Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

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Larger role in disaster planning seen for quality managers

Skills in planning, safety seen as assets for emergency management

When a disaster occurs, otherwise routine health care delivery can be complicated in a number of unexpected ways — and Hurricanes Katrina and Rita, it seems, were on a different level than disasters that had occurred in the past. As more than one emergency response expert told HBQI, no one will ever again look at disaster planning in quite the same way.

(The Joint Commission on Accreditation of Healthcare Organizations already has stated it will change the way it reviews disaster plans for larger hospitals. See story on pp. 127.)

As part of this "new look" at disaster planning, observers say, quality managers should play a larger role in emergency planning and response than they have in the past.

For example, **William Cassidy**, MD, associate professor of medicine at LSU Health Science Center in Baton Rouge, LA, wishes he had had more quality professionals on his team at the field hospital he oversaw in a former Kmart facility.

A quality manager who knows hospital systems could be invaluable in such a situation, Cassidy observes. "Absolutely, a quality manager could have helped us," he says. "You need someone who is knowledgeable but who is also able to scale back to what is effectively a field hospital environment."

Key Points

- Systems knowledge is essential, but so is the ability to scale back demands in light of reality.
- All disaster planning must be done in the context of providing optimal, safe patient care.
- Bureaucracy may be first casualty in quality manager's response to a sudden disaster.

Quality managers also can play an important role in disaster response planning, adds **Joe Cappiello**, BSN, MA, vice president of accreditation field operations, for JCAHO.

"Quality managers have a key and important role in sitting at the table to develop response plans," he asserts. "When an organization does hazard vulnerability assessment, it looks at possible scenarios that may confront that facility — hurricanes if you are in Florida, tornadoes in Kansas, earthquakes in California — or perhaps your town is surrounded by petrochemical plants. We then ask them to sit down and say, is this a situation we might reasonably encounter? All of this should be thought of in the context of how we can give optimal, safe patient care based on the situation with which we are confronted."

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If quality managers are to become part of the disaster planning and response team, it is important for them to also learn the lessons of Katrina and Rita and to understand just how different things can be in these situations.

"The first thing they can do is look at the preparation and response to Katrina versus Rita," says Coppell. "The lessons learned were immediately applied. On the hospital level, I think the lessons that will come out of New Orleans will be very key."

Lessons learned

And what were those lessons? "My own belief is that every one of those accredited hospitals [in New Orleans] had good emergency management plans, conducted drills, and were in compliance," says Cappiello. "With a storm of this size, you had not one but four situations: A hurricane, during which many stood tall and weathered the storm; then the flood; then essentially the loss of all internal support — power, water, sewage; then, a civil disturbance on top of that. A disaster plan must think not only outside of the box but outside of the carton." **(For more on 'out-of-the-carton' thinking, see story on pp. 126.)**

Cassidy saw firsthand how difficult things could be. "On Wednesday after the storm, around 7 pm, they told us we might be putting [a field] hospital in place," he recalls. "Thursday at 4:00, it was confirmed. At 4:30 we did a walk-through of the facility — it lacked lighting, electricity, phone lines, and plumbing. The volunteers from various churches came and started unloading 18-wheelers with supplies, swept and mopped the facility, partitioned up the 'big box' building with plastic Visqueen sheets that we draped on ropes between the pillars to create the 'wards.' At 10:34 p.m. Friday, we were ready to accept patients."

How must a quality manager adapt to such a situation? "First, they cannot be bureaucratic if they are going to get something done that quickly," Cassidy advises. "Also, recognize that normal procedures, like HIPAA, are suspended; credentialing is suspended." **(For more on how regulations may be altered during a disaster, see story on pp. 124.)**

Efficiency is key during disaster response, Cassidy continues. "For example, the only copy of charts would be for people leaving our place to go to someone's home," he explains. "If you go to another hospital or shelter, we would send the chart with you and save a face sheet and maybe a

routing sheet. You don't have a copy machine! Our goal is to take stable medical patients and continually flow them out into less acute settings. If you accept your goal as the need to complete medical management of certain patients and move them out, and you have to do it with a skeleton staff, then the redundancy you typically have in a normal hospital has to be suspended."

