Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

THOMSON AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

DECEMBER 2004
VOL. 11, NO. 12 • (pages 133-144)

Flu vaccine shortage creates ethical issues, safety challenges

Quality managers on interdisciplinary committees make hard choices

Even though the flu vaccine shortage has yet to have an impact in terms of an anticipated surge of patients, quality managers and other hospital professionals already are feeling its effects. Tough decisions are being made every day, and they're not always restricted to patient and staff safety issues.

"We had a powerful and positive decision to make in terms of ethics," says **Janna Hoff**, RN, BSN, MSA, director of quality management at William Beaumont Hospital in Troy, MI. Like many hospitals across the country, William Beaumont found itself short of flu vaccines, but its situation was unique.

"We were 400 doses short," she says. "We had earmarked for patients the shots that were coming from Chiron [the manufacturer whose vaccines were recalled], and those for employees were from another [manufacturer]." The result: There was an adequate supply for staff but only 50 shots for patients. "That was a huge rub," Hoff explains.

St. Vincent Medical Center in Portland, OR, faced another ethical dilemma, reports **Nancy Church**, RN, BSN, CIFC, infection control manager.

"The ethical question is: What if we have more patients arrive than we have space for, and then we get more from the area nursing homes? On any given day, if we have 50 extra people come in,

Key Points

- Decisions may have to be made as to whether staff or patients get priority.
- Centers for Disease Control and Prevention guidelines help ease choices when it comes to inoculating workers.
- Quality professionals should be aware of the legal implications of their decisions.

we will have a world of hurt; we won't have enough available staff or beds for the patients," she explains.

The other ethical challenge Church faced, she adds, were which patients and staff to immunize first, given the shortage.

Decision made by committee

In the quality department at William Beaumont, patient safety is part of the quality committee. So, in facing the ethical dilemma posed by the shortage, "We wanted to ensure the highest-risk people received immunization," Hoff explains.

"We sat down with employee health, inpatient services, nursing, and our infection control physician and hammered out an agreement on an initial allocation of these shots. We took a look at what we anticipated for use, generously thought what we would need for patients and put that aside, then took the remainder and assessed its use for staff," she continues. "We further agreed that in a month we would look at what we had left."

It was, Hoff says, "a total struggle every step of the way," with employee health, for example, arguing for more employee doses so there would be adequate staff available to treat patients.

In terms of patient care, the vaccine slush fund, she notes, "is the best part of what we did. It's a variable pot, so if we have a real influx of patients, we would move it over to the patient side. This variable pot of doses helped us be responsive to those who needed the vaccine the most."

Part of the response at Providence was aimed at avoiding the necessity of making those tough ethical decisions.

"We were not planning to [immunize] patients here, but we did have a plan to do employees," Hoff explains. "Last year, we gave over 2,300 doses; this year, we started out with 750, which has increased slightly since. Still, we are also trying to get some out to high-risk areas like nursing homes."

If the potential influx of such patients is not curtailed to some degree, she notes, "we may have to triage them to comfort care, since there are only so many people we can hold. That's why, after setting up a meeting with our intensivists, we decided to try to get to those pockets first."

An ethicist sat on the Providence committee that determined exactly how the scant supply would be apportioned, Church says.

"Some doses were sent off right away to high-risk areas — we identified clinics where they treat HIV patients, and a bunch went to dialysis patients, so we *are* immunizing patients who don't belong to us," she points out. "We're keeping a list of those facilities who call in and say they do not have any for their high-risk patients, such as the homebound and nursing home patients."

The committee approach to such issues makes sense, says **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting in Metamora, MI.

"It should be a collaborative event with infection control and patient safety both involved," she asserts.

Providence also is making some vaccines available for outside specialists, such as neonatologists,

Healthcare Benchmarks and Quality Improvement (ISSN# 1541-1052) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid in Atlanta, GA 30304. USPS# 0012-967. POSTMASTER: Send address changes to **Healthcare Benchmarks and Quality Improvement**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. Hours of operation: 8:30-6 Monday-Thursday, 8:30-4:30 Friday, EST.

