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New 2005 patient safety goals are here: Don't delay in developing strategies

A collaborative, consistent approach is key to avoiding problems

During your next survey by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), it's unknown where surveyors will go, which staff members they'll speak to, and which patients will be traced. But one thing is certain: Compliance with the National Patient Safety Goals will be a key focus.

You must be in compliance with the new goals, which include requirements for fall prevention and medication reconciliation, by Jan. 1, 2005.

"All institutions will have to make changes to meet compliance," says **Leisa Oglesby**, assistant hospital administrator of quality at Louisiana State University in Shreveport. "Changes will impact nursing and physician documentation; the way pharmacists access, store, and report medications; and the way risk management tracks and trends falls to identify those at risk and determine what actions should be taken to reduce the risk."

To ensure compliance, you'll need to review the goals with an interdisciplinary team, advises **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting in Metamora, MI. "You need to look at all the people in the organization the goal is going to affect. Make sure you have a consistent approach before disseminating the information in terms of compliance."

In some cases, the goals are put out over an organization's intranet or posted on bulletin boards, but that is not an effective approach if you fail to communicate a clear strategy for how to comply, Homa-Lowry says. You'll also need a way to measure compliance with the goals, whether through performance improvement and risk management data or via feedback from observation rounds or patient tracers, she adds.

There were a few surprises in the 2005 goals, says Oglesby. "JCAHO had said the revisions in the goals would be related to Sentinel Event Alerts and/or sentinel events reported. However, the changes requested to meet compliance have not been reported through published Sentinel Event Alerts," she says. "Nor has JCAHO published definitions related to meeting compliance."

Here is a partial list of the specific requirements of the 2005 goals, with strategies for meeting each:

- **Define timeliness for reporting of critical test results.**

At Louisiana State, a team is reviewing current organizational and departmental policies to determine "timeliness" and how it should be measured, Oglesby says. "The process will be implemented before Jan. 1 to meet compliance with the new standards," she says. "Each organization will need to define what is timely."

• Identify look-alike/sound-alike medications.

The hospital's pharmacy and therapeutics committee has spent several months working with the pharmacy to identify look-alike/sound-alike medications and to determine what additional steps, if any, should be taken, Oglesby reports.

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"According to our recent survey, it is more than look-alike, sound-alike medications," says Oglesby. "The surveyor stated that different strengths of the same medication could not be stored in the same drawer."

This new goal allows room for interpretation, Oglesby adds. "I anticipate that the JCAHO will be answering a lot of questions concerning this goal," she says. "Who will define which medications look alike and sound alike, and determine what actions are appropriate? This is very subjective according to who is surveying compliance."

The hospital's pharmacy has taken many actions over the past year to improve safety, such as separating look-alike medications, flagging bins where drugs are kept, highlighting differences in look-alike medications, and placing warning flags to alert pharmacists to sound-alike medications, says Oglesby.

"The main issue is narrowing down the list so that the pharmacist will heed the warning," she says. "If you have too many, they may get in the habit of seeing them and miss an important one."

• Assess the risk of patient harm from falls.

The new goal requires not only assessment of a patient's risk for falling, but periodic reassessment of the risk. This is a daunting challenge for large institutions due to patient volume and acuity, Oglesby says. "The more services provided by an organization, the more areas that must be included in the list for assessment," she says. "That's not to mention the increased time it will take for documentation by staff that are already overworked."

A team is reviewing how the organization can meet this new standard. So far, areas at highest risk for patient falls have been identified, and a team of nurses has been assigned to select the tool that will be used to identify patients at risk, determine when to reassess a patient's risk of falling, and address how falls are tracked and reported.

"We will be using the same scale for measuring falls as we do with variance reporting," Oglesby says.

At Cheshire Medical Center/Dartmouth Hitchcock Keene (NH), a falls prevention team has been in place for more than a year, and a variety of tools have been implemented to assess fall risk, says **Chaele Ellsworth**, RN, MBA, director of quality improvement/risk management/case management.

To comply with the new goal, falls prevention now is part of every inpatient initial nursing

assessment, with various interventions implemented based on the patient's score, Ellsworth says. "The new policy calls for the assessment to be done daily or as the patient's condition changes," she says. "We are also changing our occurrence reporting forms to have a more detailed report completed for patient falls."

Although many organizations have purchased bed alarms or low beds for patients at risk for falling and have implemented policies for sitters to observe patients with the goal of avoiding restraints, patient education often is overlooked, says Homa-Lowry.

"Providing better documentation of education of patients about risk of falling when they get their medications is really important," she says. "Sometimes staff may say they have told the patient they are at risk for falling, but it's often not specifically written in the medical records."

• **Reconcile medications across the continuum of care.**

Of all the new goals, this one is the most problematic, says **Tony Simek**, Joint Commission coordinator at Abington (PA) Memorial Hospital. "This is a very challenging and worthwhile goal, but it requires automation to be efficient," he says. "Otherwise, it can be very, very labor-intensive — in other words, unrealistic."

Obtain list of patient's current medications

The goal requires you to develop a process for obtaining and documenting a complete list of the patient's current medications upon the patient's entry to the organization, with the involvement of the patient. This process must allow for comparison of the medications the organization gives with those on the patient's list. In addition, a complete list of the patient's medications must be communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner, or level of care, whether within or outside the organization.

"First of all, the whole idea of trying to get a current list of the medications a patient is on is going to be difficult," Homa-Lowry says. "Sometimes the patient is not the best resource, and the information is only going to be as good as what they give you."

Still, you should develop an approach for compliance as soon as possible, Homa-Lowry warns. "You've got about a year to do this," she says. She recommends doing a failure mode and effects analysis to determine the best approach. "Test what you want to do and see how effective it is. Have a group of people who really represent the continuum of care, and look at how they can come into compliance," she says.