In addition, the facility did not have infection control at first, Cassidy says. "Volunteers came with food, but instead of putting rolls on single plates, people would just reach in and take the rolls," he notes. "There was no plumbing; we had to rely on people putting antibacterial gel on their hands. So, this was a quality manager's issue: How do you guide people like church volunteers, who are meeting a need but do not have formal training in institutional food presentation?"

Cassidy also cites a specific instance where a quality manager could have offered skills not available from a volunteer. "A quality manager looks into all facets of hospital operations," he notes. "What our volunteer coordinator did was tag along. She told me she saw her role as following along with nurses, doctors, the facility manager, the food person, and hearing that they needed 'x' done and telling the volunteers to get it done. You could see a quality manager tagging along with the other members of the team, and saying, 'Okay, you need to have an intake and registration system, a system to move patients between wards, and a way to track their departure. Here's how it's normally done, and here's how the process can be adapted.'"

A unique model?

Having a quality professional intimately involved with disaster planning may not be the norm, but at William Beaumont Hospital in Royal Oak, MI, the chairperson of the emergency management committee is a quality professional — **Kay Beauregard**, RN, MSA, the facility's Director of Hospital Accreditation and Nursing Quality, as well as its safety officer.

Beauregard was given this responsibility shortly after 9/11, and to her it makes perfect sense. "It is an interesting overlap," she says, "But there is a relationship. Many quality people oversee patient safety, and this position oversees employee safety. I think more organizations are starting to see this overlap."

"It's a wise place for quality managers to be — on the disaster planning committee," says Cappiello. "While we don't by standards mandate who should sit on that, or publish the roster, one would think a common sense approach is you would gather an array of experts who can advise the hospital on the development of plans, assist in the development of drills, and be called upon should disaster strike to provide guidance for the office of emergency management and the administration as they conduct their response."

In her role, Beauregard has overall responsibility for the group that assesses the hospital's risks, what could happen to its infrastructure, events that might possibly occur in the area around them, and what patients they might receive. "Then, based on that information, we put plans in place to try to decrease the likelihood of the events occurring and have a plan in place to respond if they do," she says.

There are other reasons quality managers are well qualified for such responsibility, she continues. "They bring performance improvement expertise, and that's what this is — to take a chaotic situation and organize it into an action plan is similar to taking a quality issue and organizing it into an action plan," she observes.

Many organizations have their emergency departments (EDs) in charge of this committee, "but we've learned that disasters impact the entire organization, and the rest of the hospital is needed to help the ED to provide resources," Beauregard says. "It involves coordinating bigger issues — like supply chain, electrical outage problems, and so forth — that do not just hinge around the ED."

Quality managers, she continues, also are often involved in regulatory compliance. "Regulators have standards regarding disaster management — they are used to reviewing those standards and making sure the hospital is in compliance."

Beauregard also is among those who believe the recent disasters will cause everyone involved to take a second look at their own plans. "We are definitely going to review our disaster plan," she says. "This hurricane has taught us that we need to look at issues like sending our hospital staff to respond to disasters outside of ours, whether down the street or in a different state. We need to look at a lot of issues — licensure in other states; liability; workman's comp.

"Internally, we learned we need to revisit our evacuation plan — particularly, how would we evacuate the entire hospital? That's a 'biggy,' because we have over 1,000 beds." **(On what basis should evacuation decisions be made? See**

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related story, page 125.)

If you do not have an official role such as Beauregard's, you could nevertheless play an important role if a disaster strikes your area. "One volunteer coordinator just showed up and started hanging around the field hospital, where patients were being dispositioned out of the original triage hospital," recalls Cassidy. "I ran into him and said, 'We may be creating this hospital — would you want to help and be our volunteer coordinator?' If someone presented themselves to me and said, 'I know hospital systems — can I help?' my answer would have been 'Yes!'" ■

A new compliance reality when disaster strikes

Concentrate on providing safest, best care

Quality managers involved in disaster planning and response should not be overly concerned with following the letter of compliance law if a disaster occurs, says **Joe Cappiello**, BSN, MA, vice president of accreditation field operations, for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

"The emphasis is not so much on the written plan, because it becomes moot in minutes," he notes. "It's the thoughtful process and communication that goes into the preparation, and the things you learn from drilling that allow you to adapt to situations that present themselves."