Subscription rates: U.S.A., one year (12 issues), $539. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $87 each. (GST registration number R128870672.)

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Church says. "We want to make sure we have some services available; it is most critical to have the staff to care for the patients," she notes.

Homa-Lowry adds that, in terms of those patients who are in the hospital, "You should have a way in the census to identify who would be at higher risk — the elderly or the young, those predisposed to respiratory conditions, and so on. You might also go to case management and to your physicians to examine comorbidities — and make sure the hospital is supportive of your decisions."

Who gets immunized?

This, in turn, leads to another dilemma: Which staff should be immunized? In addition to ethical and quality considerations, there is a set of guideline available from the Centers for Disease Control and Prevention (CDC) at www.cdc.gov/flu.

"We really stepped back to what the CDC was recommending — their revised guidelines — and this is what we are actually going to follow," says Hoff. "You can't make a better decision than them."

The key question to address is, "How do you define 'direct health care workers' who give hands-on patient care?" she notes. (Part of CDC's newest guidelines.)

"We said, 'If you are in close enough proximity that you can reach out and touch a patient three times a day, we consider you a direct caregiver,'" Hoff explains.

"We also instituted an immunization assessment form; we had to design it for our pneumonia core measure," she continues.

In light of the CDC's revised guidelines, the staff changed the assessment form to match the CDC criteria exactly. "We will start screening using the revised criteria until we run out," Hoff adds.

At Providence, the initial cut of immunized staff was the emergency department (ED) — people from 0.6 full-time equivalent (FTE) to one FTE. "We also immunized ED docs, nurse practitioners, and CNAs [certified nursing assistants] who would work there, as well as respiratory therapists, hospitalists, and the residents," says Church.

Any such method of prioritization is bound to create angst among the employees not chosen to receive the vaccine, she adds.

"We initially told them to get shots at local shopping centers, but some were unsuccessful, and then the state started putting restrictions on who could get it," Church notes.

"So, we got together with two other hospitals and defined the population to be immunized in the first two weeks." Now, all three hospitals in the Portland service area use the same guidelines. "This helps limit the anger of the employees," she adds.

According to Homa-Lowry, there's a legal limit as to how much you can really know about the conditions of individual employees.

In fact, while many of the important decisions will be made based on ethics, ultimately they probably will need to be blessed by your attorneys, she says.

"I know of a hospital where some of the people were able to get in and get the vaccine before the shortage, but they were nondirect health care workers," Homa-Lowry adds.

"It's almost more like a legal issue — how do you cut the number [of people getting the vaccine] down if there was a real need? I think it might involve a committee that really does not typically get used — the bioethics committee. But once a decision has been made there, it will probably need to be reviewed by the hospital legal team so it is not seen as a discriminatory process," she continues.

The best-laid plans . . .

Despite optimal planning, the bottom line is that the shortage remains, and at some point, there will be no more vaccines available. "We anticipate we'll be out in the middle of the season," Hoff predicts.

Is there anything else quality managers can do to minimize the impact of the shortage? Other preventive measures may help, she says.

"We immediately put an article in the hospital newsletter about the shortage, explaining the CDC criteria and other employees who would meet our criteria — such as an asthmatic nurse," Hoff says.

"But for patients or employees who can't get the shot, we provide tips to avoid influenza — hand washing, covering your mouth, respiratory hygiene, and so on. We stress to staff that if they are not in the high-risk group, they should just practice the avoidance techniques we've give them," she adds.

And beyond that?

"I get the feeling it may be a mild flu season, but we have a pandemic plan in place and would

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implement it if we needed to," Hoff notes.

"Who knows what kind of flu season we will have?" Church adds.

"If we have a big one, it will bring up a whole list of issues. We would have the ethicist there; at what point do you say, 'We will let *you* in, but we won't let *you* in? It's a decision *we* can't make," she points out.

Providence also is stressing respiratory etiquette to those staff not receiving the vaccine, including wearing masks and teaching patients to cough into tissues.

