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OCTOBER 2008
VOL. 33, NO. 10 • (pages 129-140)

Using antibiotic stewardship programs to curb resistance in fight against HAIs

With the arrival of the Centers for Medicare & Medicaid's no-pay rules, The Joint Commission's National Patient Safety Goals, and the ever-growing emphasis on quality improvement on patient care, prevention has become the name of the game. In this issue we show how participation in multiple quality improvement, automated data surveillance, and antibiotic stewardship programs has garnered successes for hospitals in terms of improving systems and in turn care and cost.

Which came first: the chicken or the egg? Likewise, are what the Centers for Medicare & Medicaid Services labels "never events" really never events if they happen? The philosophical ramblings on this are endless, and whether these events are eradicable, it's become a reality this month that if a patient acquires an infection in your hospital, your hospital will be footing the bill. And whether or not you can eliminate infections, it is incumbent now that you find effective and cost-appropriate ways of dealing with them.

Data tracking measures, mandatory reporting requirements, and no-pay rules for hospital-acquired infections (HAIs) put the issue front and center this month, and in the absence of what many see as clear guidelines on prevention, it is every hospital for itself in determining best practices to deal with HAIs, and to do it cost-effectively.

Antimicrobial stewardship programs are one of the hot trends, and VHA Inc. and Premier Inc. have rolled out measures to help hospitals manage their own infection patterns. According to health care attorney and blog author **David Harlow**, hospitals involved in programs such as these "are on the cutting edge, and anyone who's not involved in a program like that through a purchasing association or otherwise is going to have do that soon because they're going to have to address every way of reducing hospital-acquired infections."

What he refers to as once "fringe behavior" — that is, the move to avoid overuse of antibiotics — is going to become much more crucial. And that is what these programs are banking on.

Antibiotic stewardship/surveillance

An article in the Feb. 14 issue of the *Journal of Antimicrobial Chemotherapy*, reads: "Antibiotic use is widely accepted as being responsi-

ble for the selection and maintenance of antibiotic resistance. It is less obvious, however, that it is also responsible for increasing transmissibility and pathogenicity of many multiresistant bacteria and may actually be increasing the number of hospital-acquired infections. Antibiotic stewardship should be given much more emphasis in the fight against HAI."[1]

Robert Pickoff, MD, MMM, chief medical officer at Hunterdon Medical Center in Flemington, NJ, says the hospital was looking into how to address the sensitivity patterns of bacteria at the facility when VHA approached them about being a test site for its antibiotic stewardship "Bugs and Drugs" program.

As part of its participation, Pickoff worked with John Gums, PharmD, professor of pharmacy and medicine at the University of Florida, who helped create VHA's antimicrobial resistance database, which participants can use to review resistance patterns and to benchmark them regionally or nationally. "[Gums'] interest," Pickoff says, "was in taking hospital information, that is the pattern of antibiotic use and the antibiogram, which is the resistance and sensitivity patterns of the bacteria in the hospital, and analyzing the data to see what could be done to reverse the trend of rapidly increasing resistance."

PharmD intervention critical

In implementing the recommendations it received from Gums, Hunterdon brought on doctoral-level pharmacists affiliated with Rutgers' teaching faculty and Hunterdon's own pharmacy residency program to work in sync with the medical staff. Pickoff credits this interaction as being critical to the success the facility would have.

Each hospital must make its own priorities in stemming the tide of resistance, Pickoff says. Hunterdon chose Cipro as its first target and in studying its resistance patterns created guidelines for the drug's use as an empiric therapy. The outcome was an order form for physicians. When an antibiotic is ordered, the doctor has to indicate "whether it is empiric or therapeutic, what cultures were done, and what the results were," he says. The doctoral-level pharmacists then review the form and make suggestions as needed on the antibiotic chosen for treatment.

Pickoff says the test case examined two specific bacteria against Cipro. "We showed a sensitivity for two bacteria," he reports, "*Klebsiella* and *Pseudomonas*, and in one case, the sensitivity went up from 21% to 54% and in the other it went from 51% or so to 79%."

