

Healthcare Benchmarks and Quality Improvement

The
Newsletter
of Best
Practices



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Communication, vaccinations are among key H1N1 quality concerns

Myths must be exploded; even staff require more education

The good news — if you can call it that — about H1N1 is that it gave us a “sneak peak” this past spring and summer at what it is and how it works, hopefully making it easier to prepare for another, potentially more serious outbreak during this flu season.

The bad news? Quality managers still have a lot of work ahead of them.

“I think what we’ve learned for the most part is that we weren’t really ready,” says **Katherine West**, BSN, MSED, CIC, infection control consultant, Infection Control/Emerging Concepts in Manassas, VA. “Even though we did not have the severity of the disease we feared, it was a good wakeup call to dust off plans and see if they are truly workable.”

One of the keys to making your plan succeed, quality managers agree, is communication. “That’s one of the lessons we learned; that this had a lot to do with communication,” says **Rita Stockman**, RN, MSA, director, accreditation and quality at William Beaumont Hospital, Royal Oak, MI.

What is required, she found, is more routine communication — as often as possible. “You need to make presentations to administration and to the team — to let them know where you’re at with staff call-in rates, or personal protective equipment stock levels — how many we have in stock.” That applies to levels of all

Key Points

- Communicate with staff on every aspect of your planning.
- One-on-one education sessions may be most effective.
- Strive to have as many employees as possible vaccinated.

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materials, she emphasizes.

“What I really learned is that we need to run this more like an emergency management situation,” she continues. “That became clear as more opinions were expressed. If you plan it out that way, and anticipate the surge, you will have far superior outcomes.”

The communication responsibilities of the quality manager become even greater when, as in Stockman’s case, he or she plays a lead role in preparing the response. “I think the role we play depends on how much control you have,” she says. “I’ve worked hand in hand to support infection control and our epidemiology team as they made the plan. If I were not a leader, I would not

be as involved, but rather playing a supporting role.”

In addition, she notes, as data collectors, the quality team gains even greater importance. “People need to be told what’s known on a daily basis,” she says. “The doctors will want to know what’s going on in the community.”

Communication boosts awareness

“When you talk about quality and patient safety, a lot of it comes down to communication awareness,” says **Anne R. Van Waes**, RN, MS, CIC, coordinator of infection control at Anne Arundel Medical Center in Annapolis, MD. Van Waes says she has seen an impressive communications effort by the facility’s quality manager, to whom she reports.

“One of the biggest lessons we’ve learned is that you can never communicate enough about anything,” she says. “Communicate on a regular basis, and then move to an ‘all points alert’ when there has to be an emergency response.”

Part of that communications effort, she continues, is to counteract what she calls “media hype.” “That becomes a big component — talking with people and trying to keep them from being too alarmed, so they are able to work without fear,” she says.

Staff presentations play an important role in H1N1 communications at Anne Arundel. “We did a presentation to the staff the other day on the different components of response — patient surge and how we developed our plan, and an alternate care site within the hospital where patients can be directed for rapid treatment and turnover,” Van Waes shares.

“In quality and patient safety, we have a number of specialized personnel like Spanish translators and patient advocates,” Van Waes continues. “By being able to talk through with them the different plans under way, they can help us be sure that we cover all the bases. For example, we have had talks about rapid discharge procedures — how to make sure patients are educated appropriately so that they feel safe when they leave the hospital.”

Other topics of discussion, she notes, include stockpiling and workforce readiness. “We try to get the message out in as many directions as we can — for example, whether employees should call out sick if a family member is sick and they are not; what kind of staffing patterns we’d have if there were a 30% reduction in the workforce;

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Editorial Questions

For questions or comments, call **Steve Lewis** at (770) 442-9805.