"We've got a big push all over the hospital and signage asking visitors who are ill [with the flu] not to come in," Church adds.

If it is a bad flu season, she continues, one important element will be missing.

"The National Guard is all in Iraq, and they are the most well-trained people," Church says. "They have the ability to run massive drills, and they could have been a huge resource for something like this." ■

Longitudinal records enable instant QI changes

Big difference in meds-related patient safety

A multifaceted system of electronic record keeping has enabled the quality staff at Evanston (IL) Northwestern Healthcare (ENH) to quickly identify and respond to improvement opportunities while also reducing the chances of medication errors.

ENH estimates the system will save the organization $10 million per year.

The ENH system integrates computerized physician order entry (CPOE) with electronic medical records, so all charting of patients, ordering of tests, procedures, medications, registration, scheduling, and physician billing are done electronically through one system.

"It creates a longitudinal patient record, which is very powerful," says **Peggy King**, RN, CHE, senior vice president of quality initiatives.

"Continuity of care is inescapable. The patient information from prior visits to our organization is available to subsequent treaters, and all results from our lab, radiology, and cardiology systems appear in Epic [the computerized system created by Epic Systems Corp., Madison, WI]," she explains.

"We still have departmental systems," notes **Tom Smith**, CIO. "They also feed data back to Epic."

In recognition of the system's effectiveness, ENH was named the sole winner of the 2004 HIMSS (Healthcare Information and Management Systems Society) Nicholas E. Davies Award of Excellence for Healthcare Organizations.

Thinking big works

ENH considered such a system several years ago, Smith notes, but the quality of available software "was insufficient for patient safety or for improving the work environment for docs and nurses. Finally, Epic created a system for large physician groups and decided to move into the hospital market."

As HIMSS noted in presenting the award, the system was rolled out successfully in the system's three hospitals in fewer than 18 months.

"The key was, once the decision was made, we had complete top-down support and prioritization, and it was the major strategic focus at all levels of the organization," King explains.

"The breadth and scope at which we did it was

Key Points

- The system will save the hospital an estimated $10 million per year.
- Computerized physician order entry is integrated with other electronic records at the facility.
- A done-deal attitude by leadership gets staff on board in 18 months.

the only strategy you can have," she says.

"We did not go into this as a pilot or a 'maybe,' but as a done deal," Smith adds.

Just the process of installing the system had quality benefits, King notes. "We took the first six months with interdisciplinary teams involving everyone who contributes to patient care, to drill down and understand processes. I look at this as the organization's largest PI program ever."

The teams examined what was done in each unit; how it was done; identified the resources with which they did it and with whom they interacted to get the job done.

"We did a workflow analysis of current processes, laid Epic over it, and saw what was possible — how to eliminate nonessential redundancies, variations, and build to that workflow," King explains. "Once that was complete, then we started the systems analysis and retooling everywhere."

Of the three hospitals, two had been together 20 to 30 years, but the third had only joined the system in 2000, Smith notes.

"We had migrated them to our computer systems, and that certainly helped, but there were still a lot of different workarounds," he says.

"We also have 500 employee docs practicing in 65 office locations, and each of them did things a little differently. We now had the ability to get all of them to do the same thing, at least as much as possible; and in general, we now have one set of workflows," Smith explains.

"As it grows, we have the opportunity to build tools that are decision-support systems and can promote evidence-based medicine through order sets and plans of care," King adds. "Then the data accumulate, and we find ways to extract discreet data to see how we're doing."

Real-world benefits seen

The system already has demonstrated its value many times over. Take, for example, the recent recall of Vioxx. Within hours of the announcement, ENH built an alert into the patient record system that blocked new prescriptions or renewals for Vioxx, offered other medication options to physicians, and provided a link to the Food and Drug Administration press release.

Simultaneously, ENH identified any of its patients who had ever received a prescription of Vioxx, which amounted to more than 2,700 in the past 18 months. It sent each physician's office a list of their affected patients so the offices could proactively contact them.

Another example involved paradoxical reactions of patients to Dilaudid. "They had no lasting harm, but they were still unanticipated reactions," King says.

