Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

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JCAHO and CMS to align quality measures: PI efforts will benefit

While action generally hailed, some point out potential pitfalls

In a move widely welcomed by health care quality professionals, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare & Medicaid Services (CMS) have signed an agreement to completely align current and future common Hospital Quality Measures in their condition-specific measure sets.

These measures are included in JCAHO's ORYX Core Measures and CMS' 7th Scope of Work Quality of Care Measures on heart attack, heart failure, pneumonia, and surgical infection prevention.

Both organizations have made available on their web sites a common measures specification manual, which includes a data dictionary, measure information forms, algorithms, and other technical support information. They are targeting full alignment of common measures by the time data for January patient discharges begin.

"This agreement moves us a lot further toward our common goal of having a standardized set of measures for inpatient hospital services," says **Trent Haywood**, MD, JD, CMS's acting deputy chief medical officer and acting director for the quality measurement and health assessment group.

"I truly think the benefit of getting a unified set of measures is

Key Points

- Quality measures cover heart attack, heart failure, pneumonia, and surgical infection prevention.
- Using common metrics, data definitions will strengthen comparative data efforts.
- Some are concerned that tracking could affect decisions concerning sicker patients.

that it makes it easier for all parties interested in the QI process to become meaningfully engaged," adds **Ken Anderson**, DO, MS, CPE, vice president of clinical effectiveness at Memorial Hospital and Health System in South Bend, IN.

A plus for comparative data

For quality professionals focusing on comparative data, this move clearly will yield big benefits, says **Robert G. Gift**, vice president of strategic planning and business development at Memorial Health Care System in Chattanooga, TN.

"From a comparative data perspective, it will be beneficial to have both of those groups on the same page, using the same metrics, counting things the same way, and using common data definitions for each of the things they are examining," he asserts.

Melissa Roden, vice president for performance management at Memorial, agrees.

"It allows for consistent data," she says. "Right now, with even a small difference in the indicators, depending on what you measure, you may have two different numbers to keep up with in terms of data source."

In addition, Gift says, "when you look at the comparative data, it gives you increased numbers in the sample, where the resultant benchmarks should carry with them greater credibility."

"For people who might do benchmarking," Haywood adds, "you need standardized performance measures. Providers in particular were concerned that by not having fully aligned benchmarks, it might be difficult [to be scored fairly] if the way you develop measures for scoring are different.

"Someone who scores well on JCAHO will now similarly score well on CMS; it's more of an apples-to-apples situation," he explains.

"We have long been looking for a set of indicators for which we will be held accountable to track, improve, and record so we can get a uniform set of benchmark standards," Anderson notes.

"We have historically had problems because of definitions, the ability to select from a listing of measures; it's been hard to find what the *real* benchmarks might be. The ability for CMS and JCAHO to say that *these* are the important measures allows us to really get enriched data, so our benchmarks are better," he says.

Overall QI efforts strengthened

The new JCAHO/CMS alignment will be broadly beneficial for quality improvement efforts, Anderson adds.

"From a provider perspective, when we hear from so many different, but important, sources that they'd like us to track, improve, and report upon a variety of discordant measures, there is little overlap," he notes.

"It thus becomes difficult for provider groups to focus their QI efforts. From a patient perspective, it is difficult for them to understand the nuances when they are not looking at apples to apples. Also, this gives greater power from the perspective of a national agenda to focus on and improve U.S. health care delivery," Anderson adds.

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Quality professionals now will be on the same page, he adds. "Quality professionals have a tendency to want to standardize as best we can. If we can't come to an agreement on a QI project or standards, it's difficult to determine what's most important for our own organization."

"The biggest difference for QI professionals is that this reduces their burden," Haywood asserts.

"Traditionally, they have been required to submit information to JCAHO, and similar information — but in a different process — to CMS. This makes their life easier; we'll both be asking for the same type of information in the same format," he points out.

This change will have long-range benefits as well, Haywood says. "The best thing for quality managers to do is to look at and understand the process we use, because that will be the process going forward," he advises.

"We may have 10 measures on the CMS web site today, but we will continue to build them out. However, the processes will be the same, so quality professionals will be able to anticipate how they will work," Haywood says.

Hidden dangers?

Despite his generally positive response to the JCAHO/CMS agreement, Anderson says he does have some concerns about individuals relying on the measures too heavily, or responding inappropriately.