This is a good way to work through glitches before a new process for reconciling medications is implemented, she says. "Look at what you want to do, and run it through the analysis to see how well you think it would be complied with, instead of just putting it out there," she says. "Determine each step that can fail and how it can fail, and determine the effect if it does fail."

Electronic medical record may help

The best way to meet this standard is still being discussed at Cheshire Medical/Dartmouth Hitchcock, says Ellsworth. "We hope that the electronic medical record used in our physician offices will help us with this," she says. In addition, a new medication administration check system will be implemented throughout the hospital for both inpatients and outpatients, she reports.

Two members of the organization's medication safety committee have participated in Irving, TX-based VHA's Medication Error Prevention Initiative since its inception, Ellsworth notes. "This collaborative of hospitals in New England has shared information and worked together on a variety of medication error reduction projects. I think this has kept us ahead of the curve on the goals related to medication use," she says.

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Why did 2005 safety goals omit bar coding?

New autoidentification systems are on the horizon

The finalized 2005 National Patient Safety Goals of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) bore a close resemblance to the proposed goals announced earlier, with one notable exception: The elimination of the bar-coding requirement. This was in large part due to feedback received from health care organizations during the field review for the goals being considered, according to **Paul Schyve**, MD, senior vice president at the Joint Commission.

The main objection to bar coding: New and emerging technologies likely will be more efficient and effective than bar coding. As a result, the Sentinel Event Advisory Group did not include the bar-code requirement in the 2005 Goals it recommended to the Board of Commissioners.

This year was the first time feedback was solicited before the goals were finalized. The purpose was to get information from the field about specific technical issues and possible barriers to implementation, as well as to get an idea of where the goals fall in organizations' lists of priorities, Schyve says.

"The information that came back to us told us that bar coding was a good goal and a worthwhile idea, but there were some technical issues around its implementation at this point that led people to suggest that maybe it wasn't yet ready for that small list of priorities for 2005," he explains.

Bar coding may soon be rendered obsolete

The main concern was the idea that bar coding soon might be replaced by up-and-coming autoidentification technologies, such as radio frequency identification. "The concern was that if this suddenly became a requirement for accredited organizations, they would invest in bar coding, which is not cheap to put into place. Then, a couple of years later, they'll find out they would be better off with new technology, but they'll lack the resources to quickly replace the bar-coding technology," says Schyve.

Cost was a significant worry, especially for smaller organizations, Schyve says. "It is not an inexpensive technology to replace, even for a larger organization, but obviously it becomes more of an issue for smaller organizations," he says. "The concern was that this will be a relatively big investment, and it would be a shame to make that investment only to learn a couple of years later that it has been superseded by a different technology."

One organization argued that this would result in health care being a generation behind other industries in terms of use of technology, Schyve says.

After these concerns were shared with the Sentinel Event Advisory Group, a decision was made to get more information on potential problems with implementation of bar-coding systems and to learn more about alternatives for autoidentification.

But since there was a general consensus that autoidentification systems improve safety, why not simply require organizations to implement a system of their choosing instead of specifying bar coding? "If that were to be made a goal, then at the same time, the JCAHO needs to be able to tell the field about the advantages and disadvantages of the different options," says Schyve. "While people would have their own choices, they would need something more from the JCAHO than 'just go do this autoidentification thing.'"

Many organizations have not yet taken any definite steps toward implementation of autoidentification systems, Schyve says. "It is clear from the feedback we received that there are those who had not really thought about this and did not know what the technology might provide," he says.

To address this, a Sentinel Event Alert will be issued sometime next year to provide information on the benefits of autoidentification and the different options currently available, Schyve says. "There is little doubt in my mind that sooner or later, most health care organizations will be using an autoidentification system of some sort," he says.

There are a number of advantages in addition to the patient safety aspect, says Schyve. "Wal-Mart, for example, uses it because it's one of the most effective ways for them to track what is going on in their organization and helps with efficiency," he says. "This is a technology that people will be increasingly focused on. It certainly will continue to be a focus of discussion by the Sentinel Event Advisory Group. Within that context, it may or may not become a National Patient Safety Goal in a future year." ■

Bill would increase CMS' authority over JCAHO

Law would end JCAHO's special regulatory status

(Editor's note: This is the second in a two-part series on the recent General Accounting Office report on the Joint Commission on Accreditation of Healthcare Organizations. Last month, we covered the report's controversial findings and the Joint Commission's response. This month, we cover new legislation that could affect your future surveys.)

A recent report from the Washington, DC-based General Accounting Office (GAO) already has questioned the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)'s ability to detect serious problems in the quality of patient care, but newly introduced legislation could have a longer-term impact.

Bills introduced by Congressman **Pete Stark** (D-CA) and Senator **Charles Grassley** (R-IA) would enact the report's key recommendation — that the Joint Commission's hospital accreditation program be made specifically accountable to the federal government for deemed status purposes. The bill would give the Centers for Medicare & Medicaid Services (CMS) the same oversight authority over the Joint Commission as is currently the case for other organizations with accreditation authority.

If passed, the bill would put an end to the unique status the Joint Commission has held for nearly 40 years, when the original Medicare Act of 1965 granted the Joint Commission the authority to deem hospitals as eligible for Medicare payments with virtually no federal oversight.

"The issue is that the JCAHO hospital accreditation enjoys a different regulatory status than other accrediting programs — even those run by JCAHO," says **Patrice L. Spath**, RHIT, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates. "Because of this, CMS can only recommend changes to the process, but cannot enforce that those changes are made."