On the docket now is how these interventions might affect cost and even throughput. "We're looking now at the effect of appropriate antibiotic use on length of stay and cost per case. We think that by using antibiotics appropriately, we are going to be able to effect change," Pickoff says.

He reiterates the PharmD intervention in the

Hospital Peer Review® (ISSN# 0149-2632) is published monthly, and **Discharge Planning Advisor**™ and **Patient Satisfaction Planner**™ are published quarterly, by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to *Hospital Peer Review*®, P.O. Box 740059, Atlanta, GA 30374.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

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Subscription rates: U.S.A., one year (12 issues), $479. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

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Making your doctors, PharmDs play nice

When Hunterdon Medical Center added doctoral-level pharmacists to initiatives to stem antibiotic resistance, productive interaction between the PharmDs and the other medical staff became crucial to its success.

Robert Pickoff, MD, MMM, chief medical officer, says doctors had to learn new ways of using antibiotics. Key to this was having a reliable resource staff could use. In order to get physician buy in, Pickoff says, "you need someone who can go toe to toe with a physician educationally, and a PharmD is certainly on that level."

And at Hunterdon that proved to be true. Now, when physicians call in an order, they first consult with the PharmD on staff for advice. "When a PharmD makes a recommendation on a chart, there's an 89-90% rate of an order being changed based on that recommendation, and that's really key," he says.

That interaction, he says, was "key to success in turning the tide on resistance because it's a very credible form of information that the medical staff at this point have totally bought into."

Education key to change

When **Sarah Bland**, RPh, senior clinical pharmacist with the Center for Drug Policy at the University of Wisconsin Hospital and Clinics, brought on Premier Inc.'s web-based infection tracking SafetySurveillor tool on board, communication between the pharmacy and the medical team also became integral.

That relationship, she says, has been a harmonious one. "It's not like we just sit here and swoop down on them when they make a mistake," she says. The pharmacy team does inservices and speaks with medical staff at their weekly coffee section sessions. "We'll go and talk to them about subjects they like, and they get to know us as more than just people who are calling. If they're having problems, we're there to try to help them with that. We developed guidelines and are using their advice and input."

As far as her administration, when they saw results after the first year the tool was implemented, she says, they bought right in. ■

success with the Cipro case. "That's the intervention that has made the difference" — that is, the back and forth communication and the educational aspect. "In addition to having these PharmDs making rounds in the intensive care unit with the intensivists on a daily basis, it's also interacting with the physicians and nurses and affecting change in the use of antibiotic therapy. The combination of those and the team approach is what we think is key to the success we've had in reversing the tide of resistance to Cipro."

Now, it's on to another antibiotic of choice for Hunterdon as it tries to replicate the success it had with its first case. But Pickoff says interventions can never be successful if they only happen in the hospital. Any strategy that's worth its weight must include the community, of which the hospital is only a part.

"One thing we've learned is that if you want to effect change inside the hospital," he says, "you really have to go outside of the walls of the hospital to influence what's being done in the community. Because if you get a patient in from the community already having resistant patterns... the hospital inherits those resistance patterns and it becomes a pattern of the hospital."

And it's not only the community at large, but in the primary care setting. When outpatient facilities in the primary care network involved with the hospital use electronic prescription writing, Pickoff says, they're also able to interact with the PharmDs "just as much as the inpatient physician does in terms of the advice for antibiotic choices and taking advantage of that advice."

Reference

1. Gould, IM. Antibiotic policies to control hospital-acquired infection, *J Antimicrob Chemother* February 2008. doi:10.1093/jac/dkn039. ■

Reversing the trend of resistant infections

Cutting costs with automated screening

"It was pretty primitive, what we were doing," says **Sarah Bland**, RPh, senior clinical pharmacist, Center for Drug

Pending legislation, standards on HAIs

With the STAAR bill, which in part would establish an Office of Antimicrobial Resistance under the auspices of the Department of Health and Human Services, pending in Congress, what other regulations and requirements could be part of the future for hospital-acquired infection prevention?

