Inside the Joint Commission

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Medication management

Pharmacist-led antibiotic stewardship leads to C.diff reduction, cost savings

Adding a pharmacist to your antimicrobial stewardship program can give your facility the additional leadership and expertise it needs to drive antibiotic usage down and provide your hospital a notable cost savings for the effort.

Pharmacists lend an additional level of expertise to your stewardship efforts and help better manage antibiotic-use consistency

*(see **Stewardship**, p. 4)*

CMS

Final rules to adopt 2012 NFPA codes, emergency planning COPs may be in last stages

Two proposed CMS rules that could have significant impact on hospital fire safety and disaster preparedness management — as well as hospital budgets — are currently before the Office of Management and Budget (OMB) for review, one of the last steps before either could become final.

The OMB review takes a look at the financial impact of the final rules, which could then be released for final publication in the Federal Register or sent back to the drawing board for further work.

*(see **Proposed rules**, p. 6)*

Readmissions

OIG advisory opinion, upcoming CMS rule suggest open road for patient vans

When looking for ways to help patients make post-hospital medical appointments — and help your hospital avoid readmission penalties — consider patient transport as part of your facility's future. A new OIG Advisory Opinion (AO) appears to clear the way for providers with multiple addresses to provide shuttle van service to patients.

The opinion, posted Oct. 21, involves an "integrated health system" in a rural area that wants to run free patient shuttle vans among its community hospitals, medical center, clinic and ambulatory surgical center.

Experts say OIG's approval of the arrangement combined with a pending CMS final rule suggest the federal government is prepared to let providers ferry patients between locations.

"I have clients that are factoring appropriate transportation assistance programs into their strategic planning and budget forecasts," says Jennifer F. Skeels, attorney with Hall, Render, Killian, Heath & Lyman, in Indianapolis.

In blessing the transportation plan, the opinion lists eight conditions, including no "marketing of health care items and services" in the vans and no consideration of "the past or anticipated volume or value of federal health care program business" in offering the service. It also warns that "the value of the transportation could exceed $10 per transport or $50 on an annual basis," which could violate the anti-kickback statute.

But even that barrier could fall if OIG finalizes a rule it proposed in October 2014 offering an anti-kickback safe harbor for several services, including free patient transportation. The rule and the opinion share many requirements, including the aforementioned marketing and anticipated value ones.

Feds focus on access to care

The opinion is in line with a general trend toward quality-of-care models in federal health care, says Matthew R. Fisher, attorney with the Mirick O'Connell law firm in Worcester, Mass. "It makes sense that if patients can make their appointments more easily, it will have an impact on compliance with care plans," he says.

The opinion and the rule could give courage to large providers such as hospitals and mega-practices that may have been frightened out of investing in any patient transportation at all by recent ambulance services fraud cases, including a Department of Justice settlement with nine Jacksonville-area hospitals, says Brian H. Mahany, a Milwaukee attorney specializing in fraud recovery.

"CMS has to be careful not to hurt access to patient care in its zeal to address Medicare fraud," says Mahany. "The message here is that you can pass muster if you are

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very careful in your plan, show CMS how the plan won't increase Medicare costs and show that failure to offer transportation affects access to patient care."

3 tips for the transport-curious

Keep these three factors in mind if you want to pursue the new direction:

1. Don't use the opinion as a blanket approval. Even if the "fact pattern" of your own transportation plan is close to this one, remember "even the slightest difference in facts can shift an OIG opinion and be very costly for the provider who wanted to save a dollar and not pay for an opinion," says Kenneth Joel Haber, former assistant U.S. attorney and senior attorney for the Office of Inspector General (OIG), now in private practice in Boyds, Md.

2. Pay attention to specifics. For example, note that the opinion is on a system in a rural setting "where there's presumably not much public transportation, and private services, such as cab companies, could end up being costly," says Fisher. If public transportation options are available, as in a city, "a plan like this probably won't fly."

3. Avoid appearance of competitive interest. The opinion "suggests there are no other providers [affected], so it's not like they're trying to poach patients," says Fisher. If it looks to OIG as if you're using transportation as a tool to attract patients from competitors in the same market — that is, by "leapfrogging" other providers that patients have access to — you probably won't get away with it. — *Roy Edroso (redroso@decisionhealth.com)*

NPSG

AAMI compendium offers array of tips, toolkits to help manage clinical alarms

This is a reminder: With the second phase of The Joint Commission's National Patient Safety Goal on clinical alarms management approaching, review your existing policies as well as those that are in progress in order to make sure that you are prepared for the new year.