"Here are some of the vulnerabilities: Not all hospitals are alike, and one of my fears is that in response to this standardized reporting methodology, some hospitals who have historically taken care of any and all patients with a given clinical condition may now focus on their indicator success, and by focusing so much on that, might be more selective in the patients they care for," he warns.

"If, for example, we are measured on how well we do with outcomes of MI [myocardial infarction], and if I know I am being tracked and reported on outcomes of MI, I may wish to take care of only those patients with fairly standard, garden-variety heart attacks. Then, what happens with the others?" Anderson asks.

He sees a challenge at his own facility in terms of stroke data. "We are a referral center, so we see complicated stroke patients in fairly large numbers," he notes.

"A cursory glance at outcomes may indicate we are not as good as we really are." That makes it all the more important, Anderson stresses, to make sure your definitions are very clear, that people have the opportunity to look at their cohorts of patients, and in a meaningful way, explain to the public that these patients may be able to be stratified so they can look at the differences between patient cohorts.

He sees still another potential problem area. "On the current CMS national volunteer reporting, you do not necessarily have to report on all indicators, so you may not elect to report on those that are not good for you.

"Consequently, the group that you included so that you were in the top 10 percentile may be a cohort smaller than the universe of possible reporting institutions," Anderson notes.

"If there are 6,000 hospitals and only 3,000 choose to report on MI data, and if you are in the top 10 percentile, that's really good, but it *also* may be good to be in the top 50 percentile because those who were not reporting were not good, so you could *really* be in the top 20%," he explains.

"This is a nuance that is sometimes difficult for

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the public to grasp," Anderson points out.

Gift, however, does not share all of Anderson's concerns.

"Seeking greater commonality around the data should eliminate a lot of that uniqueness [among hospitals]," he says.

"One of the chief barriers in benchmarking is that we *are* different — the degree to which we can have common data eliminates a lot of that artificial difference," Gift continues.

However, there may be those instances in which benchmarks potentially could be misleading, he concedes.

"For example, if you look at mortality or LOS numbers for the Medicare population, they may be substantively different than those for non-Medicare," Gift points out. But in such cases, "you just need to keep that in mind — which goes back to the data definitions you are looking at." ■

MPEGs deliver message in patient safety program

Army medical center program takes award

A distance-learning patient safety improvement program developed at Brooke Army Medical Center in San Antonio by Maj. **Danny Jaghab**, MS, RD, LD, has won a prestigious John M. Eisenberg Patient Safety and Quality Award.

The award, which is presented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Quality Forum (NQF), was given for "Innovation in Patient Safety and Quality at a National or Regional Level."

When described, the program seems fairly straightforward: It's a series of two- or three-minute MPEG video clips, each addressing an aspect of patient safety.

Key Points

- Video clips, each two to three minutes in length, address key goal or issue.
- All medical center staff were expected to embrace a culture of safety.
- Having commander endorse, introduce series proved an effective strategy.

But first looks can be deceiving.

"What Danny did was incredibly innovative in its approach, recognizing that one of the ways to capture people's attention is through video," says **Ann Halliday**, RN, MSN, CPHQ, chief of the department of quality services at Brooke.

"He made maximum use of the video clips only two or three minutes in length, sent forth a very succinct message, and left people with education that they could immediately implement," she says.

That was particularly important at Brooke, which has a large (2,500) medical center staff, all of whom were expected to embrace safety.

Those staff included housekeeping, lab techs, physicians, nurses, and the dietary department, Halliday explains.

"One of the challenges was how to reach out in an efficient manner to educate our staff on critical principals," she adds.

Using MPEGs to communicate

Jaghab, who currently is nutrition staff officer at the U.S. Army Center for Health Promotion and Preventive Medicine in Maryland, previously had used MPEGs to encourage the consumption of vital minerals by eating colorful fruits and vegetables, and it was very successful.

The impetus for this program came from a meeting at JCAHO headquarters.

"I had heard about the new [2003] patient safety goals coming up and had gone to a JCAHO session," he recalls. "We were also preparing for a survey. I had a real passion for the goals and how we could better educate our staff."

Jaghab's idea was to put together an MPEG series on patient safety and create a distance-learning program to keep on the intranet and e-mail out to all staff.