The National Quality Forum-endorsed 2009 Safe Practices are currently being updated, with final practices to be published the first week of January. According to **Charles Denham**, co-chairman of the NQF's Safe Practices group, "there will be 34 practices. They're being updated from the 2006 update, and there will be eight new ones, and all of the health care-associated infections will be included. They also will align with the [Centers for Medicare & Medicaid Services] health care-associated infections so I think that's big news."

"Clearly evidence-based," Denham says, the practices have been reviewed by the Infectious Disease Society of America and numerous other organizations and will be further reviewed and refined until they are voted on in December.

The NQF also has been working with a lineup of other health care agencies — among those The Joint Commission, CMS, ARC, The Leapfrog Group, the Institute for Healthcare Improvement, and the Centers for Disease Control and Prevention — to develop what Denham refers to as "the most harmonized, synchronized set of activities and steps taken to reduce infections that has ever been put out. All of these organizations have come to agreement about what works," Denham says.

Though each agency will pursue its own areas, the collaboration's efforts on this front will be revealed this month. And Denham's excitement about it is palpable.

"The recommendations and, in some ways, requirements have been harmonized in a way that has never been done before," he says, "and a synchronized road map has been developed to help hospitals reach the goal of dramatic reductions in infections."

The work to avoid HAIs has just begun in earnest for some hospitals, and how close to "never" they can get remains to be seen. Health care lawyer and blog writer **David Harlow** recalls a law passed about 20 years ago in reference to nursing homes and certain deficiencies in care. The law, like the CMS never-event policies, had a zero tolerance approach.

After many years of comments from industry, Harlow says, the final regulations adopted a "substantial compliance approach even though the statue required 100% compliance. The regulatory agency eventually realized that that was completely impossible and unrealistic." In that case, he says, the zero tolerance policy was deemed "unadministratable." ■

Policy at the University of Wisconsin Hospital and Clinics, referring to the method of screening drug orders before she began to use Premier Inc.'s web-based tools.

"I would print from the pharmacy billing system a list of patients who were on a dozen different antibiotics we were targeting for reasons of high cost and high risk in terms of resistance. It wouldn't tell me how long they had been on them. It was time-consuming, and I couldn't really look in depth."

Saving time with automated surveillance

That was before Premier Inc. pitched an automated system to flag positive culture results and screen pharmacy data to the hospital's infection control department. With the new system, Bland says, instead of being able to look at only a dozen or so drugs, she could screen all antibiotic orders if she thought it necessary or at least screen orders that raise concern — for instance, patients who have been on vancomycin for three days.

In trying to identify candidates at risk for infections, clinicians can spend two to five hours a day sifting through paperwork, says Premier's **Scott Pope**, PharmD, national director for SafetySurveillor, a web-based tracking tool.

With the product in hand, Bland and an infectious disease physician set up the parameters they wanted to track. For instance, they wanted to be alerted each time a broad-spectrum drug was ordered for a gram-negative organism, because as she explains, there "aren't really any new drugs in the pipeline for gram-negative organisms so we want to hold on and conserve those drugs very tightly."

Once she is flagged about the order, she can review the patient's medical record to determine if the prescription is appropriate. If she thinks it

is, she can then review the culture after three days. "Now I want to look when the cultures are back, is it appropriate? Does the patient have an organism based on the culture results that justifies the continued use of the drug?" She continues to receive alerts in these cases to determine if the treatment period has been sufficient or if it's necessary to run the patient on a full course.

While "it may not be a significant change for the individual patient," she says, "since that patient is going to get better whether they hit eight days, 10 days, or 12 days, but if I can get eight days maybe some future patient is going to be better off."

And that's where tight screening pays off, she says. She acknowledges that if a patient develops a hospital-acquired infection (HAI) the hospital will not receive reimbursement but points out that since the hospital is paying it's better to not pay for the care of a resistant and more time- and resource-consuming infection.

Every day Bland runs a report and goes through the 60-90 alerts she might get. Going through those, she whittles the cases down to about 15 that need follow up. In concert with the infectious disease physician, she narrows that list further to identify ones that require intervention.