"We understood that the way physicians were ordering the drug did not necessarily take into account whether the patient had previous experience with [Dilaudid] or not, and might be more prone to some complications," she says.

So the committee came up with two different order sets — an opiate-naïve one vs. one for patients who had had the drug.

"We put it immediately into Epic, so it reminds the physician to take it into consideration and select the appropriate order set," King says.

When it came to the Joint Commission on Accreditation of Healthcare Organization's national patient safety goals, one of ENH's desires was to identify strategies to prevent deep vein thrombosis.

"Our multidiscipline team looked for ways to help prevent it, and they were very quickly able to load into Epic a risk-assessment tool the physician could fill out with admitting orders, and if the patient scored above a certain level, there were recommendations associated with different scores," King explains.

"Because you can load something like that overnight, the clinician can get to use it very quickly," she says.

Big savings projected

It was Smith who came up with the $10 million savings calculation. "We spent $30 million in capital money up front," he notes, "But the savings come about from a series of relatively small increments in individual departments."

Two-thirds of the savings are in personnel — not through downsizing, but through shifting workers when other positions were eliminated.

"For example, we no longer have to scan

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medical records into the documentation system, so five or six employees took other positions in medical records," King points out.

There also were big savings on the revenue side. "We either get the money faster, because we're not denied the first time, or the percentages of money collected more quickly are up, and so on," Smith adds. "We do a better job of checking addresses, so we save on returned mail," he says.

"Averted costs are difficult to quantify, but if you avoid a malpractice claim by not placing a decimal point incorrectly in the pharmacy, that can save you a lot of money," King notes. "You can make assumptions based on past experience and project it out."

In addition, she notes, having sophisticated clinical pathways embedded into the system guides clinicians to consistently hit evidence-based best practices, which is "very powerful. It really promotes dialogue and the advancement of care, and when you identify an opportunity for improvement, your ability to respond is almost instantaneous," King points out.

Finally, the paper chase is a thing of the past at ENH. "We basically have no charts in the hospital now," Smith adds. ■

Survey a launching pad for wide-ranging improvement

Despite buy-in, opportunities to improve identified

The performance improvement team at the M.D. Anderson Cancer Center in Houston has used an employee opinion survey as a guidepost to opportunities for improvement.

The ultimate result: an ongoing program called "Create Solutions" that has generated more than 150 PI projects to date. The survey, conducted about three years ago, was a first for the facility and generated a 60% response.

"We learned that everyone was really behind our mission and vision, but that there were still some opportunities for improvement," explains **Tina Smith**, MBA, manager of new programs for M.D. Anderson's Institute for Healthcare Excellence.

Each executive vice president in the organization was tasked with taking the survey and looking at those opportunities, she explains. "We report to the COO, and what we suggested to them was that under the COO umbrella, we take [the survey results] to the frontline employees and ask them what *their* suggestions were for improvement," Smith says.

Key Points

- Frontline employees were solicited for recommendations for improvement opportunities.
- Several teams were formed, with coaches and team leaders receiving training before starting projects.
- Project outlines and successes are shared through a database on the hospital intranet.

Creating the teams

To accomplish their goals, the frontline employees first had to be taught how to facilitate outcomes, she says.

"We formed teams of employees, chose team leaders, and taught them PDCA [plan-do-check-act]," Smith recalls. Training also included teaching team leaders and managers how to coach teams.

The charge to the teams was to work with leadership to focus on one question off the survey that affected their area the most.

"Then we would try to do an analysis around what caused that score to be where it was and pick one of *those* areas to run a quick-win team on," Smith explains. (Topics chosen varied from nursing orientation to communication, from patient flow to room utilization to building trust.)

Two initial rounds of these team projects were run — which generated "a lot of learning and growth," says **Duke Rohe**, systems improvement specialist. "From that grew a more formal program from January to September this year, which we ran at a higher level."

It began with communication with top-level executives in January, followed by kickoff meetings with midlevel managers in February.

"In March, we held a conference-style session for team leaders and managers, and there were about 175 participants," Rohe adds.