There are 34 videos in all; Jaghab wrote the script, which was broken into three parts:

1. Root causes of sentinel events and their relationship to the various patient safety goals.
2. Risk factors and risk-reduction strategies pertaining to each goal.
3. Brooke Army Medical Center guidance (medical command's guidance) on how the goal should be approached.

Participants simply go to the web site, select a viewer, and scroll down to the topic of their choosing. **(For the web sites, see information box, p. 125.)**

Once he had written the first script, Jaghab

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For MPEG Links, go to:

- **AMEDD Center and School Knowledge Management web site:** E-Learning section https://ke.army.mil/jcaho/index.php.
- **DoD Patient Safety web site:** www.qmo.amedd.army.mil/ptsafety/pts.htm. Click on NPSG MPEGs.
- **MEDCOM web site:** https://patientsafety.satx.disa.mil/.

went to Col. Laura Kostner, RD, and showed it to her. She was enthusiastic and suggested he partner with quality services and patient safety. Then, after getting the go-ahead, he sent out a link to the program by e-mail.

After clicking the link, participants saw a message from Gen. Fox, the commander, asking them to watch the videos.

"We also had endorsements from key leaders, staff, and civilians, such as the Air Force chief of surgery to introduce the video on wrong-site surgery," Jaghab notes.

A similar approach would work with a hospital, he asserts. "You need someone from above to endorse it; that means something."

Individuals who completed the program received a certificate, which in turn went into their credentialing folders.

Success undeniable

When JCAHO surveyors came to survey the facility, "they complimented us on the program, and shared it with the medical command of the Department of Defense (DoD)," Jaghab explains. In fact, it is now on the DoD patient safety web site.

"It served two purposes," Halliday adds. "Its primary purpose was to enhance our patient safety program. And second, not insignificantly, was to help us prepare for the JCAHO survey."

How did they do? "We have a patient safety committee that monitors staff member compliance with patient safety goals," she explains. "And we found that as these clips were released to staff members that compliance with those goals was remarkable. It was new, innovative, and easy."

As for the survey, "We were excellent; we did really well," Halliday says. "Our surveyors were as excited at our innovation as our own staff was." ■

PASTE plus teams at core of award-winning program

Safety initiative identifies four key subprocesses

A medication safety improvement initiative at Heartland Health in St. Joseph, MO, employed a structure centered around PASTE plus teams and four key subprocesses to achieve significant process improvement and earn the Missouri Team Quality Award.

PASTE (problem analysis solution transition and evaluation) is a customized version of the DMAIC (define, measure, analyze, improve, control) model common to Six Sigma projects.

"We use it for all of our quality initiatives," says **David B. Lloyd**, RN, MBA, service leader for clinical services. "Plus, we brought in additional Six Sigma tools."

The four subprocesses were:

1. **ordering** the meds (which involved mainly physicians);
2. **transcription** into the computer systems;

Key Points

- PASTE is a customized version of the Six Sigma DMAIC model.
- Best practices should not be taken at face value; you must have your own data to analyze.
- Develop a specific measurement plan for each project to accurately determine level of success.

3. **dispensing** (pharmacy);
4. **administration** (nursing).

"We used the PASTE plus teams for all but dispensing," says Lloyd. "When we looked at our internal data [on errors], dispensing ranks very low; pharmacy tends to have their act together."

He adds that subprocesses make sense, because you easily can get bogged down in projects with a bigger focus.

The award-winning initiative, which used 2002 as a baseline year, was preceded by several less successful attempts by Lloyd and his colleagues, which in turn all became part of a learning curve.

"In 1997, I was on a med/surg unit, and my boss told me to go out and do a quality project," he recalls.

He decided to look at wrong meds, and "took a few initial stabs," but realized he did not have good internal information. "We could not even get information on how many doses the unit gave every month," Lloyd explains, thus underscoring lesson No. 1.

Subsequently, he followed best practices in the literature from sources such as the Institute for Healthcare Improvement and the Healthcare Advisory Board, and "just went in and implemented, implemented, implemented." Lloyd notes:

"We did not argue with the best practices or measure if they were worthwhile; we just assumed they were good." Lesson No. 2: "Rather than take best practices at face value, we had to have our own data," he explains.