Relaying this to the unit pharmacist, physicians get recommendations on drug coverage such as warnings about redundant coverage or switching from IV to oral therapy — "simple cost-saving measures," Bland says.

Measures that add up.

Reducing cost per admission

Bland is analyzing "whether we've been able to stem the tide of resistant organism development" and has found that the cost of antibiotics had been increasing at about 10-15% before the implementation of the tracking tool. "We were able to stop that cold," she says. "In fact, we've been able to actually reduce the cost per admission in terms of antibiotics by about 10%" by reducing the "cost of antibiotics in terms of percentage of the overall drug budget."

Beyond the financial success, though, she adds that the real benefit to curbing resistance is that "when you're reducing antibiotic use, you're reducing the pressure on the microbe environment in the hospital and thereby you're going to be able to reduce resistance in the hospital."

What does she credit for the success they've had and their "pretty stable" antibiogram? "It's a combination of good infection control practices, good Antibiotic management, keeping patients well isolated, and keeping antibiotic use to a minimum," she says.

Steps to reduce resistance

Narrowing coverage, Bland says, is integral to reducing resistance. Other suggestions she offers:

- keep antibiotic use limited to what's appropriate and the appropriate length of time;
- dose appropriately;
- don't forget cases in which you're running antibiotics, which happens Bland says because side effects from that are not necessarily noticeable.

As far as wiping those infections out of hospitals, Bland says: "You're not going to eradicate a hospital-acquired infection. You're not going to eliminate the possibility that all of your patients will not pick up an infection. But I think you can lessen the risk that you're going to have some highly resistant organisms with good infection control and good antibiotic management."

For smaller, standalone hospitals that can't afford technology like Premier's, she suggests starting any automated system and allowing that system to sort through the drug orders. "Don't waste your personnel going through and sorting the orders, the sort of thing a microprocessor can do," she adds.

"Have an education component every so often to not abuse antibiotics. Inappropriate antibiotic use is just a lack of familiarity or a fear of not covering appropriately. If people have the right information, they will do the right thing." ■

Oversight group holds RCA teams accountable

Don't let process get off track

The Joint Commission requires a "thorough and credible" root cause analysis (RCA) for all Sentinel Events, but the process is sometimes less effective than hoped. Quality leaders at the Mayo Clinic came up with a novel solution: An oversight group to keep the process on track.

The teams assigned to perform RCAs are scheduled to meet with the hospital's Safety Advisory Panel a minimum of two times, and

more if needed.

"It is through these dialogues, as well as through periodic written reports, that we monitor the teams' progress," says **Bridget Griffin,** MPH, the hospital's sentinel event program coordinator.

From the very beginning, the team knows it must have a measurement strategy to determine if the intervention was successful or not. Before an event is closed, the measurement data must be assessed and shared with the Safety Advisory Panel.

Here are some benefits:

• The Safety Advisory Panel provides moral support for the teams working on interventions.

"The teams know that someone believes in what they are doing," says Griffin.

• The panel provides access to resources that the teams may not have known about, and/or may not have been able to access on their own.

"The expertise of the engineering department to help redesign or enhance a device, or of the Simulation Center in setting up a new training model, are both examples of such resources," says Griffin.

• The panel pushes the teams to think outside of the box and stretch themselves, in terms of interventions and measurement strategies.

An example of this is encouraging teams to begin looking closely at their near-miss data. "When possible, they need to monitor and assess those incidents that did not reach the patient, where harm did not occur under the same circumstances, and to ask why it did not occur," says Griffin.

• The panel reviews intervention plans early enough to be able to influence their direction.

"Occasionally, the panel will uncover a stated root cause that really isn't a root cause, but is actually a contributing factor," says Griffin.

Other times, they will uncover a root cause for which there are no interventions that directly tie back to it. The panel has also discovered interventions already underway that are not tied to the root cause. "For example, sometimes education and training is well intended but does not address the root cause," says Griffin.

• The panel assists teams in thinking through the measurement strategy, occasionally spotting less than robust strategies. Advice is given on how to improve these.