Having gone through two pilot programs, it had become clear that there was a wide variety of skill levels among the teams, so the learning sessions were separated into three class levels:

- **Level 1** is for those with the least amount of experience and knowledge.
- **Level 2** is for those with greater knowledge and experience.

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- **Level 3** is for the most advanced.

The four-hour session was kicked off by presentations from the COO and chief nursing officer, with a concluding keynote address by a physician who shared his thoughts on why he became a physician and what it meant for him to work at M.D. Anderson.

Once the teams were off and running, they had a growing body of knowledge upon which to draw; the round 1 and round 2 outcomes had been entered into a database, which they could access via the organization's Intranet to model, to brainstorm, and to benchmark.

"The database was originally set up two years ago and has evolved over time," Rohe says. "Its whole purpose is to be a proven practices database. You can, for example, do a key word search," he explains.

"You could also perform a search of any question from the survey," Smith adds. "You could see who else had worked on it and what they had done."

Rohe's goal is to have every improvement-related project entered into the database; at present, he says, there are about 175.

"There is also a virtual side," he adds. "If a team feels they want some hand-holding, I can sit there [at my computer] and ask, for example, if they have considered certain options. They can e-mail me a question, or I can view it myself and fire them off a note; it's also a great use of my time."

Hand in hand with this phase was a webcast, hosted by Rohe and Smith, that addressed key steps in Create Solutions:

- What is the project purpose?
- What are the main causes of the problem?
- What was the implementation plan?
- What was the baseline level of performance?
- What was the solution?
- How will you measure and maintain improvement?

"This included a team walk, where we'd go out and feature a team that did a particular step and what their experience was," Rohe relates.

Other sessions covered specific tools, such as cause-and-effect diagrams. "As we were coming up to our JCAHO survey, we sprinkled some of that in, too," he adds.

While the initiative still is in its infancy, Rohe says that so far, "It's been great." As of the summer, he notes, 105 projects had proven results — with the data to back them up.

While Create Solutions originally was designed for the employee survey response team, "We knew it would grow, and we would open it up to all PI projects," Smith notes.

"It could be services, safety — anything," Rohe concludes. ■

Strong collaboration sets QI program apart

Top performer bases compensation on quality

What sets one quality improvement program apart from all the others? To hear the staff at El Camino Hospital in Mountain View, CA, tell it, it's the unique relationship between the physicians and nurses.

"What makes us unique is an extremely strong collaborative quality program," says **Diana Russell,** RN, vice president of patient care services.

"We do not look at quality initiatives in silos but as an overarching program where physicians, nurses, and other caregivers regularly come together in monthly meetings to review the quality outcomes of their particular division or service," she adds.

El Camino, which is one of only four hospitals nationwide recently named as a "top performer" in a report from the Commonwealth

Key Points

- Quality initiatives are not viewed in silos, but in a global, hospitalwide framework.
- All new physicians must learn the computer system — and treat nurses with respect.
- Facility participates in as many state, regional, and national benchmark projects as possible.

Fund — *Hospital Quality: Ingredients for Success* — has a very strong physician/RN relationship, she continues.

"Nurses are highly respected by the physician staff and seen as co-caregivers," Russell notes. This, in turn, has led to a long-tenured nursing staff, and low vacancy and turnover rates.

When new physicians come on board, she says, there are two major expectations: "They must learn the computer system, and they must treat nurses with respect — and that comes from the other physicians. It is a very unique culture and environment."

Support from the top

Support from the highest levels of leadership also is evident. "When I came here four years ago, we already had a culture built around putting the patient first and delivering high quality," recalls **Lee Domanico**, El Camino's CEO.

"We proceeded to set up five areas in which we needed to be excellent — people, service, quality, growth, financial performance. Organizationwide goals were set, and we rated ourselves on how well we did; the employees rated from within," he explains.

Quality actually is part of the annual performance review for the entire executive team, says Domanico.

"It is one of five key indicators on which their compensation and performance review — and mine — are based," he adds, "And it is even more heavily weighted for Diana and the other people who work in quality."