Currently, the Healthcare Facilities Accreditation Program of the Chicago-based American Osteopathic Association is the only other voluntary accrediting organization with deeming authority from CMS to survey hospitals under Medicare. This deeming authority is subject to direct review and approval by CMS. In contrast, CMS has limited oversight authority over JCAHO's hospital accreditation program.

"It was a serious mistake to pass a law saying that whether Medicare funds went to hospitals depends on passing JCAHO inspections," argues **Sidney Wolfe**, MD, director of the Health Research Group for Public Citizen, a Washington, DC-based nonprofit public interest organization. "JCAHO shouldn't have any role in terms of the decision of whether the hospital gets Medicare funds. They should not have any kind of authority over that. The real inspection function is too important to be left to JCAHO and should be done by state health agencies."

However, the legislation would not change the Joint Commission's role as the primary provider of accreditation surveys for Medicare hospitals, according to Rep. Stark, ranking member of the House Ways and Means Health Subcommittee. The Joint Commission currently accredits more than 80% of U.S. hospitals.

"Hospital quality managers will continue to work with JCAHO," Stark says. "Our legislation just gives Congress and CMS clear oversight authority over JCAHO's Medicare deeming activities. It will require JCAHO to report directly to CMS to ensure that the surveying processes used protect the quality and safety of patient care, rather than the interests of the hospitals and their physician providers."

Even if the Joint Commission's accreditation program is placed under federal oversight, that won't have much of an impact on your future surveys, according to **Margaret VanAmringe**, vice president for public policy and government relations at JCAHO. "I don't think it will impact the survey process at all," she says. "We have always acted as if the executive branch had the authority over our accreditation program, so whenever CMS asked for standard interpretation or to put a new standard in process, we have done that and acted in full cooperation. So we won't be any less cooperative, or more; we will be just as cooperative as we have always been."

However, surveyors will be reminded to ensure that they have looked at all of the areas that are consistent with the Medicare Conditions of Participation (CoPs), VanAmringe acknowledges.

In addition, surveyors are now paying a lot more attention to what they document during surveys, VanAmringe says. She explains that surveyors previously may have noticed certain things that, while irregular, did not amount to

a deficiency and thus were not documented. "So if we didn't record them, it looks as though we didn't find them or care about them, when that's not the case," she says.

This is one reason why JCAHO says the GAO's methodology used is flawed. JCAHO argues that the GAO needed to look at what actually was found during surveys, as opposed to looking only at what was documented, VanAmringe says. "That is the true measure of our capabilities as a detective in quality," she says. "They failed to do that. We are left with a report that reflects poorly on us, but in my view reflects more poorly on the GAO and their methodology."

If the new legislation is passed, the Joint Commission will then need to apply for deemed status, which it has never had to do before, says VanAmringe. This would require JCAHO to demonstrate in a crosswalk that its requirements are equivalent to or exceed the Medicare CoPs. "It is very difficult to prove that, although we know they exceed the Medicare standards, and I don't think that anybody would say otherwise," VanAmringe says.

The problem is that the standards and the scoring process are not easy to compare, in part because the Joint Commission uses 2004 standards, while Medicare's standards date back to 1984, says VanAmringe. "We are so different in our process and our actual requirements. We've been trying to determine how to crosswalk something that is so vastly different," she says.

In essence, the quality goals of JCAHO and Medicare's CoPs are the same, such as ensuring that patients are taking the right medications and that there are sufficient staff in the organization. "But how we go about measuring these things could not be more different," VanAmringe says.

For this reason, JCAHO is requesting that Congress not put new legislation into effect until CMS updates its hospital standards to make them 2004-compliant. "Otherwise, it will take us a year to 18 months to apply," VanAmringe says.

Though the Joint Commission itself is not disputing the change, some quality professionals still feel that patients would be better served by leaving the Joint Commission's status as it currently is. "It might be wise to pause a moment before adding additional costly oversight to a system that, although imperfect, is working," says **Patti Muller-Smith**, RN, EdD, CPHQ, a consultant for Shawnee, OK-based Administrative Consulting Services. Muller-Smith works with hospitals on performance improvement and regulatory compliance. "Efforts to improve a good system may be less costly and of more benefit to the patient — who, after all, is what it is all about."

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- *The text of the proposed legislation to make the Joint Commission's hospital accreditation program specifically accountable to the federal government for deemed status purposes can be accessed at no charge on Congressman Pete Stark's web site (www.house.gov/stark). Click on "News," then "7/20/04—Press Release—Hospital Accreditation," then "Text of Stark Bill."]* ■

How to create and monitor your measures of success

Consider each step in the process

Unless your organization is lucky enough to be found 100% compliant after your next survey by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or after completing the periodic performance review, you'll have to address noncompliant areas for which you must set measures of success (MOS) and then gather data to evaluate improvement.

"Many organizations run into trouble because they create MOS that are not meaningful or accurate," says **Michelle H. Pelling**, MBA, RN, president of the Newberg, OR-based health care consulting firm The ProPell Group.

To avoid problems, consider following these steps to create useful and effective MOS:

1. Develop selective measures of success. "One of the most important things to remember is

(Continued on page 143)

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Clinic serves as a model for care of the uninsured

Volunteers play key role

In April 2002, **Donna Zazworsky**, MS, RN, CCM, FAAN, director of grants, partnerships, and policy at St. Elizabeth of Hungary Clinic in Tucson, AZ, got a telephone call from a case manager at a local hospital who wanted to know if the clinic had a hospital bed it could donate for use by a 17-year-old patient who was being discharged.

"She said they had a young man who was not insured, with a gunshot wound to the head, who had been stabilized after several weeks in the hospital, but who was paralyzed and still had a tracheostomy tube and a gastrostomy tube," Zazworsky explains.

The boy's mother was coming to take care of him, the case manager explained, but a hospital bed was needed, and she wondered if there was one available from the clinic's medical equipment loan chest.