APIC, ASHES offer tips for patients

Quality managers and other professionals seeking to deal with potential disease outbreaks know that patient education and cooperation are critical elements in keeping things under control and ensuring optimal patient and staff safety. The Association for Professionals in Infection Control and Epidemiology (APIC) and the American Society for Healthcare Environmental Services (ASHES) have come up with a list of tips for ensuring a clean, healthy environment in a health care facility that you may wish to share with your patients:

- **Hand hygiene is job one: Clean your hands — and request that others do the same**

Germs reside on many surfaces in the hospital — including bed rails, stethoscopes, faucets, and even the TV remote control. You and your health care workers can pick up these germs on hands. So it is important to keep hands away from your tubes, wounds, and face, and wash or sanitize your hands frequently. Cover your cough or sneeze with a tissue or your sleeve. Watch the staff to make sure they wash or sanitize their hands with waterless sanitizer before providing care — and remind them if they forget. Ask for waterless hand sanitizer near your bedside.

- **Survey your room — does it look clean?**

Just like home, your hospital room should look and smell clean. Rooms should be cleaned daily. The areas of the patient room most at risk for harboring and spreading infection are those frequently touched by you and by health care workers. These are called “high-touch surfaces” and include bed rails, bedside tables, IV poles, call bells, door handles, bathroom surfaces, and computer keyboards. Environmental services (ES) staff should put on a new pair of gloves when they enter your room, and focus on comprehensive cleaning of the high-touch surfaces. Observe the cleaning process to ensure the high-touch areas are being cleaned. Don’t be shy — if you believe they have missed something, say something! ES technicians might leave a card to let you know if they cleaned while you were away. If you have questions, call or ask nursing to call. Alerting the environmental staff of a concern will help to

ensure a clean, healthy environment.

- **Don’t contribute to the clutter.**

Limit personal items and reduce clutter to ease the critical job of cleaning hospital rooms. Keep personal items off the floor and away from waste containers. Ask for a trash basket near your bed and have visitors dispose of their trash promptly — including pizza boxes and take-out food containers.

- **Clean your over-the-bed tray**

Your over-the-bed table should be cleaned/disinfected at least once a day. This should be done by your environmental services staff, but can be repeated just before you eat by the person delivering your meal tray.

- **Never use a dirty pillow**

Notify a staff member if your pillow falls on the floor or becomes soiled.

- **Observe visitor etiquette.**

To keep your environment as clean as possible, visitors should not sit on your bed or handle your equipment. Ask visitors to sanitize their hands when entering and leaving your room to avoid bringing in and carrying out germs. Guests should not visit if they are sick or have had any symptoms within the last three days including nausea, vomiting, diarrhea, fever (or feeling feverish), uncontrolled cough or rash.

- **Take your slippers off.**

To prevent germs on the floor from contaminating your bed, remove your slippers, socks or footies before putting your feet on or in your bed.

- **A word about patient bathrooms.**

Patient bathrooms are just for patients. Visitors should use common bathrooms in the lobby or hallways.

- **Meet your infection preventionist and your environmental services technician**

Patients often see many health care workers, but they don’t usually see those who work behind the scenes to ensure the prevention of health care-associated infections. All hospitals have an infection preventionist — a qualified nurse or other professional who manages the hospital’s infection prevention program, as well as a team of environmental services technicians. To learn more about infection prevention, ask to see the infection preventionist.

Additional information is available at www.preventinfection.org and www.ashes.org.

Source: The Association for Professionals in Infection Control and Epidemiology and the American Society for Healthcare Environmental Services.

and alternate job roles,” says Van Waes. “We try to encourage them to figure out the jobs they are doing that are absolutely essential for keeping the hospital fully functioning and what types of goals

might have to go by the wayside in an event that everyone is needed to help with patient response. For example, an employee doing a desk job might be asked to help pass out linens or water, help

with discharge or transportation — do things they are not used to doing but to which they could try to apply their skill level in the best way possible to help deal with a high level of patients.”

Handling staff vaccinations

One of the trickiest areas when it comes to preparation, experts agree, is how to handle staff vaccinations. Some states, such as New York, have taken the problem out of the hospitals’ hands; all health care workers are now required to receive the seasonal flu vaccination.

But many hospital policies try to find a happy medium. “One hospital in Michigan has made vaccination mandatory, but here, we very strongly recommend it; you have to either accept the vaccination or sign a declination statement stating, ‘I know that I am eligible for the flu shot, and I am at risk of acquiring influenza infection. I understand that I may spread influenza to others, even if I have do not have symptoms. I have been given the opportunity to be vaccinated with influenza vaccine at no charge to myself.