El Camino participates in as many statewide, regional, and nationwide benchmarking studies as it can, Domanico continues.

"That's why the Commonwealth award was so significant; they compared us to 3,000 hospitals, and we came out as one of the four they chose to benchmark," he says.

Finally, Domanico notes, the hospital invests aggressively in technology. "We try to eliminate the chance someone will make a mistake, because technology won't allow a mistake to be made," he explains.

Another one of the hospital's strengths, adds **Chris Hunter**, RN, manager of clinical decision support (supporting quality efforts with data), is its 35 active clinical pathways, which have been in place 10-12 years.

"They really are part of the infrastructure, built into the process of care," he says. "We track and trend LOS [length of stay] and costs, as well as outcomes, and capture our gains. We have also reduced variation in care."

"Computerized care plans, critical paths, and protocols allow us to better standardize our care, and it gives us some advantages in terms of limiting variation," Domanico explains.

Putting it all to work

Over the years, El Camino has translated the aforementioned approaches into a number of quality successes.

One of the more recent examples is an effort to create a new alcohol withdrawal protocol. The multidisciplinary team includes nursing, respiratory therapy, physicians from critical care and behavioral health, chemical dependency professionals, care coordination, and general medical internists.

"We rolled it out a few months ago and have been able to demonstrate not only shorter LOS [from 4.4 to 3.4 days], but also less use of critical care, sitters, restraints, and decreased patient falls," Russell notes.

"When the team first got together, they felt if they did not decrease overall LOS, then at least they would seek to cut utilization of the CCU [critical care unit]," she recalls. "The driver behind it was to improve patient care."

"The team felt these patients that were treated with IV benzodiazepine tended be agitated and needed to be restrained or required sitters," Hunter adds, noting that the team ultimately decided to use oral benzodiazepine whenever possible, based on symptoms.

"I sat in on the initial meetings," Russell explains. "They had a very cooperative dialogue on how to achieve the best results. It was very evidence-based; they did the research, brought it back, and discussed it together. It was not just a case of physicians saying, 'Do this.'"

In addition to shorter LOS, use of restraints was reduced from 21% to 6%, and there also was a pretty clear-cut drop in falls as well, she points out.

Average cost per patient dropped from $4,170 to $1,755 from the 2002 baseline.

The medication administration team, which focused on reducing errors, has benefited from the introduction of new technology, Russell adds.

"It has really helped facilitate and achieved a reduction in medication errors," she points out. "We have CPOE [computerized physician order

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entry], first of all, which helps eliminate handwriting and abbreviation issues. Then, we have a Pyxis [from Cardinal Health] automated drug-dispensing system, which, combined with CPOE, has been able to reduce our time for pharmacist order verification significantly. And we're just getting started with bar coding."

In addition, Russell notes, last year El Camino converted to a new "smart" IV pump. "It can react with a higher alert level if the medication dosage is set out of range," she explains. ■

ED crisis presents a new set of quality challenges

Patient harm, delays in care major consequences

By its very nature and location, the emergency department (ED) inextricably is bound to the rest of the hospital; what occurs there has profound repercussions throughout the facility.

The same goes for what *doesn't* happen there, and what isn't happening today is adequate coverage by specialists — and sometimes even generalists — for patients in desperate need of immediate care.

According to a recent report from the Irving, TX-based American College of Emergency Physicians (ACEP), "The decrease in the number of medical specialists willing to be on call to the nation's emergency departments is a looming national health care crisis of supply and demand."[1]

There are myriad reasons, not the least of which is declining reimbursement and an increase in the number of underinsured and uninsured patients, but of greater concern for quality managers is the impact on patient care and safety.

In the ACEP study, respondents were asked to select the top three consequences of the shortages. No. 1 was "risk of harm to patients who needed specialist care."

"As you can well imagine, it sets off a cascade of events," notes **Art Gruen**, MD, FACEP, president and CEO of Emergency and Acute Care Medical Corp. (EA) in Rancho Santa Fe, CA, a management services organization that provides call panel compensation solutions to encourage specialist participation in ED call at client hospitals.