"I said I could probably get a bed," Zazworsky recalls, "but then I asked her, 'Who is going to oversee his care?'"

That question, and its answer, set in motion a series of events, she says, that has everything to do with how discharge planners and case managers need to approach the problem of getting care for uninsured patients.

What the case manager told her, Zazworsky says, is that the young man had an appointment to come back and see a neurosurgeon in two weeks.

"Inside, I went nuts," she adds. "I said, 'Who is going to be there for the mother? She's the one giving care, and he has a trach tube, a G-tube, and a three-inch hole in his head? They need backup support. No one at the neurosurgeon's office is going to provide that.'"

While the Emergency Component of the Arizona Health Care Cost Containment System (AHCCCS), the state Medicaid program, had paid for the patient's initial care because his condition was life-threatening, Zazworsky learned, he didn't qualify for home health services because he was an undocumented immigrant. There was no primary care physician in the picture, she notes, because he had never needed one before.

"I told the case manager to have his mother come to the clinic, bring the papers we need — proof of work or a utility bill to show residence here and a photo ID — and said I would go out and do a home visit," she explains. Without her intervention, Zazworsky says, "I can guarantee you that he would have been in the emergency department [ED] in two days."

Instead, the coordination she provided through the clinic — using a myriad of carefully developed resources and affiliations — resulted in a program of care that was not only cost-effective, but far superior in quality to the reactive, stop-gap measures that otherwise would have comprised the young patient's follow-up treatment.

"The bottom line with discharge planning if somebody is not uninsured," she says, "is you need to really work on connecting people with a medical home that will provide primary care and case management to help people get through the system and to get them set up with a follow-up visit."

St. Elizabeth of Hungary Clinic, a nonprofit primary and specialty care clinic operated under the auspices of Catholic Community Services, serves individuals who are not eligible for federal or state-funded health care programs, Zazworsky explains. "They are the working poor, the recent immigrants and refugees." If the clinic's coordinated approach to care were used universally for the uninsured, she suggests, ED visits and overall costs would be reduced dramatically.

In the case of Daniel, the 17-year-old gunshot

victim, if she had not intervened, "the neurosurgeon would have followed through in some way, shape or form," Zazworsky says, "but what happens when I take over is that I start working with our volunteers. We got it done more efficiently and affordably."

Without that coordination, she adds, "he would have been in and out of the hospital many times, racking up a lot of bills."

In arranging care for the more than 18,000 active patients who are seen annually at the clinic, Zazworsky notes, she draws on not only an in-house administrative/provider staff of 52, but on 150 volunteer physicians, dentists, nurse practitioners, and nurses from throughout the Tucson community.

These volunteer practitioners, she says, either come to the clinic to provide care or donate slots of their office time. Among other arrangements with community providers, Zazworsky notes, a teleradiology set-up with radiologists at a local hospital allows St. Elizabeth's to send the day's X-rays to the hospital, where the physicians read the X-rays for free on their lunch hour and send them back to the clinic.

St. Elizabeth's contracts for laboratory services with another hospital, which maintains a drawing station at the clinic and gives its patients a discount, she adds. "They can get the lab done right there during their visit," Zazworsky says, after which the lab technician coordinates regular pickups of the specimens and takes them to the hospital and then sends back the results.

The ability to have laboratory services performed during a primary care appointment is an example of the kind of accommodation that is important in caring for the uninsured, she points out. "Most of our patients work low-income jobs and cannot afford to miss an hour or two. They might even be fired if they have to miss work. So one-stop shopping must be addressed."

Patients at St. Elizabeth's "have to pay for care," Zazworsky emphasizes. "It might be a $10 administrative fee. That's a big, important thing to get across. People need to keep their dignity for their well-being."

Fees are based on a sliding scale and are negotiated with the patient, she says. "We will bill them over time — even if they pay $5." In Daniel's case, for example, the family paid the $52 per round trip it cost for a specially equipped van to take him back and forth from the clinic.

The clinic gets some primary health care funding from the state: "a flat amount of money to provide care for the uninsured" that amounts to maybe $70 per patient (this includes the provider visit, lab, and other services), Zazworsky says. "It usually runs out in March or April, so from that time until about the end of June (the end of the fiscal year), we might bump up the fee."

"What happens," she adds, "is that you see our visits go down, because it's harder for people to pay, and ED visits go up." At present, Zazworsky adds, the evidence of that link is mostly anecdotal, but a local group of hospital administrators and business leaders is looking at doing an analysis of ED visits that would substantiate it.

"People can't be turned away at the ED," she notes. "They're either going there for a primary care visit that could have been done at the office; or they're not being cared for at all, and something more serious has happened; and they're going for that."

A cautious start

When Zazworsky left St. Elizabeth's to make that first visit to Daniel's home, she recounts, she took along the clinic's medical director, who looked at her and said, "Donna, we can't do too many of these." He was referring to the likelihood that the case would be very complex and require many resources, she adds, "and that was true in the first month. I made visits two or three times a week, and the medical director went weekly."

When they arrived at the tiny home in South Tucson, Zazworsky says, they found the mother, who speaks only Spanish, and her son, head bandaged, unable to turn on his own, and with the eyes of a deer caught in headlights. But having thought they might find the young man in a coma, she adds, they were thankful to see that "He was all there."

Zazworsky set about coordinating some care into the home, she says. "The mother knew how to manage the wound and was somewhat comfortable with the tubes but certainly not independent. I called a home health company I know, and they sent out a respiratory therapist who put in a talking trach. So then he could talk to us."

Discovering that Daniel could not yet tolerate bolus feeding, whereby a cup of tube feeding is put directly into the stomach through the G-tube, she asked for a nutritionist and a kangaroo pump that would deliver the food slowly in measured amounts.