As of Jan. 1, surveyors will begin surveying against the final two expectations outlined in **NPSG.06.01.01** on improving clinical alarm safety. Under the last two elements of performance (EPs), hospitals should have established policies and procedures for managing critical alarms (**EP 3**) and begun to educate staff and licensed independent practitioners about the purpose and proper operation of the alarm systems for which they are responsible (**EP 4**).

To help hospitals that still need assistance in developing and implementing the appropriate policies and procedures, the Association for the Advancement of Medical Instrumentation recently released a guidebook titled the "Clinical Alarm Management Compendium."

Endorsed by both TJC and the American Hospital Association for its guidance, the compendium offers everything from common alarm management challenges to sample alarm parameter settings to burden and management toolkits. Some of the tips and advice from the free compendium:

- **Bring together a multidisciplinary team to spearhead action and build consensus.** A diverse range of expertise is critical to improving alarm management, and your team should include a number of individuals who have a stake in the subject. Some of these members include clinicians, patient safety managers, information technology professionals, researchers, pharmacists, facilities managers, patients and patient advocates. You may consider bringing in a skilled facilitator to ensure that everyone within the team has a voice.
- **Prioritize patient safety vulnerabilities and risks when planning**. Use data collected during the planning process of alarm management improvement. For example, look at items such as the priority/risk level of alarm conditions for particular medical devices; the level of oversight/response needed for alarm conditions based on the priority or risk level; the level of oversight/response typically available for alarm conditions; and the gap between the needed and current levels of oversight/response.
- **Set and share goals, objectives and activities to better address patient safety vulnerabilities and risks**. Though alarm management task forces and committees can accomplish a lot on their own

Taking a holiday

This is the 24th issue of *Inside the Joint Commission* for 2015 and so we're taking a holiday for the rest of the year. *IJC* will return on Jan. 11, 2016. Until then, be safe and well.

to improve alarm management, system-wide changes require facility-wide support. Formalize goals, objectives and activities and share them with institutional leaders in order to gain the support and funding necessary to drive large-scale change in the hospital.

• **Evaluate the effectiveness of improvements and make adjustments as needed**. Process improvement should be ongoing, and reviewing the data, both baseline and that collected after implementation of changes, is necessary to sustain positive changes and get the most effectiveness possible out of those changes. Communicate data findings and share insights with pilot participants, executive sponsors and other key stakeholders.

To view more tips and tools from the 68-page compendium, visit the the AAMI's compendium website at *http://tinyurl.com/AAMI-alarms-compendium*. — *Steven Dashiell (sdashiell@decisionhealth.com)*

Stewardship

(continued from p. 1)

in your interventions, says Jessica Holt, Pharm.D, infectious diseases pharmacy coordinator and infectious diseases residency program director at Abbott Northwestern Hospital in Minneapolis.

Abbott launched its antibiotic stewardship program in 2009, earning the American Society of Health-System Pharmacists (ASHP) Best Practices Award in 2011 for its innovative use of pharmacists in the course of care.

Over a two-year period, the program produced these results:

• A 4.6% decrease in total antibiotic days of therapy (DOT) per 1,000 patient days and a 15.8% decrease in antibiotic cost per patient day compared to baseline.

• An antibiotic cost savings of more than $350,000 over two years.

• Reduction of overall *Clostridium difficile* (C.diff.) infections within the participating hospitals by 50%.

The 629-bed community teaching hospital is part of a larger, 13-hospital health system that features three different private physician groups that see patients, making the involvement of just one infectious disease (ID) physician in a stewardship program a difficult endeavor, and coordination between physicians too unwieldy and time consuming, explains Holt.

It was these ID physicians that recommended a pharmacist-centric approach to the antimicrobial stewardship program with the intent of creating a single point of oversight and consistency for antibiotic prescriptions.

Start one step at a time

Holt served as the primary pharmacist for the program, which began as a pilot in just one patient care unit before being expanded to additional units and hospitals. Before implementation, Holt worked with ID physicians to review existing antibiotic policies in order to ensure they were up to date and appropriate for the goals of the program. For example, prescribing duties of antibiotics were delegated to physicians alone.

Once policies and guidelines were established, Holt reviewed all antibiotic orders daily for adult patients who did not have an active ID physician consult. Upon reviewing these orders, recommendations were made based on current published best practices and guidelines, as well as the hospital's own usage guidelines and medication policies.

By filtering prescriptions through a single point of access, Abbott prevented 61 antibiotic-related Joint Commission core measure "misses" as a result of inappropriate surgical prophylaxis or pneumonia antibiotic therapy in 2010. Total antibiotic and fluoroquinolone usage was also reduced, leading to a 26% reduction in rates of hospital-acquired *C.diff* infections for the year.