"If an emergency physicians spends 15 minutes making calls for a doctor to take care of a patient with a heart attack, that's 15 minutes he could have spent with the patient — not to mention the backlog of patients this creates.

"This cascade could actually end up shutting down the ED or preventing ambulances from delivering patients because of the backlog," he explains. "It can impair patient safety all the way down the line."

The type of care affected is virtually unlimited, adds **Brad Zlotnick**, MD, FACEP, a San Diego emergency physician and director of strategic development for EA.

"Even basic emergency services — i.e., general surgery, OB/GYN, cardiology, orthopedics — are often lacking or delayed," he asserts.

Clearly, not all emergency patients have life-threatening conditions, but they *all* need care — and fairly soon, stresses **Joe Smith**, EA's COO and former hospital CEO.

"The problem with the current system, where the on-call physician may not be compensated, is that if they are in their office, it detracts from their productivity to come see a patient," he observes. "If it's not a life-threatening emergency, their tendency is to say, 'I'll see them in the morning.' For a hospital, that's bad not only from a care point of view, but also from a PR point of view."

Ultimately, the impact may not be restricted to a given hospital, Gruen says.

Key Points

- Emergency department (ED) coverage crisis may affect not only specialist care but basic emergency services.
- Finances and lifestyle issues keep many specialists from covering the ED.
- Fee-for-service programs and stipends for physicians can provide a coverage incentive.

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"Let's say an internist admits a patient with gastrointestinal bleeding," he poses. "If a specialist is not available, there may be a longer LOS. This creates a bed shortage, which impacts the ED, which, in turn, impacts the health of the community."

EA has sought to find a solution to filling understaffed call panel rosters by creating a program that, among other things, assures physicians they will get paid fairly. Their strategies include:

- **Implementing fee-for-service programs:** When the physician provides a service, he or she receives a straight fee per unit of service (RVU or relative value unit). A hybrid model also is available, where a stipend pays for availability and the fee is based on actual services.
- **Paying physicians by stipend:** A flat fee can be guaranteed whether the physician is called or not.
- **Establishing regional calls panels:** Prearranged transfer agreements may be established among EA's hospital clients.
- **Providing specialized CPT on-call coding and billing expertise:** Twelve years' experience with proprietary productivity analyses and electronic information transfer support accurate, prompt coding, and specialist payment.

"The bottom line is we want to promote a situation whereby a specialist will agree to take care of a patient," Gruen says. The key issues, he notes, are finances and lifestyle. "As you can imagine, a doctor does not cherish getting up at 3 a.m., but if the compensation is adequate and guaranteed, they will support the mission of the hospital."

"Hospitals spend tremendous resources to improve quality of care, and that includes ED throughput," Zlotnick adds.

"Care and satisfaction are quality measures. What we try do is work with the hospital; we are a resource to them for a manageable, predictable way for compensating specialists," he adds.

Being able to participate in such a program is not restricted by hospital size or budget, Smith notes. "This program works effectively pretty much at all hospital sizes," he says. "We have systems where every specialty is covered, and others where only one, or two, or three are covered. It has to do with carefully evaluating what issues really need to be resolved. Hopefully, we'll find solutions that mitigate the toughest of their problems; as time moves on, you will see those hospitals that only have a few specialties covered will begin to cover everyone."

Finally, Zlotnick says, when hospitals try to solve these problems on their own, they bear the extra burden of ensuring compliance with the regulatory requirements of the Centers for Medicare & Medicaid Services, Stark self-referral laws, and the Emergency Medical Treatment and Labor Act (EMTALA), which, among other things, governs conditions under which emergency treatment is provided. "EA is compliant with all of these," he notes. "So a lot of the background work has already been done."

Reference

1. American College of Emergency Physicians. *On-Call Specialist Coverage in U.S. Emergency Departments. ACEP Survey of Emergency Department Directors.* Irving, TX; September 2004. Web site: www.acep.org. ■

NEWS BRIEFS

CBO: Jury still out on disease management

Insufficient evidence exists to prove that disease management programs can lower overall health care costs, concluded the Congressional Budget Office (CBO) in an Oct. 13, 2004, press release.