Each subprocess team was distinct, both in composition and goals. There also was another team that looked at the larger process, just tracking and measuring adverse drug events. Even this was a departure from the past, including a switch from a punitive to a nonpunitive report system.

"We streamlined [reporting] from a big, full piece of paper with check boxes to an orange 5" x 7" card that asked for very basic information," Lloyd notes. **(See example, below.)**

"We also put a dedicated nurse on as our medical safety nurse. All cards get put through her to be tracked and trended and root cause determined, and then put into a sophisticated database we built," he adds.

The order subprocess team was very unusual, since it was physician-driven, Lloyd notes. "We had about 11 physicians — including surgeons, GPs, specialists — and they took it very seriously, providing good suggestions and solutions," he continues.

"One that was very helpful was a revamped order form. It has a table built into it, which prompts you to put in a drug name, dose, route time, and PRN indications, which have really helped a lot," Lloyd adds.

The form ensured all required elements were provided in order, and have driven compliance upward, he reports. "There has been a 78% reduction in the number of adverse drug events related to ordering," LLoyd declares.

The transcription team engendered a huge process change, including a severely streamlined new pharmacy information system.

"In the past, a single order had to be entered into two systems, neither of which talked to each other," Lloyd says.

"This system takes things out of the hands of

Adverse Drug Event Report Card

What to report: Any occurrence during the medication use process that could or did cause an adverse event.

Patient name:_____ Room #: _____ Date: _____ Time: _____

Drug: _____ Concerns:_____

Person submitting:_____ Dept. phone/ext./pager: _____

"When in doubt, fill it out."

Please drop in the designated box on your unit or fax to 555-1234.

Contact Jane Jones with questions. Phone: 555-5678. Pager: 44-5577.

Source: Heartland Health, St. Joseph, MO.

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the secretarial staff and interfaces back to the nursing system, which creates the MAR [medication administration record]," he explains. The results: a 64% reduction in errors.

Administration "did not quite hit our goal," says Lloyd, while noting that his team had set tenfold stretch goals. They *did* achieve a 34% reduction, however. The No. 1 solutions? "The nursing staff were heavily involved in the report process," he adds.

"They created standard processes, changed training, tools, and references through standardization, which was significant," Lloyd says.

In addition, there was a change in the MAR and labeling on meds, and increased utilization of preprinted order sets.

"The new ones were vetted through nurses and physicians to make sure they were concise and clear," Lloyd explains.

"As we move forward with a complete move to CPOE [computerized physician order entry] in the next two to three years, these order sets will move right into it." At present, there are some 300 already in use, he notes.

The area of dispensing, which had no subprocess team, still saw a 17% improvement due to various internal PI efforts, including streamlining processes and training staff.

Measurement also critical

All reports now come in through the voluntary reporting system and are put within two large categories: actual adverse events (those that touch patients) and potential adverse drug events.

"This includes anything in the chain of activity like illegible writing, mislabeled but caught, and so on; we still want to know that," says Lloyd. "We drill into it — why it occurred, and how we can prevent it from ever happen again. Our goal is to push the error farther away from the patient; it's a very beneficial learning."

But his staff's biggest learning, he adds, is: "The better your measurements, the more validation you get for your work. "But it is also very hard to do and tends to evolve over time."

Over time, then, the staff learned how to measure results and relate those results back to expenses, Lloyd explains. "You have to be very precise; our accounting personnel were quite helpful in designing the measurements so they were realistic."

"We can now empirically measure how we make a difference, which is so much better than saying, 'I feel we are making a difference,'" he points out.

Still, LLoyd says, dollars are nothing more or less than a positive side benefit of improving quality. "Your focus should always be on providing better, safer care for patients and achieving optimal outcomes at an earlier date," he asserts.

TQM, Lloyd concedes, is hard work, "but if you take a structured approach to it, it *does* work, and you can get the gains you're looking for," he concludes. ■

CA hospitals continue closing: A quality crisis?

Some factors may spread across the nation

With at least eight California hospitals closed in 2004 and more closings expected before year's end, the nation's quality managers could not be blamed for hoping that this time the adage that "Everything starts in California" does not prove true.

In fact, there are some California-specific issues involved in this disturbing trend, but that doesn't necessarily mean the problem will remain isolated on the West Coast.