"We needed to find out if he would have

enough calories and fluid for healing," she adds. "He was on a variety of medications, so we needed to see if changes should be made based on the G-tube route. I coordinated and oversaw all that."

Physical and occupational therapists, volunteers of the clinic, came out to do an evaluation, she says, and gave Daniel's mother instruction on basic exercises that should be done daily to reduce muscle contractures that occur when muscles are not used because of paralysis.

His mother, meanwhile, was calling the clinic regularly because she understandably had a lot of questions, says Zazworsky, who ended up giving the woman her cell phone number to facilitate the communication.

To make it easier to oversee Daniel's care, she asked the Arizona Telemedicine Program — which provides services to communities throughout the state from its base at the University of Arizona College of Medicine — to set up a unit in the home "so we could call him up and I could assess him from the clinic," she notes. "He thought that was so cool. He said, 'Donna, it's like [the television show] 'Big Brother.'"

When she discovered that the family had only a cell phone, Zazworsky adds, "I had to back up a few steps and call the telephone company and get a phone jack put in."

Once the telemed was put in, Zazworsky adds, "they managed very well. I went out every other week and then monthly. The medical director would come out if needed."

When she wanted to have Daniel hospitalized to have his tracheostomy and gastrostomy tubes removed, AHCCCS couldn't pay for it because it wasn't an emergency, she says. So Zazworsky arranged to have the procedures done by volunteer physicians at an outpatient clinic.

Later, she was able to get Daniel a "scholarship" through the foundation of a local rehabilitation facility, she notes. "They gave him five inpatient days where they taught him and his mom how to work better together — how to transfer from bed to chair, how to dress, daily living skills."

After Zazworsky made some contacts and assisted with paperwork, Daniel was able to enroll in classes through the home program of the local school district, she adds, using computer, television, and the Internet to keep up with his studies.

Daniel's case "is such a classic story of how you have to work the system," she says. "He was somebody who could easily have been dropped. We picked up [his care] in April 2002, the tracheostomy and gastrostomy [procedures] happened that April and May, and then we got his head closed that August. Now we don't have to spend much time on him. He's a healthy young man — he just has this brain injury — and the most amazing person."

Although St. Elizabeth's is a faith-based clinic and currently does not qualify for federal funds, Zazworsky points out, there are more than 700 federally qualified community health centers throughout the country that receive money from the federal government to care for the uninsured (http:ask.hrsa.gov/pc).

In most cases, she adds, the clinics have a case manager who knows how to leverage funding for optimal benefit.

"[Hospital] case managers need to learn where the resources are," Zazworsky stresses. "Caring for the uninsured takes a lot of coordination, a lot of support from people in the community."

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Uninsured cases increase in number, complexity

'We try to educate them'

Arranging care for uninsured and underinsured patients has become more complicated in the past four or five years, says **Jennifer DeCamp**, MSW, LSW, a social worker at Swedish Covenant Hospital in Chicago.

"It seems there are more patients who do not have insurance and more challenging cases of all ages," she adds. "It might be someone who is 64 and won't get Medicare for a couple of months, or, as with a patient I talked with today, a working woman who has health care insurance that pays 10% of the cost of her medicine and nothing else."

In the latter case, DeCamp notes, the woman already has missed several days of work, can't work for at least another week, but has to pay rent, utilities, and other expenses, not to mention

most of the cost of her medication.

DeCamp says she gave the woman information on how to request help from the Salvation Army, and the Chicago Department of Human Services.

There are a number of patients who are in the country illegally, she says, and so don't qualify for coverage under any of the state or federal programs. "We'll see patients and treat them, but after discharge, if they need follow-up care, they usually get it at the public health hospital."

She also deals with foreign patients who become ill while visiting the United States, DeCamp notes, as was the case with a recent stroke victim whose care became extremely problematic.

"The patient, who is in his 40s or 50s, needed a hospital bed, G-tube feeding, and a special mattress on the bed to prevent skin breakdown," she explains. "In cases like that, we work a lot with durable medical equipment [DME] companies. They are able to get us some breaks when people are so low-income."

If the patient had been living and working in this country, he would have qualified for public aid, DeCamp notes. Although he had been visiting family members here, they were unable or unwilling to take him home after his hospital stay, she points out. "They said they couldn't afford it."

That patient, she says, stayed in the hospital far longer than his medical condition warranted, simply because there was nowhere else for him to go.

Getting the family involved

DeCamp says she has noticed that in many cases there seems to be a lack of any feeling of family obligation toward a patient who needs ongoing care. "It is the family's responsibility to care for their loved one," she says. "That's what people miss out on. If someone gets really sick, they need to step up and take care of them."

"We have a lot of nursing homes in this country, but if you don't have Medicare or public aid, they are not an option," DeCamp adds. "The only other option is to go home."

With that in mind, she adds, Swedish Covenant tries to give as much information as possible to patient and family. "I try to educate, to say, 'Here's what you're up against, here's what you can do, and here are tools to help you do it.'"

Exploring free or low-cost care options can take a lot of research and time, DeCamp continues, so in most cases social workers provide telephone numbers and addresses for resources, such as the city or state Department of Human Services or the Salvation Army, which may provide help with emergency housing, clothing, food, and medication.

The American Cancer Society has a used-equipment program, as well as other resources for those who need financial help, and the Alzheimer's Association has a family relief program, adds DeCamp. "Depending on the diagnosis, you can go to one of those associations."

"We have a patient right now who is going to turn 65 in a few months and has very bad wounds, is on intravenous antibiotics, and doesn't have insurance," she says.

"He is in that little pocket where — if he doesn't work and can't pay for his own care — we can't send a home health nurse. We will have to teach him how to do dressing changes and care for the wounds, make sure they're healing." DeCamp points out.