A disaster is not the time to wonder if you are in 100% compliance, he continues, "But we still expect that as a facility responds to a particular event there is a thought of how to provide the safest, best care, in the most reasonable environment possible. In the first minutes right after the disaster, when you are looking at survival and preservation of the facility, that's hard, but when the dust sort of settles and you realize you have a large number of casualties, and you may have to expand to the surge facility outside of the medical center, you have to start thinking of how you can give the best care possible under such circumstances."

Key roles for quality

One of the key roles the quality manager can play, he says, "Is to help keep the ethical, moral, realistic compass pointed in the right direction. Act as a supporter for the staff as they start to think things through."

Government agencies clearly recognize that full compliance is not possible during disasters. Shortly after Katrina hit the Gulf coast, for example, the Centers for Medicare & Medicaid Services (CMS) acted to assure that Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) would flex to accommodate the emergency health care needs of beneficiaries and medical providers in the Hurricane Katrina-devastated states.

Many of the programs' normal operating procedures were relaxed. For example, CMS announced that:

- Normal licensing requirements for doctors, nurses, and other health care professionals who cross state lines to provide emergency care in stricken areas would be waived as long as the provider was licensed in their home state.
- Health care providers that furnish medical services in good faith but cannot comply with normal program requirements because of Hurricane Katrina would be paid for services provided and would be exempt from sanctions for noncompliance, unless it was discovered that fraud or abuse occurred.
- Crisis services provided to Medicare and Medicaid patients who have been transferred to facilities not certified to participate in the programs would be paid.
- Programs would reimburse facilities for providing dialysis to patients with kidney failure in alternative settings.

• Normal prior authorization and out-of-network requirements also would be waived for enrollees of Medicare, Medicaid, or SCHIP managed care plans.

• Certain HIPAA privacy requirements would be waived so that health care providers could talk to family members about a patient's condition even if that patient was unable to grant that permission to the provider.

• Hospitals and other facilities could be flexible in billing for beds that have been dedicated to other uses; for example, if a psychiatric unit bed was used for an acute care patient admitted during the crisis.

• Hospital emergency departments would not be held liable under the Emergency Medical Treatment and Labor Act for transferring patients to other facilities for assessment, if the original facility was in the area where a public health emergency had been declared.

In times like these, Cappiello concludes, it's most important to keep things in perspective. "Just don't throw the standards away and say all bets are off," he advises. "You still have a moral and ethical responsibility to provide the best possible care given the circumstances." ■

To evacuate or not to evacuate?

Communication will help make decision easier

Whether to evacuate patients prior to the arrival of a storm such as the recent Gulf Coast hurricanes often is not a cut-and-dried decision, says **Robert Wise**, MD, Vice President, Division of Standards and Survey Methods for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

"There are two kinds of decisions that need to be made," he says. "The first is at the community level, where the municipality determines whether the population should evacuate. Then, the actual hospital has to decide essentially if it is going to evacuate patients. A lot has to do with the physical facility and the hospital's ability to withstand being isolated."

In discussions with facilities in areas that get hit by hurricanes on a regular basis, says Wise, "Many have hardened their structures to handle the assault a hurricane can deliver." The most critical considerations, he says, include whether the generators can continue to operate, whether there is a water supply, and whether staff will remain available.

Of course, if your facility is about to be hit by a Category 5 storm, much depends on whether the facility itself can sustain the blow. "The vulnerability of a hospital is based on the actual structure itself and whether it can endure," Wise says. "The other part is whether it can maintain operations. The most important piece in that equation is the generators."

Water and staff

Some hospitals, he notes, have moved their generators to higher floors, to avoid flood waters. "This makes sense," he says, "But if you go back to [tropical storm] Allison in Houston, a lot of hospitals had their generators on the third or fourth floor, but they had the switching components in the basement. You can't have any critical components on the lower floors."