"In the past two years, our cost of providing quality services increased 23%, but payments

Key Points

- The trend of hospital closings, now at eight, is expected to continue for the rest of the year.
- Uninsured patients, unfunded mandates are among key causes behind closings.
- Organization estimates more than half of all hospitals in California are operating in the red.

for those services increased only 4%," notes **Jan Emerson**, a spokeswoman for the California Healthcare Association. "Hospitals in California have reached a tipping point."

She identifies key causes for the closings:

- **An unrelenting number of uninsured patients.**

In fact, one in five patients seen in the state is uninsured. "In 2003, hospitals spent $5.1 billion in uncompensated care — uninsured and [underinsured] Medicaid patients," Emerson explains.

- **Unfunded state mandates.**

There are two major unfunded mandates in California: A new nurse-to-patient ratio law, which took effect in January, and a state law addressing the retrofitting of hospital buildings to meet seismic standards.

"According to the state, it will cost an additional $1 billion per year in salaries and benefits to meet the staffing ratios, and $24 billion to meet the earthquake requirements, which take effect in three years," she notes.

"That's more than the depreciated value of all the hospitals in California."

- **Medicaid reimbursement.**

"California ranks dead last," Emerson asserts. "For example, New York pays $7,600 per Medicaid enrollee; Medical pays $2,069. The environment in California can't continue to operate as is and expect to have hospitals stay open."

What, us worry?

That may be true, but are there any issues in play in California that should concern quality managers in other states? "Yes, other than the earthquake requirements, and Medicaid in certain states," she says. "Uninsured patients is certainly a national issue, and as for nurse-to-patient ratios, unions are trying to take this across the country."

How do these ratios affect hospitals? First of all, the ratios vary between units, Emerson explains.

For example, in California emergency departments, the ratio is one nurse to every four patients. In trauma centers, it's 1-to-1; in med/surg, it's 1-to-6, which may drop to 1-to-5 in January.

"Conceptually, you'd think more nurses means better patient care, but if you do not have enough nurses in the work force, you run into the exact opposite of what you intended," she says.

"There are not enough nurses in California; you have to hire out-of-state travelers nurses, who are not part of the staff, and who don't know the culture." **(For more on quality issues related to nurses who are not part of permanent staff, see *Healthcare Benchmarks and Quality Improvement*, October 2004, p. 109.)**

Emerson says California hospitals would love to have all their shifts covered by on-staff nurses — it's less expensive, and the quality of care is superior.

"But quality care requires that we have enough staff, and we have the worst nursing shortage in the country," she adds.

That's not the only impact these trends are having on quality, Emerson continues. "If you are barely keeping your doors open — an estimated 51% of all hospitals in California are operating in the red — it's hard to focus on quality," she asserts. "A lot of quality involves investing in new technology, for example."

Quality professionals in California, she says, are doing the best they can by seeking creative solutions, "but what we are facing is beyond what any individual in a hospital or a system can solve; these are public policy issues and public money issues," she emphasizes.

"We are now where the meltdown is happening, but if some broader public discussions are not held and serious discussions about getting people coverage are not held, this will affect every single state in the country," Emerson adds. ■

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WebM&M teaches by example with case studies

Site draws quality managers, safety professionals

"One of the great challenges in the whole world of quality and patient safety is learning to take advantage of the richness of clinical cases," says **Robert M. Wachter**, MD, professor and associate chairman in the department of

medicine at the University of California, San Francisco (UCSF) and chief of the medical service at UCSF Medical Center.

"It's a great challenge whether you are a doctor, nurse, risk manager, quality leader, hospital CEO, or a therapist," he says.

Wachter says he is beginning to believe that AHRQ WebM&M (http://webmm.ahrq. gov), an on-line journal (of which he is the editor) and forum on patient safety and health care quality sponsored by the Agency for Healthcare Research & Quality, is accomplishing just that.

Launched early 2003, WebM&M features:

- expert analysis of medical errors reported anonymously by readers;
- interactive learning modules on patient safety ("Spotlight Cases");
- forums for on-line discussion.

"It's grown incrementally over time, exceeding expectations," says Wachter, who notes that there are about 7,500 registered users and 700 unique visitors to the site daily. What's more, he notes, the average visitor stays on site for 12 minutes, "so it's likely they're reading the information," he observes."