The patient's medicine will have to be taken by mouth, she adds, and if he continues to need IV antibiotics, he will have to stay in the hospital.

"There is also a company that provides specialized wound treatment equipment that has a benevolence program," DeCamp notes. "It takes a lot of paperwork and contact with the family."

Discounts also can be obtained from DME companies, she adds, and various agencies maintain DME lending closets. If the patient is terminally ill, hospice organizations are good sources of help for the uninsured, providing such things as pain medication, a hospital bed, oxygen or nursing support, DeCamp explains.

While Swedish Covenant provides a large amount of free care each year, there is a focus, she adds, on encouraging the patient to take responsibility for his or her own care once he or she is discharged.

"We're getting them started, but for follow-up, they need to take over," DeCamp notes. "We try very, very hard to prepare everybody not to anticipate that once they go home, they can depend on us to make all the necessary calls."

"We try to educate them to get in touch with the appropriate agencies on their own," she adds, "so if something breaks down, or they need help, they have more control."

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(Continued from page 138)

that measurement is counting," says Pelling. "It is the quantification of anything capable of being quantified."

The first step is determining the question to be answered. "Remember that you cannot measure everything," Pelling says. "You need to be selective and relate what you are measuring to the question you are trying to answer."

Do not develop broadly defined measures or try to measure too much at one time; instead, choose specific, focused measures, Pelling recommends.

"You are trying to answer one question with each measure — not two or three," says Pelling. Any measure that includes the words "and," "or," "if," "after," "until," or "when" could cause you to collect information about two or more elements, or to be so vague or ambiguous that it becomes impossible to gather meaningful data, she explains.

At Willis-Knighton Health System in Shreveport, LA, each requirement for improvement was assigned to either a team, committee, or department for follow-up. After review, the responsible parties set their own MOS based on several factors, including history of the issue, resource availability, and time frames, says **Lisa Maxey**, MBA, RHIA, the organization's JCAHO coordinator.

2. Begin collecting data.

Once you have developed an MOS, you must begin collecting data. Pelling gives the following example of a measure of success: Are the initial nursing assessments complete in the sample of records reviewed?

For this measure, you would need to define the terms "complete," "nursing assessment," and "initial." You also must determine when in the process you can get these data, such as 24 hours after admission, and who can give them to you — for example, nursing staff, says Pelling.

Next, determine how you can collect the data with minimum effort and chance of error, such as retrospectively or concurrently at the point of care. In addition, determine what else you need to capture data for future analysis, reference, and trackability. For example, if sections are incomplete, you may need to know which sections are incomplete and what specifically is missing from them, Pelling says.

During a March 2004 survey at Willis-Knighton, surveyors required the organization to implement improvements in pain assessment/reassessment. "The issue was, not only was the patient assessed, but also, were they reassessed?" says Maxey. When the pain management committee developed an audit tool to measure improvement in this area, it first had to define the relevant areas and create definitions for which data were "not applicable," she adds.

When are pain reassessments necessary?

"The most difficult part was identifying the appropriate departments to determine which were performing pain assessments/reassessments and which were not," says Maxey. "For example, we explained to our departments that if a work conditioning-type patient is seen for a urine drug screen test, those records would not need to be part of the reassessment audit. Similarly, a patient in one of our physician's offices may not need to be reassessed if they are only scheduled to receive a routine B-12 injection."

To educate staff about the requirements, inservices were given on pain assessment, and an online educational tool was developed. "It really was primarily the outpatient areas that were hard to get our arms around because of the limited amount of time the patient spends on campus, as opposed to patients who are seen over longer periods of time or inpatients where assessments are done during each shift," says Maxey.

Policies and procedures were revised to include all the inpatient and outpatient areas. "We then had to educate the staff that we now require them to perform chart audits and to report their findings to the committee, so we are getting the data from the actual department," says Maxey.

During collection of the data, a weighted value is assigned, since department size and chart volume can differ greatly across the system. The different statistics from each department then are merged in order to come up with an average. "Those statistics are reported to the pain management committee, as well as to the JCAHO preparation team," Maxey says.

3. Design your data collection system to minimize bias.

"Bias results in data that is not representative of the natural state of the process," says Pelling. Common causes of biased data include a misunderstanding of how to collect and record data, inaccurate measuring instruments, changes in the process during data collection, subtle disregard for the facts, poor choice of data collection period, poor sampling techniques, and lost data.

To minimize bias results in your data collection, Pelling recommends doing the following:

- Consider potential sources of bias before data collection.
- Conduct a small trial of data-collection forms to see if they are easy to use.
- Provide thorough training and explanations for how to complete the forms, and address all concerns.
- Audit the data-collection process by examining data as they come in. Verify that you are getting complete information by observing data collectors or cross-checking numbers from other sources.

4. Monitor your success.

Although organizations are given four months to submit MOS data to JCAHO, it's better to monitor compliance more often, Maxey recommends. "Our goal is to monitor our compliance each month, rather than waiting until the four-month period is over and it is time to submit this information to JCAHO," she says.

When the organization submitted evidence of standards compliance, the organization had to enter a percentage into JCAHO's extranet site for the stated goals for each requirement for improvement, Maxey says. "If, at the end of the four-month period, we are not in compliance with our stated goals, we will have to suffer the consequences from JCAHO," she says. "That's why we are measuring and reporting on a monthly basis, following the adage of 'trust but verify.'"

Initially, some units failed to report MOS data, because not all areas were aware that they had to gather and present data, Maxey says. "More education was done for these areas," she says. "Also, some areas, such as the work conditioning area, should not have been reporting." To address this, the pain management committee went back to the drawing board to further define the areas that should be required to assess/reassess pain and report those statistics.