Another consideration, says Wise, is how long you expect to depend on your generators for electrical power. "A typical generator is not meant to hold a hospital for several weeks at a time," he points out.

If you know your facility can withstand the storm, the other key questions involve water and staff. Having potable water and being able to maintain sanitary conditions are essential. It is also, of course, impossible to run a facility without staff. "They are devastated, too," says Wise, "Because they may have lost all their belongings. You can have a facility that is able to run, but [it can't run] if you have a staff that feels it has to go home and take care of its own needs."

How do you overcome this problem? "Some

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hospitals put together crews to protect staff houses," says Wise.

The bottom line is that evacuation is never an easy decision, says **Randy Pilgrim**, MD, president and chief medical officer of The Schumacher Group, a Lafayette, LA-based practice management firm that provides emergency medicine, staffing, and practice management services to 104 facilities, including 30 in Louisiana, and which was heavily involved the Katrina response process. His says his experiences have taught him a valuable lesson.

"I think that the biggest opportunity for change lies in having a clear idea of not necessarily when you'll make the decision but how the different ingredients of command and control will come together when the decision is imminent," says Pilgrim. "What I noticed is that there are incredible pressures on the leadership structure, given that health care is thought of in America as nearly an inalienable right and the last thing you want to take from people. That mindset leads to the fact that hospitals will stay open long past when other businesses would have closed, shut down, boarded up, and evacuated. As you do that, more chaos surrounds you. In that confusion, you must have great clarity of thought and input." ■

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In disaster planning, imagination is critical

Brainstorming scenarios can help

As **Joe Cappiello**, BSN, MA, vice president of accreditation field operations for the Joint Commission, indicated in this month's cover story, the Hurricane Katrina disaster in New Orleans was really a "perfect storm" of four separate disasters. It was a confluence of events that few had foreseen, and that's all the more reason, say the experts, to let your imagination run wild when planning for disasters, experts say.

"The biggest thing is that people need to sit and talk and have a kind of twisted imagination," says **Mary Frost**, RN, trauma coordinator at Texas Children's Hospital in Houston. That's exactly what the city's health care community did in the wake of Hurricane Allison in 2001, creating Houston's Regional Unified Medical Command Center. The result? After Katrina hit New Orleans, Houston was deluged with about 25,000 addition hospital patients, yet almost all of the city's hospitals were kept off diversion.

"Things that seemed were the questions to ask turned out not to be; this is bigger than anything anyone else has ever seen," says **William (Kip) Schumacher**, MD, CEO and founder of The Schumacher Group, a Lafayette, LA-based practice management firm that provides emergency medicine, staffing, and practice management services to 104 facilities, including 30 in Louisiana, and which was heavily involved in the Katrina response process.

"It was so catastrophic, so big, that every time I thought we had a grasp on the situation I realized everything we had done was so far under what could have been done," he says.

The "rules," he adds, changed totally. "They were talking about evacuating hospitals with pickup trucks, because air evacuation had difficult access," he recalls. "We had hospitals evacuated by boats that our docs were pushing and paddling."

In preparing for the unexpected, says **Randy Pilgrim**, MD, president and chief medical officer of The Schumacher Group, "do a number of scenarios that you can play out prior to an event, so you can understand how key decisions might be made. Know who to contact, how to get hold of them if normal communications do not work. Think of who needs to have a satellite phone now, while the storm is still coming."

Those scenarios could include evacuation of patients ahead of the storm, he says. "It may be advisable, but you have to acknowledge that there is tremendous risk in making that decision," he warns.

"It's very difficult to understand what magnitude of deficit will hit you once the storm hits," Pilgrim continues. "What is key is to prepare yourself ahead of time by orderly examination of what may happen when it hits." ■

JCAHO makes changes to disaster plan review

Change affects larger hospitals

If your hospital has 200 beds or more, your emergency management committee members should be aware of a new change in the way the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will review disaster plans.