However, I decline the influenza vaccine at this time,’” says **Paula Keller**, MS, CIC, technical director epidemiology at William Beaumont. “We also have a respiratory hygiene plan that includes the placing of masks and hand sanitizer, solutions, and tissues at all information desks, registration desks, and in the doctors’ offices.” As part of the plan, she adds, everyone is expected to wash their hands and to wear a mask or cover their mouths with a tissue when they cough, discard the tissue in the trash, then cleanse their hands. A mask is placed on people who cannot reliably cover their cough.

“We have two methods of surveillance for hand hygiene,” says Keller. “Infection control practitioners directly observe; they are on the units nearly every day. We also have ‘secret’ observers — individuals from the units; we are really serious about this.”

Communication is critical here as well. “If someone is not following the proper hygiene practice, we will correct them immediately; I’d say, for example, ‘Hi, I’m from infection control, and Paula, I noticed that you didn’t wash your hands.’” The same holds true for isolation protection, she notes.

If someone tells her that a physician has not washed his or her hands, for example, she will write a letter to the physician “non-washer” and

to his or her supervisor.

Communication also helps improve participation rates, says Keller. “Last year some staff members filed declinations that included their reasons for not taking the flu vaccine, and there were those who said, ‘I don’t believe it works,’” she shares. “So, we give them scientific data. We give them all the real information — not smoke and mirrors — because we want people to trust us.” Participation rates, she says, improve every year.

“The Joint Commission is looking at vaccination as a patient safety issue,” adds West, who says that she doesn’t think a mandatory policy is the best approach. “We have only 33% of health care workers who participate; you have to do it through education,” she asserts.

A lot of facilities, West continues, are taking short-cuts in this area. “You should use an infection preventionist to do face-to-face, one-on-one training,” she advises. “This way they can get a feel for the group, learn their concerns, and answer them. If people are using taped and computerized programs, I don’t think it will completely help the facility get to the root of the participation issue.”

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Is an outcomes-based approach the best?

Surgical collaborative moving in that direction

An ongoing study of nearly 200 hospitals in a collaborative sponsored by the American College of Surgeons (ACS) appears to make a strong argument for outcomes-based QI

Key Points

- Morbidity, mortality rates improve in outcomes-based collaborative.
- Risk-adjusted clinical data provide clearer picture of performance.
- “Everything in moderation” is best way to use alternate approaches.

programs such as the National Surgical Quality Improvement Program (NSQIP), described in an article published in the September issue of the *Annals of Surgery*.¹ The results of the study showed that morbidity rates improved for 82% of the participants and mortality rates improved for 66% of the participants.

“NSQIP is a quality program that targets surgery, and the unique aspect is that it uses clinical data as opposed to administrative or claims data, and it is risk-adjusted with clinical data; that works a lot better to do the risk adjustment than claims data,” explains **Clifford Y. Ko, MD, MS, MSHS, FACS**, director of the ACS division of research and optimal patient care, and one of the article’s authors. “It is outcomes-based rather than process-based. Finally, within the program, there is data feedback to help target where improvement should happen and expertise providing guidelines, and case studies as well, so you can learn how others decrease length of stay, improve efficiency, and so forth.”

Outcome vs. process

Ko notes that with a process-based approach, the belief is that, “if everyone can think of the right things to do and we all do them, that’s good quality care.” In an outcomes-based approach, he explains, “You send people to facilities that have good outcomes; it does not matter how many patients they see.” This runs contrary to some current thinking that, for example, hospitals that perform the greatest number of open-heart surgeries are likely to have the best outcomes.

“The real kicker is that we found — and others are starting to report — that there’s a lack of correlation between processes and quality,” says Ko. “A lot our strategies are based on process — like giving aspirin and beta blockers. But we’ve started to find in surgery, for example, that there are a number of process measures like prophylactic antibiotics within an hour of surgery that have little or no correlation to outcomes. In other

words, you’d expect those who are 99% compliant to have better outcomes than those that are 55% compliance, but there’s not necessarily a correlation.”