"The panel has a finger on the pulse of what else is happening across the institution, so we don't reinvent wheels," says Griffin. "In the end, the panel holds the teams accountable to do and to measure what they tell us they are going to do and measure."

• Some improvements that were made as a result of the RCA process include:

• Engineering worked with nursing to design a connector clip to be used with dialysis tubing.

• Pharmacy added medications to its "look alike/sound alike" computer-based alert system.

• The Simulation Center developed new training scenarios.

• Human factors and ergonomics assessments were completed in procedural and storage areas.

The panel is responsible for ensuring that teams identify measurement strategies and collect outcome data.

"However, our root cause analysis process is owned by the departments involved in a root cause analysis," says Griffin.

The departments are responsible for identifying and implementing viable interventions and ensuring that the gains are sustained. "It is the responsibility of the panel and the sentinel event program staff to ensure that teams understand this from the start," says Griffin.

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Improving surgical outcomes with data tool

Keep your finger on the pulse with objective data

The National Surgical Quality Improvement Program (NSQIP) began in 1994 in response to concern over the quality of care, specifically operative mortality rates, in VA hospitals. Since then it has expanded to all hospital settings and come under the auspices of the American College of Surgeons (ACS).

When **Pierre Saldinger**, MD, FACS, chairman of the department of surgery at Danbury Hospital (CT) came across the NSQIP booth at an ACS annual hospital, he decided to compel his administration to sign up for it and the hospital became one of the first outside of the initial pilot to participate. His intention was to find "a database or system that would help me do objec-

tive data measurement" and he says he found it with NSQIP.

When Danbury sends its data to NSQIP, they are all blinded and are benchmarked against data the organization already has on the 200 or so participating hospitals. Saldinger can choose to run reports "on any permutation" he wants — surgeon-specific, procedure-specific or by hospital category according to admission, scope, or bedside. And twice a year, he gets a risk-adjusted assessment of the data. This is what makes the difference, he says, setting the data apart as more objective, more useful.

When you go through the peer review process, he says, the "bottom line" of the resulting data is that "we don't know because it may be a blip or it may be real, but with those data there's really no way to tell."

The risk-adjustment, he says, eliminates that variable. "I think honestly this is the only way to track performance," Saldinger says. "It's independent, it's objective, all the complications are defined." The ACS audits the data once a year, and hospitals are allowed only a 5% discrepancy.

Crucial to the program is what NSQIP refers to as a clinical nurse reviewer. Only the nurse and Saldinger are privy to the data returned from ACS. Instead of placing her in the department of surgery, Saldinger decided to place her in the performance improvement department, where she would have more team support. She is jointly accountable to Saldinger and the chief risk officer. The three meet monthly, and he says the collaboration has been key.

Currently, Danbury has a module for both the general vascular surgery department and its bariatric surgery program. Saldinger culls data on "anything from wound infection, which has a lot of traction these days; to DVTs; to renal failure; reintubation; prolonged intubation; cardiac events" and all of these within 30 days.

The other part, he says, is it is combined with the hospital's peer review process. For instance, he says, "we had a surgeon who had a cluster of complications in a short period of time, which throws everyone into a loop and everyone gets nervous and excited about it." They compared that surgeon with a similar profile in terms of cases and complication profile. "And other than the fact that they came clustered in time, they had an almost identical profile. So now you can say, we'll keep monitoring but there doesn't seem to be a problem. It's just bad luck."

In searching through the data he and the nurse reviewer receive, Saldinger says they come across other discrepancies that wouldn't have been revealed. "If you present that to the hospital administrator," he says, "that will resonate right away because of Joint Commission readiness and the stuff that goes along with that."

Keeping your 'finger on the pulse'

Because he can pull data on any time for any measure he deems necessary, Saldinger says participation in the program allows him to "constantly keep his finger on the pulse."

One of the things his team is looking at is if they should get a cardiology workup for surgery and if it's currently applied in the right way. Who makes that decision and whose discretion it is are the indicators he's looking at.