Starting in 2006, larger hospitals will participate in an emergency management committee session, which will commence in the hospital's incident command center, said **Jerry Gervais**, associate director of standards for the JCAHO. Gervais spoke at the Wisconsin Department of Health and Family Service's Annual Preparedness Conference in Milwaukee on September 13.

Highlights of the two-to-four hour session will include:

• A review of the hospital's emergency management plan.

• Surveyors choosing a detailed, predetermined disaster scenario based on the facility's hazard vulnerability analysis and then going out in the departments to determine whether hospital staff understands their roles in such a scenario.

Surveyors will receive training on this new session at the JCAHO annual surveyor training conference in January, Gervais said.

JCAHO hasn't forgotten smaller facilities. The agency has issued a step-by-step guide, "Standing Together: An Emergency Planning Guide for America's Communities," for small, rural and suburban communities to both prepare for and successfully respond to major local and regional emergencies — whether they be hurricanes, floods, terrorist attacks, major infectious outbreaks, hazardous materials spills, or other catastrophic occurrences.

It includes such topics as:

• safeguarding data and systems in the event of a natural disaster;

• establishing linkages with federal and state mental health resources;

• ensuring culturally sensitive communication;

• identifying appropriate planning partners.

For a complete copy of the Joint Commission planning guide, go to 'Headline News' at www.jcaho.org. ■

ICU patients at risk for preventable errors

AHRQ study puts spotlight on adverse events

Patients face a significant risk for preventable adverse events and serious medical errors in hospital critical care units, according to a study sponsored by the Agency for Healthcare Research and Quality (AHRQ). The study, "The Critical Care Safety Study: The incidence and nature of adverse events and serious medical errors in intensive care," was published in the August issue of *Critical Care Medicine*.[1]

The researchers found that more than 20% of the patients admitted to two intensive care units at an academic hospital, a medical intensive care unit (MICU), and a coronary critical care unit (CCU) experienced an adverse event. Of the adverse events in the sample, almost half (45%) were preventable. A significant number of the adverse events involved medications — most commonly, giving patients the wrong dose. More than 90% of all incidents occurred during routine care, not on admission or during an emergency intervention.

The researchers conducted direct continuous observations in the MICU and CCU during nine three-week periods, distributed throughout 12 months from July 2002 through June 2003. This was supplemented by confidential incident reporting, a computerized adverse drug event detection monitor, and chart reviews.

This study was part of a larger research effort examining the effect of eliminating extended work shifts and work hours on serious medical errors by interns, explains lead author **Jeffrey M. Rothschild**, MD, MPH, Assistant Professor of Medicine at Harvard Medical School, and a member of the division of general medicine at Brigham

Key Points

- More than 90% of events occurred during routine care.
- Most common medication error involved giving patients the wrong dose.
- Surprisingly, most of the errors involved lapses of care, which are more readily preventable.

& Women's Hospital in Boston. "This was a secondary analysis," he says. "The method was we followed the interns but reported any errors we found."

While noting that the findings may not be generalizable because Brigham & Women's is a teaching hospital, he adds that "we have certain built-in elements that reduce errors, like computerized physician order entry [CPOE], pharmacists participating on rounds, and full-time attendings in the unit. But to counterbalance that, [patients in the ICU] unit may be sicker than in other places, so the number of events may not be generalizable."

The findings are nevertheless important, he continues, because critical care units provide an increasingly greater proportion of care. "During our lifetimes, we can expect to be admitted to an ICU at least once. We hope these findings will stimulate the adoption of known interventions, like ensuring hand washing, better physician/nurse communications, and greater use of health IT," he says.

Results not surprising

Rothschild asserts that the results (i.e., 45% of the adverse events being preventable) are "quite consistent with the research we've seen elsewhere."

What did surprise him slightly, he says, was that most of the errors were the kinds that could easily be fixed. "They involved lapses in care — forgetting to do the right thing, forgetting to start certain meds, or slips in which [the provider] incorrectly ordered something because they entered the wrong amount or ordered it for the wrong patient," he notes. These types of errors, he points out, can be more easily corrected than things like making the wrong diagnosis, or problems associated with procedures.