This seems to indicate the site has achieved one of its primary goals, which was to make its case commentaries relatively brief and nearly jargon-free. "We did not want it to feel plodding and academic," Wachter explains.

Patrice Spath, of Brown-Spath & Associates in Forest Grove, OR, also is impressed with the site. "What makes it different from many other health care-related web sites is that this one is specific to what the health care professional needs to do to improve patient safety," says Spath, who serves on WebM&M's advisory board.

"It is constantly updated with new ideas, and has a high caliber of advisors. Also, there's a very systematic, scientific analysis of the incidents they present — not just random commentary," she continues.

A tremendous epiphany

In numerous discussions with health care professionals, Wachter had noted a common theme.

"What I would hear as we'd go from hospital to hospital is something like this: 'We had this particularly troubling and interesting case, but we can't even figure out how to get the information to our other units or departments,'" he recalls.

"AHRQ's and our epiphany was that there is a tremendous richness in clinical cases, but no one had figured out a way to present them as real, and in a manner that was accessible, lively, and useful. I honestly don't think anyone else does it," Wachter explains.

By using the web interface, people can send the site cases anonymously from anywhere in the world, he notes.

"Through AHRQ's resources, we are able to compensate case submitters, which gives them an incentive to submit and enables us to engage the world's experts," Wachter says.

So, for example, if a case is submitted on a medication error, or on wrong-site surgery, when staff consider who the best person would be to provide expert discussion and commentary, they usually can get them. "Plus, we have a strong editorial team, and all cases read well and in an interesting way," Wachter adds.

"We work hard with the authors to be sure they are as engaging, as practical, and as interesting as possible," he says.

Quality managers taking advantage

While WebM&M originally was oriented toward physicians, a survey this past May indicated the following breakdown: 24% were nurses; 21% were physicians; 4% were pharmacists; 11% were health care administration/managers; and 32% fell into a broad category that included quality managers, risk managers, systems engineers, and ethicists.

"It was equally split between providers and nonproviders," Wachter notes. When asked to rate the educational value of the site, 75% of the respondents rated it as "excellent."

There are many ways quality managers can and should use the site to improve performance, Wachter says.

"For one thing, this field is so broad I don't think anyone knows *all* they need to know," he asserts. "The average quality manager or leader or risk manager will learn from the site because the cases we've posted range from psychiatry to surgery and safety problems, and from wrong-site surgery to errors related to implementation of IT to cognitive psychology and teamwork."

Just as importantly, Wachter says, it can be used to spread education across hospital silos.

"Many [quality managers] have taken to sending an issue or an individual case and mailing the web link to a doctor or nurse on the patient safety committee, because they believe they can learn

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from it," he notes. "Then, somebody who might not have gotten the journal might pick it up and then be hooked."

Each month, he explains, there is a "spotlight case" presented with a PowerPoint slide set. "Many people use that as a way of starting each month's quality or patient safety meeting; if you're looking for teaching materials, we've done some of the work for you."

'Could this happen here?'

Spath agrees. "There are two ways quality managers can use this site. First, they can download the PowerPoint from the feature case and use it at patient safety committee meetings, staff meetings, and so forth as a learning tool. But perhaps a more powerful way of using it is something I've been teaching people to do, which is a technique called, 'Could this happen here?'" she points out.

The technique works like this: The case is reviewed and discussed, and group members are asked whether a similar event could occur in their organization. "If the answer is that it could, you then ask what would have to go wrong for it to happen," Spath continues.

The response itself tells her a lot about the culture of an organization, she explains.

"If people look at the case and say it could *never* happen, that tells me they are not willing to admit that mistakes can happen, which is a significant culture problem," Spath says.

Using a case from another facility has an additional advantage, Spath explains: It takes known faces and names out of the equation, allowing staff to talk about problems they have a little more objectively.

"If you say, 'Here's what happened because of an error by Nurse B,' that puts a face and personalities to the incident, and you can't get past that to talk about underlying system issues," Spath observes.

"In this method, people do not feel so threatened, and therefore, they don't feel the need to try and protect themselves," she says.

Once the potential for error is identified (what would have to go wrong), the next step is to show how it can be kept from going wrong, Spath adds.

"That leads to process improvement," she asserts. "Because these incidents are presented in sufficient detail, it makes them even more valuable for a 'Could this happen here?' exercise."

"These cases hold lessons for individual institutions," Wachter concludes.