He also says "now there's a big emphasis on normathermia so we've got an initiative to maintain body temperature, particularly in colorectal surgery. The whole initiative that pertains to glycemic control is all part of the surgical site infection and even though we're low, we want to stay that way."

The NSQIP program is closely tied to the Surgical Care Improvement Project (SCIP) measures. Saldinger says his team found they weren't doing as well as they would have liked on those. So they went to the data gatherers to find out how data were collected and noticed "for the most part, it was a lack of documentation and and processes."

In response, they created an order form for preop orders according to the SCIP measures. Only one antibiotic is listed for a variety of surgeries and if a doctor selects another, he or she has to explain why that decision was made. All the DVT prophylactic measures are included as well as beta-blockers. Documentation during surgery as to the DVT prophylaxis, one of the measures, is now also done.

Now they are reviewing their preop processes as their data show part of the problem is they have a low threshold in getting duplex ultrasounds postoperatively.

The cost factor

Beyond the annual fee, the program calls for an FTE, "which [together] generously calculated," Saldinger says, "could go anywhere from $150,000 to $200,000 a year." As the physician champion, it was Saldinger's task to sell the pro-

gram to administration. While he admits it is difficult to show direct returns, he can show administrators how, for example, if you can lower your wound infection incidents that will lower your costs, especially as Medicare no longer will pay for infections acquired in the hospital.

The private and faculty surgeons have agreed to let him look at their records, "which I felt was a big step and show of trust." Knowing that only Saldinger and the nurse reviewer have access to those data also helps in making physicians feel secure. With the multifactorial problems they face, he says, "you need to know how to navigate the system so as not to alienate people but at the same time be able to convey a problem in an objective fashion that will lead to people stepping up to the plate to contribute to performance improvement."

"I really had to convey to my department and the surgeons who participate that this is not big brother watching you." You don't want to force anyone into participating, and you don't want anyone to feel that the data will be used in a punitive fashion, he adds.

He says quality improvement personnel can be viewed as "bad people" or as "spies."

"It's a very sensitive topic, very sensitive if you give surgeons any inkling that [the data] could be used in any other way than advertised, they will not participate and your project is damned," he says. ■

Getting board members on board with education

State requirements for trustees changing

Several states are re-energizing hospital board member education efforts with moves to certify and mandate educational requirements. Minnesota has started a voluntary certification program, and New Jersey has passed laws to require education.

"I think we're going to see, especially if the new law from New Jersey goes over well, more of a push to have some kind of certification [for hospital trustees]," says **Peggy Westby**, vice president of the Minnesota Hospital Association (MHA).

Though the MHA's trustee council had been working on getting a certification program going for three years, the program launched in January, and Westby says 80 trustees are already going through the process. The association has two annual events each year for board members — a winter conference and a summer one, which they've been doing for about 22 years.

MHA's trustee council spent a lot of time narrowing down what educational components would be a part of the program, beyond the general governance practices. Components include:

- principles of governance — knowing their mission and vision, the basic role of a trustee, conflict of interest concepts, and ethics;
- strategic planning and positioning — setting goals, comprehending trends, developing policies for the overall operations, and working with physicians;
- the role of the board member in quality improvement and patient safety, which Westby says they are really pushing and include something on this at "every single conference we have";
- fiduciary responsibilities;
- board development and self-assessment.

In order to be certified in Minnesota, board members must get 36 credits and send to MHA where they got the credits, the program description, and the program content. Twelve units must be taken in principles of effective governance and the others in prescribed categories, which MHA includes in its program descriptions for participants to easily identify and track.

Westby says the winter conference used to have about 80 participants, but this year enrolled 210 people. The summer conference usually had about 135 enrollees and this year saw 190 participants so trustees are taking advantage of the new certification option.

"They're probably the most dedicated people I've seen," she says, "because in Minnesota the board members are all voluntary, they don't get paid. They do it for many different reasons." Hospitals in the state are usually in smaller areas and are the largest employers in those areas so trustees, she says, see it as a way to give back to their communities.

Conferences are always held on the weekends, starting on Friday and ending on Sunday so people with full-time jobs can attend. And the MHA often includes North Dakota and South Dakota trustees in their educational events.