Perhaps equally surprising is the fact that a little over 60% of the adverse events involved medications — most commonly, giving patients the wrong dose. With all the national attention being given to medication safety, is Rothschild concerned we are we still not making progress? "There isn't really hard data to prove it, but we do have a general sense that patient safety is more on the minds of clinicians, and the hospitals are taking a closer look at what kinds of interventions have worked," he asserts. "In general, most hospitals are making a better effort to identify opportunities for improvement; I have a sense we are going in the right direction, but we have a real long way to go."

It is Rothschild's hope that these findings "will stimulate the adoption of known interventions" to reduce errors in the future.

Improving communications among clinicians and between disciplines is a clear opportunity, he continues. "Everyone who's caring for the patient should share the same mental model and view of what's going on with that patient and should develop more teamwork in the units," he advises. "Another element is really pushing protocols and compliance with protocols."

One surprising finding, for example, was how often sterile procedures were done without complete sterile techniques. "Hand washing is still a tremendous problem," he observes. "But there are ways to improve; we now have waterless systems at every bedside, which makes it so much easier than going to the sink. That kind of innovative approach works."

He also sees technological opportunities. "We already have CPOE," he notes. "More [computerized] decision support would protect slips in dosing errors. And there are certainly opportunities in medication administration, with smart pumps and bar-coding, though the data on those are still not strong yet."

Earlier studies also have shown that that extended work hours and fatigue present real problems, he adds, noting that his final take-home message is that the number of critical care patients is expanding. "In many hospitals, a quarter of the beds are in an ICU — and that is certainly where the sickest patients go — so it is an important area to concentrate our efforts on improving safety," says Rothschild.

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Reference

1. Rothschild, JM, Landrigan, CP, Cronin, JW, Kaushal, R, Lockley, SW, Burdick, E, Stone, PH, Lilly, CM, Katz, JT, Czeisler, CA, and Bates, DW. The Critical Care Safety Study: The incidence and nature of adverse events and serious medical errors in intensive care *Critical Care Medicine*, August 2005; 33(8):1694-1700. ■

Program improves care, hospital collaborations

Surveys measured family stress level

A nationwide hospital program developed to support families visiting loved ones in the intensive care unit (ICU) has shown significant benefits for families, patients, and team members in the ICU, according to a new study.

As reported in a supplement to the September issue of *CHEST*, the peer-reviewed journal of the American College of Chest Physicians (ACCP), implementation of the Critical Care Family Assistance Program (CCFAP) significantly increased family satisfaction with communication with ICU team members and care of their loved one; decreased family stress; decreased patient anxiety; and increased staff communication and collaboration across hospital departments.

CCFAP teams at Evanston (IL) Hospital, and the VA Medical Center, in Oklahoma City, OK, collected satisfaction data from 537 families of loved ones in the ICU and hospital staff prior to and after the implementation of the CCFAP. Surveys measured family stress level, family need for specific services, family satisfaction with ICU team communication and care regarding their loved one, and family satisfaction with their own treatment and care by the ICU team. Staff surveys measured changes in staff perception of ICU climate, family satisfaction with care and communication, family stress levels, and program impact on their work environment.

Significant increases were seen in:

- family satisfaction related to care and treatment of their loved one;
- family perception of a safe hospital environment;
- improved comprehension of information provided to families;
- decreased patient anxiety.

Key Points

- Significant impact seen in degree to which families feel involved in decision-making.
- Stress levels of family members reduced when they receive information or services.
- Staff identification and referrals of families in need of services also increase.

The most profound impact was on the degree to which families felt they were involved in the decision-making process. In addition, results showed significant decreases in family members' stress/anxiety levels when they received CCFAP information or services. In regard to staff, results showed that there were significant increases in staff identification and referrals of families in need of services; staff perception of positive change in family satisfaction of communication, care, and treatment; collaboration among ICU team members and hospital departments; and the ability of hospitals to respond to family needs.