That doesn’t mean, he emphasizes, that you should throw out process measures. “What probably happens is that we identify maybe five or six of the most important things to do, but there may be another 10, 20, 30, or 50 important things you have to do to get, for example, the rate of infections down. What has happened is that we are ‘studying for the test’ — the things on which we are measured, for example, for pay for performance. But we are not targeting other things that are important; we lose the big picture, which is helping patients with outcomes.”

Improve processes?

Ironically, Ko says that once you learn that your outcomes are not as good as you’d like them to be, “You get better by improving processes.” However, he adds, “It should not be just the six things; it may be 50 things.”

It’s up to each facility, he continues, to figure out what it’s good at and what it is not good at, and how to improve. “The best way to do QI is to find out what went wrong and the best way to fix it in your hospital,” he says. The case studies and guidelines provided by NSQIP, he notes, are designed to help hospitals do just that.

The key, he explains, is to maintain balance. For example, while many preach standardization, he is opposed to what he calls “cookbook” medicine. “Everything in moderation; you can’t have the wild wild West, but you can’t standardize everything,” he asserts.

The same holds true, he continues, for tools such as Lean methodology. “Virginia Mason is one of the most advanced facilities when it comes to Lean methodology — it’s amazing to see them,” he says. “There are certain things to take from them — getting everyone on board and having that kind of culture is all great, but you have to tailor it to your medicine and your setting. Not all cultures or resources are the same.”

In an effort to achieve that balance, ACS is now working with the Centers for Medicare & Medicaid Services (CMS). “The process way to improvement is the way CMS has done incentivized programs, but we are working on a contract with them to develop more outcomes measures,” he shares. “We’re trying to help the patients and also help the providers; if there are

six or 10 or 15 process measures you have to collect data on, wouldn't it be easier to collect data on just a few outcomes measures?"

(Editor's note: For more information on ACS/NSQIP, go to: acsnsqip.org/login/default.aspx.)

Reference

1. Hall BL, Hamilton BH, Richards K, Bilimoria KY, Cohen ME, and Ko CY. Does Surgical Quality Improve in the American College of Surgeons National Surgical Quality Improvement Program? An Evaluation of All Participating Hospitals. *Ann Surg* 2009; 250. DOI: 10.1097/SLA.0b013e181b4148f. ■

Health plan, physicians collaborate, improve care

Pilot coordinates care for diabetic patients

A unique partnership between a health plan and a physician practice is helping patients with diabetes get the care and resources they need to manage their disease.

The patient-centered medical home pilot project focuses on people with diabetes who are members of BlueCross BlueShield of South Carolina, BlueChoice Health Plan of South Carolina, the State Health Plan, or BlueCross Blue Shield Federal and who are patients of Palmetto Primary Care Physicians in the Charleston, SC, area.

The pilot project began in April using a model that integrates quality improvement, coordinated care management, and patient educational services into primary care practices.

Case managers located in the physician practice corporate business office act as liaisons between individual physicians and their patients between visits. They collaborate with the health plan's disease management nurses and certified diabetes educators to help patients comply with their treatment plan, receive the recommended tests and procedures, and reduce gaps in care. The physician office-based case managers contact the patients by telephone to help them schedule appointments with specialists and access community resources when necessary.

"We believe that if patients become more educated and better able to self-manage their disease and physicians are enabled to deliver evidence-based care, patients will experience fewer hospi-

Key Points

- The pilot melds quality improvement, coordinated care management, and patient educational services into primary care practices.
- The program is aimed at lowering overall costs for employers and absenteeism.
- It is an opt-out program.

talizations and emergency room visits and enjoy a better quality of life," says **Laura Long**, MD, MPH, vice president of clinical quality and health management for BlueCross BlueShield of South Carolina.

The program should result in overall lower costs for employers and less absenteeism as well, she adds.

"Our employers are interested in patients being healthier and at work. They're looking beyond lowering their costs for health care. They want their employees to feel good on the job so they can be more productive in the workplace," she says.

Palmetto Primary Care Physicians receives the traditional fee-for-service reimbursement for the care they provide patients, as well as an additional fee per participant, per month that allows them to fund the case management program.

In addition, through BlueCross BlueShield of South Carolina's pay-for-performance program, the physician practice receives quality-based bonuses, which reward the practice for improving quality and outcomes.