One area of confusion for Minnesota members, Westby says, is the concept of the states' new adverse events law, for which the state must "literally publicize all of our mistakes." Trustees "sometimes don't see the value of telling every-

one your mistakes, but they're getting to that point where they see that transparency is only a good thing," she says.

Mandating education

While the program in Minnesota offers voluntary certification, New Jersey is now mandating board members receive education. The legislation came in response to recommendations from the New Jersey Governor's Commission on Rationalizing Health Care, know statewide as the Reinhardt Report.

The New Jersey Hospital Association (NJHA) had no objection and testified for the law to be passed. Currently, all hospital trustees from general hospitals must receive seven hours of education. **Sally Roslow**, vice president of development and trustee relations at the NJHA, says the education is crucial in giving board members "a common foundation" to work from.

The NJHA, like the MHA, offers two annual conferences, in the fall during the evening and in the summer during the day but with the new laws in place will probably expand on that. She says in her tenure at the association, the focus on governance is no longer ancillary but has become pivotal.

Educational components mirror those in Minnesota:

- ethical and fiduciary responsibilities of a member of a hospital governing body;
- role of the governing body in improving the quality of health care and mechanisms for achieving that;
- hospital financial management and understanding reimbursement and financial payment systems;
- hospital leadership and governance;
- legal and regulatory compliance issues.

As to quality, Roslow, says "you can't have quality if the board doesn't endorse that. They're the last line." Trustees are more a part of that than ever before, she says.

"Now they're getting quality reports. They're looking at compliance. They're talking to compliance officers," she says.

While boards work on compliance and quality issues on a strategic level, not on a day-to-day level, it is important for them to be the stewards of those things, Roslow says. They might not be creating the checklists, but they can suggest the

hospital have discussions about creating one.

Roslow says the NJHA has been receiving lots of calls from other states "looking to create similar programs. For us it wasn't a difficult process," she says. But they started because, she says, it was the right thing to do. ■

Is the 'Patients' Right to Know' constitutional?

Florida legislation making medical records public

Dubbed the "Patients' Right to Know Amendment," Florida's Amendment 7 has hospital watchdogs and consumer rights groups up in arms about what is constitutional and what should be revealed about hospitals' peer review records. Hospital associations hold the confidentiality of those records as sacrosanct while consumer rights activists ask, "what are they trying to hide?" While passed by Florida voters in 2004, the law is mired in the courts, and opinions on both sides are still teeming. Could your state be next?

Amendment 7 gives patients "access to any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident." And recently the Florida Supreme Court upheld the amendment, adding that it applied retroactively to any medical record created before the passage of the amendment.

The Florida Hospital Association is the lead plaintiff in a statewide lawsuit in federal court alleging that the amendment runs counter to federal statutes. **Bill Bell**, general counsel at the FHA, says Florida has a unique process for putting amendments on the ballot and questions not only the way the bill was sold to voters but its very constitutionality.

In Florida, Bell says, a voter initiative petition process holds that if you can get enough signatures on a given issue, that issue can be put on the ballot. According to Bell, the driving force behind the petition was the Florida Academy of Trial Lawyers.

Bell contends that the "way the bill was titled and the way it was sold to voters" was that any potential patient could see hospital incident records to help them select doctors and hospitals for their future care. "In other words," he says, "it's worded with the correct buzz words, focus

CNE *questions*

13. According to **Robert Pickoff**, MD, MMM, chief medical officer at Hunterdon Medical Center, what is the approximate percentage of orders being changed on a PharmD's recommendation?
A. 50%
B. 70%
C. 75%
D. 90%

14. According to **Sarah Bland**, RPh, senior clinical pharmacist, Center for Drug Policy at the University of Wisconsin Hospital and Clinics, the cost of antibiotic per admission has dropped __.
A. 10%
B. 15%
C. 20%
D. 25%

15. About how many trustees are in the process of applying for certification in Minnesota?
A. 50
B. 60
C. 70
D. 80

16. Which of these are benefits of the meetings between the RCA teams and the oversight group at Mayo Clinic?
A. The Safety Advisory Panel provides moral support.
B. The panel pushes the team to think innovatively.
C. The panel reviews intervention plans earlier.
D. All of the above

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

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

grouped, and surveyed in order to grab the voters' attention, who are going to have about 10 seconds to decide on an issue that Florida and other states have spent 30 years debating and researching and litigating."