"The Critical Care Family Assistance Program has allowed us to increase the level of service we provide for our ICU patients and their families. As a result, we have had an overwhelming positive response from families, patients, and hospital team members," says **Raymond Grady**, president and CEO of Evanston Hospital. "The success of the CCFAP at Evanston has encouraged us to consider expanding the family assistance program to other areas of the hospital."

Literature shows a need

The idea for the program arose after literature was published in 2000-2001 indicating there were gaps in the attention being paid to family needs, recalls **Robert McCaffree**, MD, Master FCCP, president of The CHEST Foundation and chief of staff at VA Medical Center Oklahoma City, OK. "At that time, there was some discussion with the Eli Lilly foundation by the people of CHEST, and Lilly agreed to support this effort," he says. "We started discussions, and agreed on some of the fundamental parts of the program and on the two pilot sites."

The program was developed in concert by the CHEST foundation and the individuals involved in the pilot sites, says McCaffree. "Among those [basic elements] were a computer kiosk with information for families," he notes. Each facility had a different approach, he said. "Evanston purchased a commercial system, while we developed our own," McCaffree explains.

Another key element was a concierge service. "We wanted to find [family members] places to sleep, transportation to and from the hospital, and places to eat when the hospital café was closed," says McCaffree. "Both hospitals set up voucher systems for hotels, taxies, meals. We were then left pretty much to our own resources to design the other parts of the program."

Need More Information?

For more information, contact:

- The CHEST Foundation at www.chestfoundation.org/, or Robert McCaffree, MD, Master FCCP, Chief of Staff, VA Medical Center Oklahoma City, 921 NE 13th St., Oklahoma City, OK 73104. Phone: (405) 270-5135. CHEST is available online at www.chestjournal.org.

At the VA medical center, for example, a 'sleep room' was developed for family members. Both hospitals renovated their waiting rooms to make them more comfortable, and each developed a 'care package' with toiletry items and so forth. "Evanston also developed a music therapy program and massage therapy program, while we are developing a pet therapy program," McCaffree adds.

Program spreads

After the initial pilot programs were evaluated, it was determined that different types of hospitals should be involved in early data gathering on the program, to see if it worked in a variety of facilities. "We now have eight — including a community/county indigent care hospital in Houston, a university hospital in Mobile, AL, a pure community hospital in Watertown, CT, and a pediatric hospital in California," McCaffree reports. "It's a real variety, and they each have brought on two or three more."

While each facility is different, there are some common elements that are key to success, says McCaffree. For example, they involve interdisciplinary teams. "Clearly, you need one person to coordinate the program — it might be a social worker as it at ours, or a nurse, as it is at others," he explains. "Then, you should include as many areas as might be involved in patient care with the ICU — physicians, nursing, respiratory therapy, chaplains, dietitians, volunteer services. Quality managers certainly can be involved."

It's critical, he adds, that the person running the program has the time to do so. "While we started the position as an additional duty of the social worker, we find it's really becoming a full-time job," he says.

McCaffree says the CCFAP can be implemented in any hospital, although a certain base budget has to be taken into consideration. "For us, it is somewhere in the range of $30,000 to $50,000," he says. "That covers beepers, hotel vouchers, taxi vouchers, meal vouchers, and the care package. Then, there's staffing."

McCaffree says this is a valuable investment. "It has really improved communication," he notes. "One hypothetical we have not yet proven is, if a critically ill patient feels his family is being taken care of, it takes that worry off of them and they can put more energy into the healing process, which will also save money for the hospital. The people involved with the program feel this is true."

Hospitals interested in the program can obtain, for a nominal feel, a "replication packet," created by facilities participating in CCFAP. It includes suggestions, experiences, strengths, and weaknesses. "Any hospital can take this and do it in their hospital," says McCaffree. ■

Flu shots not needed for health care workers?

Two national health care organizations have come out with competing positions on whether mandatory influenza vaccination for health care workers is justified.

In a new position statement, the American College of Occupational and Environmental Medicine (ACOEM), based in Elk Grove Village, IL, asserts that mandatory influenza vaccinations are not necessary. It also opposes the use of declination statements, stating that there is "no evidence to suggest that such programs will increase compliance."