"Every one has an incident report, a root-cause analysis, and we're all struggling with the same problem — how to take the power that lies in individual cases and get it to the diverse group of people that need to know about it," he adds.

(Editor's note: In future issues of Healthcare Benchmarks and Quality Improvement*, we will be reporting on individual PI projects undertaken by quality managers after reading case reports at WebM&M.)* ■

AHRQ issues guide for emergency dispensing

A new planning guide funded by the Agency for Healthcare Research and Quality (AHRQ) is designed to help communities nationwide make sure that all Americans have needed drugs and vaccines in the event of a natural epidemic or bioterrorist attack.

Developed by a team of researchers in the department of public health at Weill Medical College of Cornell University and New York-Presbyterian Hospital led by **Nathaniel Hupert**, MD, MPH, the guide complements the Strategic National Stockpile guidebook prepared by the Centers for Disease Control and Prevention, which includes a chapter on dispensing medications and vaccines.

The new guide, *Community-Based Mass*

Prophylaxis: A Planning Guide for Public Health Preparedness, is designed to help state, county, and local officials meet federal requirements for a public health emergency.

The guide contains these features:

- Provides a framework for understanding the components of epidemic outbreak response (surveillance, stockpiling, distribution, dispensing, and follow-up care) and the planning and conduct of dispensing operations using specially designated dispensing clinics.
- Applies these concepts to develop model pill-dispensing and vaccination clinics run on the Bioterrorism and Epidemic Outbreak Model (BERM), a computer staffing model also developed by Hupert and his colleagues at Weill Cornell under contract to AHRQ that can be customized to meet local community needs, which discusses implementation of a command and control framework for dispensing clinics based on the CDC's National Incident Management System.

The guide can be found at www.ahrq.gov/research/cbmprophyl/cbmpro.htm. Printed copies are available by contacting AHRQ's Publications Clearinghouse at (800) 358-9295 or by sending an e-mail to ahrqpubs@ahrq.gov. ■

Study: ACE inhibitor drugs are underused

Almost one-third of heart failure patients face an increased risk of death because they do not receive an angiotensin-converting enzyme (ACE) inhibitor, according to a report in the Aug. 3, 2004, rapid-access issue of *Circulation: Journal of the American Heart Association*.

A review of data from the Centers from Medicare & Medicaid Services' (CMS) National Heart Care Project showed that 32% of elderly heart failure patients were discharged from hospitals without prescriptions for ACE inhibitors.

Patients discharged without anti-angiotensin therapy had a 14% greater risk of dying within a year compared to patients treated with ACE inhibitors.

The use of angiotensin receptor blockers (ARBs), an alternative to ACE inhibitors in some patients with heart failure, did not explain the low rates of appropriate therapy.

Overall, 68% of the patients had prescriptions for ACE inhibitors upon hospital discharge.

The proportion of patients treated with ACE inhibitors was 69% during 1998/1999 and 67% between 2000 and 2001.

When ACE inhibitors and ARBs were considered together, 78% of patients had prescriptions at hospital discharge. ▼

CDC: Not enough children receive flu vaccine

The Centers for Disease Control and Prevention (CDC) is warning that more children need to receive the flu vaccine than have received it in the past.

According to the CDC, only 4.4% of U.S. children ages 6 months to 23 months were fully vaccinated against influenza during the 2002-2003 influenza season, and only 7.4% received at least one dose of the vaccine.

"Too few young children are protected against influenza, which for this age group, can be a very serious illness," notes CDC director **Julie Gerberding**, MD.

"This season, CDC not only encourages flu shots for young children, we recommend them," she adds.

COMING IN FUTURE MONTHS

- How call panels can improve staffing levels and improve patient flow
- Achieving physician buy-in for quality improvement efforts
- Premier launches web site on fall prevention for residents of nursing homes
- Commonwealth Fund identifies key attributes of successful community partnerships

To be fully vaccinated, previously unvaccinated children should receive two doses, according to the CDC. Children who have received any dose of flu vaccine in previous years require only one annual dose.

To get more information from the CDC report, go to: www.cdc.gov/od/oc/media/pressrel/r040923.htm.

To access a related article, including state coverage rates, go to: www.cdc.gov/mmwr/preview/mmwrhtml/mm5337a1.htm. ■

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