"Before we began this project, case management wasn't a reimbursable service so it wasn't practical for the physician practices to have case managers. By realigning reimbursement, it allows them to provide a different type of service to support their patients and to take a more proactive approach to care. It helps the physicians focus on delivering evidence-based care and quality outcomes," Long says.

The program takes a proactive approach to care and reaches out to all patients who have been identified with Type 1 or Type 2 diabetes, Long says.

"In the past, programs focused on the most complex patients. All patients are eligible for this program. Rather than just treating the patients who walk in the door, the program also reaches out to the patients who are not coming in for services and helps them overcome the obstacles to seeking care," Long says.

Once patients are identified for the program, they receive a welcome letter from the physician practice and the health plan. The introductory packet includes information on the physician practice's extended care hours, an offer for a free glucometer from the insurer, and a blood sugar tracking booklet.

The case manager follows up with a telephone call to ascertain the patient's willingness to participate. Interested patients receive another packet with information on diabetes and tips for better nutrition, diet, and exercise.

The program is an opt-out program to which most have responded favorably when the case managers call to explain the project, says **Amber Winkler**, MHA, case manager with Palmetto Primary Care Physicians.

After the initial call, case management outreach is customized based on the needs and requests of the patients.

The physician-based case managers are non-clinical staff who provide support and resources for the patients and work with the BlueCross BlueShield clinical disease managers to ensure that patients get the clinical information they need.

Each physician-based case manager works with about 500 patients.

"We strictly avoid giving patients clinical advice. We concentrate on giving the patient the resources they need to follow their treatment plan," Winkler says.

For instance, the physician-based case managers make sure that the patients keep their appointments to see their doctor, facilitate referrals when needed, make sure that the patients' test results get back in the chart, and help patients overcome obstacles to adherence.

They provide additional resources to the patients, including free week passes and discounts to local gyms; cookbooks; American Diabetes Association-approved nutrition materials such as meal plans; diabetic education classes; free glucometers; discounts on prescriptions or free samples of medication; and patient assistance programs.

Patients have access to the case managers at the corporate office and their physician offices through a secure web-based portal.

"We look at information like their last appointment date, gaps in care, and their most recent laboratory values. We assess what they are willing to learn about and do to manage their condition. When patients need clinical advice, we help them

interface with the BlueCross clinical diabetes educator and their physician's office," Winkler says.

The improved communication, coordination, and interaction between the physician offices and the health plan are unprecedented and are a key component of the program, Long says.

In the past, the two organizations tended to work in silos. Now they work together to make sure that the gaps in care are covered, she adds.

"Before we started this program, case managers and disease managers at the health plan level communicated with members and occasionally talked to someone in the physician offices. Under this model, we're tightly interfaced with the case manager in the physician office through an electronic link into the electronic medical record in the doctor's office," Long says.

"It's been a great arrangement for both of us. It's opened up a lot of communication between the physician practice and the insurer. Having direct contact with the insurer is a big help," Winkler adds.

For instance, the arrangement allows the health plan's diabetes educators to access patients' medical record and care plan as they work with them.

"The ability to follow through and the level of communication are significantly enhanced. The diabetes educators can add an electronic sticky note for the case manager or physician based on the conversation they've had with the member and vice versa," Long says.

By having access to the health plan's data, the physician office case manager can tell if the patient actually filled his or her prescription and can discuss it with the patient on the telephone and get the patient medication assistance or a coupon for a prescription if needed.

"We work so closely with the health plan and know our patients so well that we can advise them on the best way to get prescriptions or supplies. We have access to each patient's individual coverage so we can advise the patients what is best for them," Winkler says.

For instance, the case managers have suggested that patients consider generic drugs or a different glucometer because they would be covered under their plans.

One patient was paying out of pocket for his glucometer strips. Winkler advised him that his health plan would pay for the strips if he got a prescription for them and paid the copay.

"Benefits can be so complex and so difficult for patients to understand. We try to work out the

best way for the patient to get what they need and pay for it so they will keep following their treatment plan,” Winkler says.

The case managers take an individualized approach to each patient’s unique situation, identifying why gaps in care occur and working to overcome the barriers.