Various teams and committees are responsible for follow-up on requirements for improvement, and they report data directly to the Joint Commission preparation team, which was made a subcommittee of the performance improvement and medical quality council, notes Maxey. "The JCAHO prep team is held responsible by upper management and medical staff to report the data," she says. "If something is not going as it should, we have to determine quickly how to correct the issue."

It took more time than expected to submit data showing evidence of standards compliance to JCAHO's extranet, says Maxey. "That's a problem," she says. "It took us quite a long time to organize the information and then to submit it. I don't think that the JCAHO realizes how much time it takes to get all this information entered."

To decrease data errors and time expenditures, the organization's JCAHO prep team devised a standardized reporting form containing prompts for information required for follow-up on the extranet site. The standardized format ensured that each team submitted complete information and that the information was approved by the JCAHO prep team and then correctly entered. "If all information is standardized, allow eight to 10 minutes for each requirement for improvement," says Maxey.

[For more information on measures of success, contact:

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JCAHO surveyors focus on life safety code compliance

Survey fees to increase next year

As of Jan. 1, 2005, hospitals will be paying an estimated $2700 more in average triennial survey fees. This is due to the need to make further investments in the new accreditation process that was introduced this year, according to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

In addition, a certified health care engineer will be added to surveys of hospitals with 200 or more beds, which comprise about a third of the hospitals accredited by JCAHO, with an additional survey fee of $3,500. Additional training in life safety code compliance will be given to surveyors of smaller organizations. JCAHO worked with the Chicago, IL-based American Society for Healthcare Engineering to design the training curriculum and determine how to conduct the add-on

survey, says **Paul Schyve**, MD, senior vice president at the Joint Commission.

The goal is to improve the Joint Commission's ability to evaluate hospital compliance with the life safety code, a specific code of standards issued by the Quincy, MA-based National Fire Protection Association, Schyve says. A recent Government Accounting Office report indicated that of the 167 serious deficiencies identified by the Centers for Medicare & Medicaid Services' (CMS) validation program from 2000 through 2002 that were not detected by JCAHO, 87 were related to a hospital's physical environment, which includes life safety code standards for fire prevention and safety. For these three years, JCAHO failed to detect 81% of the serious physical environment deficiencies identified by state agency surveyors, according to the report.

"We have realized for many years that we could do this better," says Schyve. "The conclusion was that we wanted to find better ways to evaluate life safety code compliance, and the best way to do that would be to provide additional training for our surveyors for smaller organizations, but for surveys of some larger organizations to actually add an expert in that area as part of the survey."

Although fires are rare, they can be devastating to patients and staff when they do occur, notes Schyve.

Compliance with the life safety code requirements will definitely be a key focus during future surveys, predicts **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting in Metamora, MI.

To avoid violations, the best thing you can do is familiarize yourself with the requirements, she advises. "When you look at the environment of care chapter, it is so huge. There are plenty of related regulations that you need to be familiar with, such as the CMS requirements," she says.

Look for problems by doing proactive assessments on the units and eliciting feedback from direct caregivers, recommends Homa-Lowry. "It's good to look for potential breakdowns up front," she says. "The people working on the units have the best appreciation for what the potential risks to patient safety can be, especially if they understand the processes on the unit involving other departments. They do not necessarily need to know how to fix the process, but just be aware of when there is the potential for a problem."

If problems are discovered, resolve them without delay, Homa-Lowry urges. "If a piece of equipment needs to be tested and was overlooked by the bio-med department, contact them before using it. If there were deficiencies noted during a fire drill, make sure you address them right away, and test the corrective action, instead of waiting for the next committee or waiting for another drill," she says.

Staff should be encouraged to report problems or potential violations, Homa-Lowry says. These might include door latches that don't work properly, improper storage of oxygen near equipment that is a potential fire hazard, or storing too much oxygen. "Safety is everybody's responsibility," she says. ■

Manage organizational fear to improve safety

What are the people in your organization afraid of?

By **Patrice Spath**, RHIT
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Patient safety experts advocate elimination of fear in the workplace so staff members can more effectively identify and resolve safety concerns. The elimination of fear is necessary to create an environment of trust and cooperation, essential ingredients of initiating and sustaining patient safety improvements. Unfortunately, there is little concrete guidance on how health care managers should deal with fear in their environment. It's easy to say, "change the culture," but that can't be accomplished until managers first understand this complex organizational phenomenon. Fear is a human emotion that can never be completely eliminated, but it can be managed.

Fear that affects patient safety initiatives is present in every health care organization. If you have any doubts that there is fear in your facility, just observe how people behave in root cause analysis meetings or other discussions of patient incidents. Many of the behaviors that

you observe during these meetings can tell you a great deal about the culture of your organization. It is dangerous to rely on patient incident data that are contaminated by fear. This is why it is so difficult to address the technical problems of patient safety without addressing the social systems of the organization.

What are the people in your organization afraid of? Most fears are related to position, authority, power, and psychological and social factors of organizational or professional life. Let's take a look at some of the most common types of fear:

- **Fear of reprisal.** This type of fear generates "look-good-at-any-cost" or "just-do-what-you're-told" behavior. Fear of being disciplined or receiving poor performance appraisals can lead to behavior that inhibits patient safety improvement efforts. Fear of making a mistake is tied to fear of reprisal; reprimands are often viewed as an outcome of failure. Defensiveness, skepticism, and apathy are behaviors of people who are avoiding failure.
- **Fear of success.** While it may seem odd, it is not uncommon for people to be afraid that success will damage their relationships with their peers. Staff members sometimes can be afraid of the repercussions of success (e.g., jealousy, envy, being ostracized as a snitch, higher performance expectations, or fear of failure following a promotion).
- **Fear of change.** Resistance to change and the attitude "We've always done it this way, why change now?" are very common. Employees often resist process changes because they are generally content with what is familiar. Change may cause people to fear that they are going to lose something or feel that their autonomy or power is being diminished. Many see change as a threat to their security or to highly valued beliefs.
- **Fear of speaking up.** Staff members who bring attention to patient safety problems can become targets of criticism. It is common to find that people are afraid of speaking up about mistakes because they fear management will punish the whistleblower. When there are lots of people who are afraid to admit their department is violating safe practices, the organization is missing out on chances to learn. Leaders must forgive unsafe practices and mistakes and provide a secure forum in which everyone can learn from failures.