Success through patient-focused care

The pilot received its initial funding through the Health and Human Services (HHS) Ryan White grant, which funds primary medical care and support services in addition to clinical training and research into innovative models of care. Sustaining and expanding the program, however, depended on a continued support from stakeholders and administration.

The best way to accomplish this is by tying the goal of stewardship to patient safety and infection control quality, says Holt.

"This is especially important for smaller regional hospitals. It's hard to shift [monetary] numbers in smaller hospitals because of small patient volume," Holt explains.

Focusing instead on individual patient care and success stories allows for a stronger argument for sustainability, even if the return-on-investment (ROI) numbers may not be readily and easily available.

Medication management

Follow these six tips for developing a pharmacist-led stewardship program

For hospitals interested in creating a pharmacist-led antimicrobial stewardship program, Jessica Holt, Pharm.D, infectious diseases pharmacy coordinator and infectious diseases residency program director at Abbott Northwestern Hospital in Minneapolis, Minn., recommends the following advice:

1. **Start with a small pilot on one unit.** Starting small will allow your hospital to identify just how much work needs to be done. Abbott tracked initial patient antibiotic recommendations and acceptance of said recommendations during their pilot and found that roughly one-third of patients were recommended antibiotic prescriptions. Of those recommendations, 85% to 90% were accepted, though not all of these accepted recommendations were appropriate for the course of care. "We knew from this data that there was room for improvement."

   Starting small also allows you to better educate physicians on the goals of the program. Abbott received some early pushback from physicians who felt the program was a criticism of their knowledge or capabilities. "If you start with a pilot, go on a 'roadshow' throughout the hospital and talk about the team, their qualifications and the purpose," advises Holt.
2. **Keep the team small.** A key advantage to a pharmacist-led antimicrobial stewardship program is consistency. Not only does this keep medication recommendations more consistent over a longer period of time, but it also helps better highlight the progress made as a result of the program.
3. **Link the program to patient safety and quality.** This will be the biggest driver once you start trying to promise cost changes and will help prevent your hospital from losing sight of the goal of the program, regardless of costs.
4. **Make sure physicians understand the importance of accuracy in their notes.** If your pharmacist reviews physician medication recommendations from offsite, make sure physicians are cognizant of the importance of accurate — and legible — patient notes.
5. **Review the CDC's Core Elements of Hospital Antibiotic Stewardship.** The CDC Core Elements provide a strong guideline for creating a well rounded and effective stewardship program, one that Abbott is currently reviewing while moving forward with their own program, notes Holt. Adherence to these guidelines may also prove important should TJC proposed standards on antimicrobial stewardship come to fruition *(IJC 11/30/15)*
6. **Take the time to lay a good foundation.** Building the IT tools and data sets necessary to create an effective program can take time. Giving yourself the time to gather this data and build the processes will save you a lot of time later, notes Holt.— *Steven Dashiell (sdashiell@decisionhealth.com)*

It was this approach that allowed Abbott to hire an additional ID-trained pharmacist when the stewardship program began expanding to other hospitals within the health system.

"You need to continue to show [stakeholders] and talk about the service," says Holt. A consistent conversation and positive outlook on the program throughout the hospital made clear to the stakeholders involved how important the program was and how the hospital system stood to gain from additions to the program.

Data collection and IT essential

Abbott's prescription review measures are performed out of a central location for all participating facilities, which means a strong data collection and reporting system is necessary for effective performance, in addition to a sufficient IT structure to support electronic communication of data.

One of the biggest challenges is figuring out what kind of outcomes you are going to measure around antibiotic use, says Holt. Most hospitals will want to measure antibiotic use in one of three ways:

- Purchase data,
- Defined daily dose,
- Days of therapy.

Purchase data is not terribly helpful for measuring use by its very nature — it does not measure use itself, but how often antibiotics are purchased. Holt's team decided to start with a defined daily dose as its metric of measurement, assigning an assumed average dose per day for each antibiotic drug. Abbott eventually switched over to "days of therapy" measurement, but this was only possible after several years of data collection.

"That is the gold standard. The problem is you need the IT resources to collect that information," observes Holt.

Evolve with the industry

With the success of the program, Abbott is planning its next steps, including a further expansion to other hospitals. "There is at least one hospital without formal stewardship in place within our current region," notes Holt.

Other planned changes to the program are in accordance to the evolving expectations of the health care landscape. The National Healthcare Safety Network (NHSN) Antimicrobial Use and Resistance Module (AUR) has been one area to which Abbott has turned its attention. Participation in this module allows hospitals to report antibiotic-use or -resistance data as part of a larger regional data collection effort.