“We look at whatever we can rearrange to make the situation workable. If the patient is on a high-deductible health plan and can’t afford the deductible, we see if they qualify for a patient assistance program,” she says.

They assist patients who are eligible for Medicaid supplemental insurance but need help filling out the paperwork.

In some cases, the case managers work with the health plan to get an out-of-contract social worker visit authorized as an alternative treatment plan.

“Within this pilot, we have the ability to be flexible on a case-by-case basis,” Long says.

In one instance, a patient who had lost his job was afraid to come into the office with a broken toe and an infection because of financial problems. The case manager at the physician practice called the health plan to get approval for an office visit and get him help with his medication needs.

“The health plan bridged a gap until the physician office case managers could get other resources in place,” Winkler says.

The physician office case managers have compiled a tremendous amount of information on community resources and other programs that can help patients overcome their obstacles to getting care or complying with the treatment plan.

“Since the case managers are in the Charleston area where the patients live, they are able to identify an amazing amount of community resources that help patients overcome the barriers to care. The case managers at Palmetto Primary Care Physicians have wonderful social and organization skills, which help them connect with the patient and identify their needs. Anytime they need us, they can call us in and we’ll get involved,” Long says.

The physician office case managers work closely with the patients to make their health care dollars stretch.

“Many times when we get to know the patients, we find they are spending money unnecessarily on things that are covered by insurance and are skimping on things that they really need. We utilize every resource we can find to help the patients get what they need to keep their

disease under control,” Winkler says.

For instance, when the case managers can help patients find transportation assistance or get help with an electric bill, it frees up money to pay for medications, or if patients can get low-cost generic drugs, they can use the money they would have spent on drugs for their copay.

“It’s kind of like a shell game, a matter of arranging and maximizing the patient’s available dollars. The case managers have been very adept at identifying community and health plan resources to fill the gaps in care,” Long says. ■

TJC urges CEOs to lead the fight against MDROs

2010 deadline looms for patient safety goal

The Joint Commission is calling on health care administrators to take the lead in preventing infections with multidrug-resistant organisms (MDROs), reminding them that current patient safety goals require CEOs to take responsibility for implementing programs to prevent these deadly and costly outcomes.

The initiative is outlined in a new report: “What Every Health Care Executive Should Know: The Cost of Antibiotic Resistance,” a free, online multimedia toolkit developed by Joint Commission Resources (JCR) for hospital executives.

MDROs such as methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant *Enterococcus*, *Clostridium difficile*, and resistant gram-negative bacteria such as *Pseudomonas aeruginosa* are increasingly common causes of health care-associated infections (HAIs). The threat posed by MDROs becomes more serious every day — not only because of the failure to control known pathogens but also because of the emergence of entirely new strains, which add to the burden of prevention, the report states.

“The problem of antimicrobial resistance and MDROs is increasing in spite of tremendous efforts to make reductions,” said **Barbara Soule**, RN, MPA, CIC, practice leader for infection control services at JCR. “Although there have been some notable exceptions, we believe patients in hospitals are deeply imperiled. Leaders who effect the changing strategic direction for clinical care and patient safety are not always aware of

Key Points

- Toolkit created as “call to action to health care executives.”
- Financial impact of MDROs should compel CEOs to get involved.
- Executives are “uniquely positioned” to contribute to the end of the era of antibiotic resistance.

the full magnitude of the problem.”

Although some patients enter the hospital already colonized with MDROs, the majority of patients who acquire MDROs likely acquire them through contact with the health care system. Acquisition of an MDRO generally occurs without the knowledge of the patient or clinicians, but a sizeable proportion of colonized patients go on to develop overt infection that can be associated with an array of poor outcomes that include death, the JCR report warns.

“We created this toolkit as a call to action to health care executives, [urging them] to lead the charge to improve patient safety and minimize the costs related to MDROs,” Soule said at a recent conference call announcing the toolkit. “At every point in the toolkit, the leader’s role is emphasized. The toolkit also is designed to provide leaders with tools that they can disseminate for use up and down the hierarchy of the organization.”