The statement — Influenza Control Programs for Healthcare Workers — applies to seasonal influenza and is not necessarily appropriate during a major antigenic shift in the virus resulting in a pandemic situation.

The Society for Healthcare Epidemiology of America, based in Alexandria, VA, however, has come out with a position paper of its own that recommends health care workers who decline flu immunization must sign a declination statement.

Slated for publication in the November 2005 issue of *Infection Control and Hospital Epidemiology*, the paper is available on the SHEA web site at: www.shea-online.org.

In a nutshell, SHEA recommends that all health care workers be immunized for flu annually

unless they have a contraindication to the vaccine or actively decline vaccination.

ACOEM argues that mandatory flu shots are not justified for several reasons: the vaccine itself is variably effective; vaccination does not preclude the need for other controls; and a coercive program has the potential to harm the employer-employee relationship.

In addition, ACOEM points out that "given the ubiquitous nature of influenza in the community, patients will continue to be exposed to influenza through family members and friends regardless of the vaccination status of their health care workers, with whom they have much less intimate contact."

Declination statements

However, SHEA argues, the health care worker's flu infection may be flying below the symptomatic radar. It cites one study that found 28% of health care workers with serologically confirmed flu infections did not recall having a respiratory infection during the period. The patient receiving care may not be so lucky, the organization argues.

William Buchta, MD, MPH, FACOEM, chair of ACOEM's Medical Center Occupational Health Section and author of its paper, does note that "health care workers must also appropriately use hand washing and personal protective equipment and they should consider self-removal from work when experiencing symptoms of a communicable illness."

He adds, however, that "making people sign a statement that they have declined to receive a flu shot not only impacts the employer-employee relationship in a negative way but diverts resources from activities known to increase compliance and devotes them to enforcement of a policy with no proven benefit."

Influenza Control Programs for Healthcare Workers is available on line at www.acoem.org/ guidelines/article.asp?ID=86. ■

Back injury charges double in decade

The average hospital charge for Americans treated for disc disorders and other back problems nearly doubled between 1993 and 2003 — from $13,200 to $25,300 — according to the U.S. Agency for Healthcare Research and Quality (AHRQ). The statistics are adjusted for inflation and do not include physicians' fees.

While hospital charges were increasing, the time back patients had to stay in the hospital was falling, from an average of nearly five days in 1993 to about three days in 2003. During the same period, the number of hospital admissions for back problems increased from 528,000 to 658,000.

This information was produced using HCUPnet, an on-line query system that provides access to health statistics and information on hospital stays from AHRQ's Healthcare Cost and Utilization Project (HCUP). This project comprises a family of health care databases and related software tools developed through a federal-state-industry partnership and sponsored by AHRQ. HCUP includes the largest set of publicly available databases on all patients in the United States, regardless of type of insurance or whether the patients had insurance. To access HCUPnet, go to hcup.ahrq.gov/HCUPnet.asp. ■

Hospitals reduce mercury, overall waste

More than nine in 10 hospitals polled recognize the hazards associated with mercury use and have taken steps to reduce or eliminate mercury-containing devices, according to a survey released by the Chicago-based American Hospital Association and Washington, DC-based Hospitals for a Healthy Environment.

COMING IN FUTURE MONTHS

- Collaborative program in Pittsburgh aggressively targets MRSA prevention
- Electronic Medical Record helps cut patient wait times by over 60%
- Worker fatigue: Studies continue to show its impact on medical errors
- How to ensure staff actually are thinking as they go through the time-out or checklists

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The survey found 72% of hospitals have inventoried, labeled, or replaced all mercury-containing devices, and 80% have adopted policies, plans, or programs to reduce overall waste as part of the hospital field's commitment to a 1998 accord with the Environmental Protection Agency. Under the agreement, the AHA and its American Society for Healthcare Environmental Services and American Society for Healthcare Engineering set goals to virtually eliminate mercury-containing waste from hospitals by 2005 and cut overall hospital waste in half by 2010. ■