Discharge planning and medication reconciliation are also both on the docket for additional study, and the CDC Core Elements of Hospital Antibiotic Stewardship are all elements that hospitals will want to turn their attention to moving forward. — *Steven Dashiell (sdashiell@decisionhealth.com)*

Resources:

- CDC Core Elements of Hospital Antibiotic Stewardship: *http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html*
- CDC Antimicrobial Use and Resistance (AUR) Module: *http://www.cdc.gov/nhsn/PDFs/pscManual/11pscAURcurrent.pdf*
- Advanced Society of Health-System Pharmacists: *www.ashp.org*

Proposed rules

(continued from p. 1)

The rules, if finalized, will adopt the 2012 version of the **NFPA 101 Life Safety Code** (LSC), with some exceptions, and establish new Conditions of Participation (COPs) creating broad-ranging emergency preparedness requirements for health care organizations nationwide. Both proposals drew hundreds of comments when first published.

The first to be proposed was CMS-3178-P, "Emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers," in December 2013. It proposes establishing national disaster readiness requirements for the entire health care industry that many find onerous and unnecessary.

CMS said in its proposal that it had drawn heavily from TJC's own Emergency Management standards and that it did not anticipate a significant impact to hospitals because the majority of the nation's acute-care facilities were already under those standards.

However, several of the recommended requirements drew considerable comment, in particular one requirement for a potentially costly and time-consuming change in annual emergency generator testing.

Hospital and life safety industry leaders, including Robert Solomon, division manager of Building Fire Protection and Life Safety at the NFPA, and George Mills, engineering director for TJC, have said that the rule could have a significant impact on the business of health care.

Some 2012 LSC changes already available

Four months after the emergency preparedness proposal, CMS published the long-awaited proposed rule to upgrade from a fire code that was more than a decade old. CMS-3277-P, "Fire safety requirements for certain health care facilities," was published in April 2014 and was a result of continuing industry-wide lobbying effort that included The Joint Commission (TJC), the American Society of Healthcare Engineering (ASHE) and the National Fire Prevention Association (NFPA), among others.

The rule would adopt much of the 2012 LSC and the 2012 edition of **NFPA 99 Health Care Facilities Code** the 2012 LSC references, freeing hospitals from CMS regulations — and therefore Joint Commission standards — that require adherence to the 2000 edition of the LSC and the 1999 edition of NFPA 99 it references.

Over the last few years, CMS has allowed several categorical waivers so that hospitals could take advantage of key 2012 changes such as what was allowed to stay in corridors, suite layouts and the sizes of recycling bins in certain areas, among others.

While CMS never comments on proposed rules before they are published, the OMB review could signal that final rules are imminent. *(For highlights of concerns raised about each, see p. 7.)* OMB received both rules on Nov. 3, and their online dashboard says the review was expected to take between 30-60 days. — *A.J. Plunkett (aplunkett@decisionhealth.com)*

Resources:

- Proposed rule CMS-3277-P, "Fire safety requirements for certain health care facilities," and comments: *http://www.regulations.gov/#!docketDetail;D=CMS-2014-0058*
- Proposed rule CMS-3178-P, "Emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers," and comments: *http://www.regulations.gov/#!docketDetail;D=CMS-2013-0269*

CMS

Key concerns raised on CMS proposals on emergency preparedness, 2012 LSC

Two CMS proposed rules creating emergency preparedness Conditions of Participation (COPs) and switching to a new version of the NFPA's Life Safety Code drew hundreds of comments after they were published almost two years ago. Final versions of the rules were sent to the Office of Management and Budget for review in November. *(For more, see p. 1.)*

Here are highlights of some of the most significant concerns raised about the proposals:

Emergency preparedness

In December 2013, CMS published proposed rule CMS-3178-P, "Emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers," that would create broad disaster-readiness requirements for the entire health care industry. As proposed, the rule could require significant expenditures in time and money by hospitals to implement, according to public comments collected on the proposal.

Emergency and standby power requirements: Besides mandating that hospitals adhere to the storage requirements for emergency fuel and associated equipment and systems outlined in the LSC, CMS also proposed a requirement that facilities test emergency and standby power systems for a minimum of four continuous hours every 12 months at 100% load capacity. The same would be required of critical access hospitals and long-term care facilities.

The current requirement outlined by TJC in Environment of Care standard **EC.02.05.07** (on inspecting, testing and maintaining emergency power systems) **EP 7,** calls for a four-hour test every 36 months, with a note referencing guidance in NFPA 110, 2005 edition, "Standard for Emergency & Standby Power Systems." **EP 8** calls for diesel-powered generators to use a dynamic or static load that is at least 30% of the nameplate rating or meets other manufacturer's instruction.