Managing fear in the workplace should start with acknowledging fear's presence. Then you need to learn about the level of fear in your organization. Use the following questions for a quick assessment of organizational fear:

- Do people accept responsibility for suboptimal performance? Or is the finger of responsibility often pointed at another department or professional group or at issues considered to be beyond the person's control (for example, lack of resources or unreasonable expectations)?
- Do people make an effort to maintain the status quo rather than introduce new work processes or technologies, even when changes might improve patient safety?
- Are practitioners willing to discuss the shortcomings of their patient care practices freely, or do they have a "bad things happen elsewhere, not here" attitude?
- Can you recall the last time a member of the leadership team openly admitted making a mistake and then shared with others what they'd learned from this mistake?
- Are people quick to protect their department or professional group from criticism, even when high priorities for improvement have been identified?
- Do people spend more time discounting the reliability of comparative performance data than they do analyzing how the organization's processes can be improved?
- Are people satisfied with being just "good enough?" Are improvement actions reserved only for those situations in which your organization's performance exceeds two standard deviations of the average performance reported by other facilities?

Analysis is useless without action

Many hospitals are using more detailed staff questionnaires to gather information about the cultural factors affecting patient safety. Data analysis, however, will do nothing to change the culture if it is not followed by actions. It is the responsibility of management to initiate efforts to minimize and manage fear. There are no examples of organizationwide cultural changes that originated from the bottom of the organization. This is because only top management can make policy or establish the set of core values for the organization. To minimize and manage fear, leaders must create an environment where employees can share patient safety information without fear of repercussion.

Leaders must respond quickly to employees'

patient safety concerns and ideas. A lack of response sends the message that nothing here will change. A quick response is the best incentive to ensure people will continue to communicate their concerns and thoughts regarding better ways to do things. Leaders must reward cooperation and innovation. They must reward efforts as well as outcomes.

Organizational fear will diminish as employees develop confidence and trust in the leaders' commitment to patient safety. Creating trust is not easy. Trust takes many years to build and just one act to destroy. People must be confident that unintended mistakes will not result in repercussions to them or others and that their improvement ideas will be dealt with responsibly and not be rejected without careful consideration. In general, patients are safer in an environment where trust is high and communication is open and honest. On the other hand, low trust leads to employee uncertainty and defensive behaviors that negatively affect patient safety.

In the spirit of building trust, senior leaders and managers must share their mistakes with others as a signal that mistakes are considered opportunities for learning. In addition to questioning staff members and observing signs of fear, management should take the lead on speaking up about fear. Broaching the subject of fear informally (e.g., sharing with others one's personal experiences of failure) plants the seed that it is OK to talk about mistakes and unsafe practices and the fears surrounding these types of situations. Leaders can set the tone by being skeptical when no mistakes are reported. Lack of information about unsafe practices may be a sign of fear in the workplace. Managers should not kill the messengers; better yet, messengers should be rewarded. When people do speak up about patient safety concerns, leaders must listen and collect data before passing judgment on employees' suggestions and actions. It takes patience and understanding to manage fear.

Don't expect dramatic results when attempting to minimize and manage fear. There are no quick fixes, and serious efforts to reduce debilitating organizational fear must be continual.

CE *questions*

13. Which is a key recommendation of a National Patient Safety Goal requiring that medications be reconciled across the continuum of care?
    A. Electronic medical records cannot be used to comply.
    B. The goal only applies to inpatients.
    C. Once patients are transferred, the requirement no longer applies.
    D. You must document a complete list of the patient's current medications.

14. What is the primary reason that a bar-coding requirement was not included in the 2005 National Patient Safety Goals?
    A. Patient safety experts claim that bar coding is ineffective.
    B. Organizations have already implemented alternative autoidentification systems.
    C. New and emerging technologies will likely be more efficient and effective than bar coding.
    D. There is a concern that bar coding may increase medication errors.

15. Which is a requirement of the Medicare Conditions of Participation?
    A. Written information must be provided to each patient regarding his or her right to make decisions about medical care.
    B. Information must be provided to patients about their rights, but it doesn't have to be in writing.
    C. Written information about patient's rights must be provided, but only for inpatients.
    D. If patients are transferred, no written information about their rights needs to be given.

16. Which is recommended regarding measures of success?
    A. Select a specific and focused measure.
    B. Attempt to measure multiple things at once.
    C. Collect information about two or more elements.
    D. Data always should be collected at the point of care.

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

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Incremental progress, though it may seem to take forever, is how a climate of trust is established. The benefits of managing fear are many — improved patient safety, lower staff turnover, lower absenteeism, and better communication and coordination among all employees. Less time and energy will be spent defending current practices, which will allow process improvement and innovation to flourish. ■

NEWS BRIEF

JCAHO panel to assist with cultural issues

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has appointed an expert panel to assist in a study of hospitals' efforts to address cultural and linguistic issues that affect patient care. The 2½-year study will attempt to identify best practices for providing culturally and linguistically appropriate care in hospitals, and could play a role in future JCAHO accreditation standards. The study will involve site visits to a sample of 60 hospitals starting in May 2005. ■

CE objectives

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