The CBO based its analysis, conducted at the request of Senate Budget Chairman Don Nickels

(R-OK), on a review of medical journal studies on disease management programs for congestive heart failure, coronary artery disease, and diabetes.

The CBO found that few studies directly addressed the costs of such programs, and those that did failed to capture all forms of health care spending, excluded administrative costs, did not consider the unintended consequences of intervention and were conducted in limited, controlled settings.

If applied to a broader population, the programs actually could increase health costs, the report said.

The CBO also found little evidence to address obstacles in translating disease management into savings for Medicare, including an older, sicker population and the current fee-for-service system. But in a letter prefacing the report, CBO director **Douglas Holtz-Eakin** pointed out that "such programs could be worthwhile even if they did not reduce costs." He also said the CBO will continue new research as it becomes available. ▼

Practice strategies don't affect diabetes care

A Harvard Medical School study has found that current practice management strategies and financial arrangements have a limited impact on the quality of care for patients with diabetes. Led by **Nancy L. Keating**, MD, researchers reviewed medical records of 652 diabetes patients enrolled in three health plans in Minnesota along with the 399 physicians in 135 practices who cared for them.

Researchers defined the main outcome measures by a quality score indicating receipt of care in accordance with six accepted quality indicators.

Only 5% of the variation in quality was attributed to characteristics of physicians' practices. Quality scores tended to be higher for patients whose physicians received quality performance reports or utilization profiles from more than one source, routinely enrolled diabetic patients in disease-management programs, or received diabetes-specific reports.

The study, *The Influence of Physicians' Practice Management Strategies and Financial Arrangements on Quality of Care Among Patients With Diabetes,* is available in the September issue of *Medical Care*, the journal of the American Public Health Association. ▼

New fall prevention web resources available

The Safety Institute of Premier Inc. has launched a publicly accessible, web-based clearinghouse of resources and tools for fall prevention to define

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- Studies validate decision to implement duty hour standards
- Evidence-based tools help identify undiagnosed diabetes patients

and measure falls, identify risks, and target prevention strategies among patients and residents. (Premier has offices in San Diego; Charlotte, NC; Oak Brook, IL; and Washington, DC.)

The Premier resources include:

- risk factor identification and evidence-based interventions;
- sample prevention programs with policies and procedures;
- tools for risk assessment, fall rate calculations, targeted interventions, and patient monitoring guidance;
- definitions, consensus standards, classifications from national organizations, and annotated references;
- national quality improvement and benchmarking initiatives;
- education and training programs, including presentation templates, case studies, fact sheets, and national guidelines;
- equipment or products designed to reduce risk of falls and/or back injuries.

The fall prevention module complements the Safety Institute's back injury prevention web module, a related issue for patient, resident, and worker safety. These web resources are part of the institute's web site on patient, worker, and environmental safety, which includes downloadable tools, resources, an on-line safety store, electronic newsletter, national safety conference proceedings, and more.

The information can be accessed free at: www.premierinc.com/safety. Click on "fall prevention module" or the worker safety icon for back injury and fall prevention resources. ▼

WHO starts global patient safety group

The World Health Organization (WHO) has launched Partners in the World Alliance for Patient Safety, an international partnership aimed at improving patient safety globally.

The new partnership, which will include the U.S. Department of Health and Human Services (HHS), will focus its efforts over the next two years on reducing health care-associated infections; ensuring consistent concepts, principles, and terminology in patient safety work; conducting research; and generating and promoting best practice guidelines.

The alliance plans to build on existing efforts in individual countries in an effort to decrease adverse events worldwide.

"We have seen much progress in the last five years, but we have a long way to go to ensure that health care services provided around the world are as safe as they can be," said **Carolyn Clancy**, director of HHS' Agency for Healthcare Research and Quality, in announcing the partnership.

For more information, visit: www.who.int/mediacentre/news/releases/2004/pr74/en/. ■

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