CEOs carry presence of power

To give but one example from the report, the toolkit outlines strategies for CEOs to improve hand hygiene, a simple act that can prevent MDRO transmission on the transiently colonized hands of health care workers. “The involvement of the hospital chief executive is one of the most important factors in determining whether an organization pursues a path toward continuous quality improvement or slides toward mediocrity,” the JCR notes. “Nowhere is this more apparent than in the institutional pursuit of maximizing hand hygiene compliance by health care workers.”

As with quality interventions, the CEO carries the power of persuasion in every visit on the wards. The CEO and other leaders can directly cultivate a culture of safety and quality during leadership rounds by washing their hands when coming onto the unit or before entering any

patient room, the JCR notes. Even if they are not expecting direct patient contact, the staff observation of a CEO washing his or her hands as the first action in a clinical area sends a powerful message, the report states. In addition, the leadership team should discuss hand hygiene compliance data with the management and staff of a unit, asking about compliance rates and what obstacles exist for timely and appropriate hand hygiene. As staff express concerns or make suggestions, these should be considered and a response generated after the visit to indicate that leadership is serious about making hand hygiene a priority, the JCR emphasizes.

How many patients are dying?

In the research conducted to create the toolkit, the Joint Commission asked some compelling questions to CEOs. “Fundamentally, the question we asked of executives is how many patients at your institution died last year as a result of infection with an MDRO?” said **Stephen Weber, MD**, a JCR consultant and one of the principal authors of the toolkit. “It’s a question that, frankly, most senior executives should want to be able to answer if they are not already able to.”

While there is an ethical imperative to focus on patient safety, the massive financial impact of MDROs must be a critical part of CEO engagement, emphasized Weber, medical director of infection control and clinical quality at the University of Chicago Medical Center. “Ultimately, everyone needs to recognize that each organization has to embrace MDRO control not just because it’s a good clinical idea but because of the financial ramifications,” he said. Indeed, the report underscores that the cost of care can be more than double for patients infected with resistant bugs rather than drug-susceptible ones.

“We would like to sit back and say that just the clinical impact of these pathogens ought to be enough for us to want to seize control,” Weber said during the conference call. “But we live in a fiscal environment — seemingly more and more so every day. When it comes to the economy and health care, it would really be irrational and irresponsible not to address the financial impact of antibiotic resistance. The question that I suspect is on the minds of many CFOs, is: ‘How much did it cost our hospital last year to prevent and manage infections caused by MDROs?’ If you can’t answer that question or someone in the

organization can't provide you with that answer you ought to take a close look at [the toolkit]."

Indeed, institutional chief executives are "uniquely positioned" to contribute to the end of the era of antibiotic resistance the JCR report emphasizes. "As an advocate for patients, you are entrusted to protect their interests and safety while they are under your care," the report concludes. "As a manager and leader, you can demand that those who work under you and in collaboration with you, including physicians, meet the standards of care. As a financial leader, you are uniquely positioned to ensure that those professionals who are committed to improving care at your hospital have the tools to do so, and as an officer of the organization, you have fiduciary responsibility to ensure that the operations of your hospital are as effective and efficient as they can be. In short, the job of controlling and eradicating MDROs is the job of many, but the responsibility must ultimately be borne by organizational executives like you, rather than any other group or individual."

"The intensity and sophistication of treatment in your hospital can save patients who previously would have no antibiotic options available to them and therefore little hope for cure," the report states. "At the same time, these patients are the most vulnerable to the catastrophic effects of an MDRO infection. As the numbers of patients being saved increases, so too will the size of the population vulnerable to these infections. From a clinical perspective, the stakes have never been higher."

As big as they are, health care costs and patient consequences are not the only forces driving the MDRO issue. The JCR report advises CEOs that patient advocacy groups and the media have become more outspoken and critical in their demand for improvement in the fight against "super bugs." However until recently, clinical and policy leaders have allowed their calls to go unheeded, and the public increasingly believes that hospitals cannot or will not address this problem, the report notes. That has led to legislative action, with well-intentioned laws targeting MDRO reduction raising fears of unintended consequences.

