis, 9 cases of renal failure, and 1 death. Myositis is a class affect of statins, especially the high-potency statins like Crestor. AstraZeneca states that the drug has been used in more than 1 million patients and that its benefits outweigh the risks. The FDA banned Bayer's cerivastatin (Baycol) in 2001 because of more than 100 deaths associated with the drug due to rhabdomyolysis.

Drug Approved to Target Angiogenesis

The FDA has approved the first monoclonal antibody that targets tumor angiogenesis. Genentech's bevacizumab (Avastin) is approved for the treatment of metastatic colorectal cancer. The drug works by binding vascular endothelia growth factor, thus inhibiting the formation of new blood vessels in tumors. In clinical trials the drug was found to extend survival time in patients with metastatic colorectal cancer by several months. ■