Overall, in its comments to CMS on the proposed rule, the NFPA suggested that a simpler, better course would be to adopt emergency planning and preparedness provisions already outlined in the LSC, NFPA 99 and other NFPA codes and standards, many requirements of which were echoed in the rule.

In specific comments, the NFPA devoted much of its effort to the proposal's generator power testing requirements, as did the American Hospital Association (AHA), TJC, American Society of Healthcare Engineering (ASHE) and numerous officials with state and local health and emergency planning agencies, and individual hospitals and health systems.

The requirement, along with storage of fuel for generators and associated systems and concerns about the placement of generators, were generally criticized as being too unclear and potentially costing facilities millions of dollars — or even billions by ASHE's estimate — to move generators or upgrade to larger systems.

TJC asked for the annual testing requirement to be removed altogether, noting that CMS' justification referenced the number of hospitals that lost even emergency power in superstorm Sandy in the fall of 2012. "However, the problems that occurred during Sandy were related to the placement, location and protection of emergency generators (i.e. generators shut down due to flooding), not a lack of equipment testing."

The NFPA questioned whether the overall proposal would ultimately require hospitals to install larger generators and objected, among other things, to the call for the test to be at 100% capacity. "With the proposed increased generator size, load banks will be necessary to achieve this load. Most facilities will incur expenses to have load banks brought in annually."

Tracking of patients: CMS proposed that hospitals would have to not only keep track of both patients and staff during and after an emergency, including within the hospital and at any facility patients are relocated to, but also to plan how to provide subsistence to those people and consider whether "to maintain a store of extra provisions" for them and others who might seek shelter or offer volunteer services on site.

The AHA noted that while tracking patients and staff was optimal, often where patients went ended up in the hands of other entities, such as local or state emergency planning officials. As for subsistence, AHA said that identifying shelter and subsistence for individuals outside of patients and staff might better be handled in overall community disaster planning that could focus on available resources in individual areas.

Upgrade to 2012 NFPA codes

In April 2014, CMS proposed CMS-3277-F, "Fire safety requirements for certain health care facilities," which would adopt the 2012 versions of the **NFPA 101 Life Safety Code** (LSC), with some exceptions, as well as the **NFPA 99 Health Care Facilities Code** it references.

CMS regulations currently hold hospitals to the 2000 edition of the LSC and the 1999 edition of NFPA 99, although in recent years the agency has allowed categorical waivers on some things to allow hospitals to use the 2012 requirements.

Largely welcomed by hospital industry leaders, it was the exceptions that most often prompted concerns in public comments, including organizations such as TJC, ASHE and the National Fire Prevention Association (NFPA).

- **Occupancy:** CMS made a point of changing language in the regulations to apply the LSC to all health care facilities, regardless of size, creating an exception to the LSC itself, which applies to facilities with four or more beds.

Because the proposal covers a wide array of health care facilities, hospitals that have outpatient locations that bill under the hospital's Medicare number but have fewer than four beds could face significant new requirements under the proposal, according to ASHE, which estimated that "about 250,000 buildings will have to change services, upgrade their buildings to a higher occupancy type or close their doors completely."

In addition, according to ASHE's public comment on the rule, "We estimate it could cost health care providers up to $32 billion to comply with the more stringent interpretation of this rule, not to mention the hundreds of thousands of patient services this could displace."

TJC asked CMS to justify its reasoning behind the change, especially in light of the impact on hospitals, while the NFPA noted that it was largely unnecessary. Wanting to protect every patient equally regardless of a facility's size is laudable, but the NFPA noted its industry experts concluded that facilities with three or fewer beds would likely have sufficient staff on hand to ensure the evacuation of each patient, even at full capacity.

- **Smoke control ventilation:** The CMS proposal also made an exception regarding ventilation of smoke in anesthetizing locations without windows, such as operating rooms.

While ventilation was a requirement in earlier versions of NFPA 99, both ASHE and the NFPA noted that it was removed from the 2012 edition because modern surgical practices have largely eliminated the use of flammable anesthetics and have limited combustibles so as to make such ventilation systems unnecessary.

Many hospitals will face substantial costs to retrofit ORs with the required smoke ventilation systems — ASHE estimates $20,000 per OR — and both the 2012 edition of NFPA 99 and TJC would still require some way to vent smoke plumes, although allowing less expensive methods such as portable or more localized systems, according to TJC comments.

The time and effort would be better spent and patient safety better served, according to the NFPA, on training to prevent and respond appropriately to surgical fires when they do occur. — *A.J. Plunkett (aplunkett@decisionhealth.com)*