But, he says, since the passage of the bill, all information requests have come from medical malpractice attorneys representing patients in existing cases "to assist them in their lawsuit." Hospitals in Florida, he says, have always been committed to improving care and safety, and Florida was one of the first states to require a risk management program.

Bell says the crux of the case the association, the Florida Medical Association, and other groups have lodged is "that by opening up those discussions or those records that are created, people become a little more cautious in what they write down and that's not helpful. Really the amendment has become a fishing expedition for trial lawyers."

Bell contends that the law runs counter to several federal ones, in particular the Health Insurance Portability and Accountability Act and the Health Care Quality Improvement Act, among others, as well as the constitutional right to due process "if nothing else, for the retroactive issue. And there are federal rights for contracting, and certainly hospitals and their medical staffs entered into agreements that we think are under federal protection."

Beyond that, Bell cites the administrative burden of collecting all the fragmented records and redacting any information that the hospital otherwise cannot legally disseminate, although he says the courts now will allow hospitals to pass that cost to the requester.

As to the administrative burden, **Bill Newton**, executive director of the Florida Consumer Action Network, laughs, saying "Really? I could create some computer program for them."

Newton disputes Bell's assertion that the confidentially of the peer review process that elicits frank and open disclosure will be threatened by the amendment, saying "they're [hospitals and doctors] afraid of what might happen, and they think people might misunderstand. I think that's clear. But if you look at other examples in the marketplace, we can see that other types of businesses have been able to do this and use the information in a positive way and if we're lucky, it'll get some bad apples out of the community.

"If there was a good process set up with peer reviews now where it would be public, that would be great. But there isn't. It's done behind closed doors." And he points to sites such as angieslist.com that already are posting people's experience at hospitals and with doctors. So wouldn't hospitals want to direct that conversation if it's going to happen in this Internet-savvy environment anyway? he asks. He adds that the concept of doctors judging other doctors in regard to adverse event disclosures is only a "perceived bias. Getting real information out there. What could be wrong with that?"

But, Bell says, the FHA supports transparency and patient care. The association is supporting a bill for patient safety organizations to review information in a confidential way. It's the environment the amendment will create that he dis-

CNE objectives

To earn continuing education (CNE) credit for subscribing to *Hospital Peer Review*, CNE participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from The Joint Commission or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

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putes. "Almost every state in the United States and in addition federal acts and even the most recent one with the patient safety organization have in mind the improving of patient care," he says, "and all of them recognize the concept that if you want people to have self-critical analysis, you have to an environment conducive to self-analysis." An environment, he says, that holds confidentiality as sacred. ■

The Joint Commission talks about pain

The Joint Commission announced it is launching a campaign to help people work with their care providers in managing pain. The initiative is part of the organization's Speak Up program and coincided with the Pain Awareness Month in September.

A brochure on the topic entitled "What You Should Know about Pain Management" identifies questions and answers to aid patients' understanding of treatment for pain.

Among the topics covered are:

- taking about and describing pain;
- understanding pain treatments;
- managing pain;
- questions to ask caregivers. ■

CMS extends deadline for HCAHPS data

The Centers for Medicare & Medicaid Services (CMS) has extended the deadline for submitting HCAHPS data. Hospitals can submit data for Jan. 1-March 31 discharges to qualitynet.org by 11:50 CST, July 16. ■

Could the Joint Commission have competition in the accreditation market?

Congress is now, for the first time in three decades, requiring The Joint Commission to reapply for authority to certify hospitals, perhaps opening the ground held only by the commission to other players.

In the next issue of *Hospital Peer Review* we will cover what this could be mean both to The Joint Commission and to you.