"Many agencies, publications, guidelines and regulations are calling attention to the MDRO problem," Soule said. "The Joint Commission has increased emphasis on MDROs in the 2009 patient safety goal for preventing MDROs. What mainly distinguishes this toolkit is that it has

been designed primarily for health care leaders and addressing their role in advancing to improve care."

(Editor's note: To download the toolkit, go to: <http://www.jcrinc.com/MDRO-Toolkit-Overview/Default.aspx>.) ■

Screening may provide only modest benefits

Checking for partner violence didn't yield changes

New research suggests that universal intimate partner violence (IPV) screening in health care settings does not result in significant changes in subsequent reports of IPV or quality of life, according to a study in the Aug. 5 issue of the *Journal of the American Medical Association*.

There is a lack of consensus on the issue of screening women for IPV in health care settings. Proponents support screening because of the high prevalence of IPV and associated impairment and the availability of feasible screening techniques. But organizations such as the U.S. Preventive Services Task Force and the Canadian Task Force on Preventive Health Care have concluded that insufficient evidence exists to recommend for or against universal screening, mainly due to lack of interventions that have been proved effective for women exposed to violence and referred from health care settings. "Nevertheless, clinicians and health care organizations are being encouraged to implement IPV screening. Numerous professional societies recommend routine IPV evaluation, assessment, and/or screening as a part of standard patient care, and the standards of The Joint Commission require that hospitals have objective criteria for identifying and assessing possible victims of abuse and neglect," the authors write.

Harriet L. MacMillan, MD, MSc, FRCPC, of McMaster University, Hamilton, Ontario, Canada, and colleagues examined the effectiveness of IPV screening and communication of a positive screening result to clinicians in health care settings, compared with no screening, in reducing subsequent violence and improving quality of life. The randomized controlled trial was conducted in 11 emergency departments, 12 family practices, and three obstetrics/gynecology

clinics in Ontario, Canada, among 6,743 female patients, age 18 to 64 years.

Women in the screened group (n = 3,271; 347 positive for abuse) self-completed the Woman Abuse Screening Tool (WAST). If a woman screened positive, this information was given to her clinician before the health care visit. Subsequent discussions and/or referrals were at the discretion of the treating clinician. The non-screened group (n = 3,472; 360 positive for abuse) self-completed the WAST and other measures after their visit. Women who disclosed past-year IPV were interviewed at the start of the study and every six months until 18 months regarding subsequent incidents of IPV and quality of life, as well as several health outcomes and potential harms of screening.

The authors add that even though screening might provide some small benefits on some outcomes, "It is critical to balance the number and magnitude of potential benefits of universal screening with the human, opportunity, and resource costs required. ■

through new Spanish language consumer guides released by the Agency for Healthcare Research and Quality (AHRQ).

AHRQ also released consumer guides in Spanish comparing treatments for high blood pressure, osteoporosis in women after menopause, and renal artery stenosis. The six Spanish language guides join three previously published Spanish language guides on oral medications for Type II diabetes, osteoarthritis and acid reflux disease.

"The lack of reliable health information in Spanish plays a role in health disparities faced by Hispanics in this country," said AHRQ director Carolyn M. Clancy, MD, in a statement. "It is critical that we fill this gap because many of the nation's 44 million Hispanics need or prefer to get such information in Spanish so they can talk with their doctors about which treatments are best for them."

AHRQ's recently released 2008 National Healthcare Disparities Report shows that while the quality of health care is slowly improving for the nation as a whole, it is getting worse for Hispanics, especially those who speak little or no English.

The new Spanish language consumer guides are produced by AHRQ's Effective Health Care Program, a federal effort to conduct comparative effectiveness research. That program, authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, represents a federal effort to compare alternative treatments for health conditions and make the findings public. The program is intended to help patients, doctors, nurses, pharmacists and others choose the most effective treatments.

To access the on-line Spanish-language consumer guides, as well as AHRQ's English-language consumer guides and companion guides for clinicians, go to <http://effectivehealthcare.ahrq.gov/>. Audio versions of many guides also are available. To order free printed copies of the guides, call the AHRQ Publications Clearinghouse at 1-800-358-9295 or send an e-mail to ahrqpubs@ahrq.hhs.gov. ■

NEWS BRIEFS

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