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*A Newsletter for Healthcare Executives and Facility Managers on Issues  
Related to Accreditation and Regulatory Compliance*



## **NEW CDC GUIDELINES PROVIDE PRUDENT INFECTION CONTROL STRATEGIES**

Public, media and lawmakers are steadily gaining knowledge on indoor air quality and its impact on patient safety. For example, at least 27 states have pending or approved legislation regarding mold and/or indoor air quality. This increased awareness of indoor air quality issues among the public also brings greater attention to hospital infection control.

It is becoming more common for patients and their families to file lawsuits against hospitals because of nosocomial infections acquired during the patient stays. For example, a hospital in Florida is facing at least 100 lawsuits due to nosocomial infections. At least 20 of these lawsuits involve fatalities.

Not only do hospitals risk lawsuits from nosocomial infections, but they can also expect costs to increase and patients to spend more time within the hospital. The CDC reports the number of extra days a patient has to spend in the hospital varies depending on the type of infection he or she gets: an estimated 1 to 4 days for a urinary tract infection, 7 to 8 days for an infection at the site of a surgery procedure, 7 to 21 days for a bloodstream infection, and 7 to 30 days for pneumonia. *(Continued on Page 4)*

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## **HIPAA & WIRELESS TECHNOLOGY: SAFETY & SECURITY**

Much has been debated regarding the application of wireless clinical IT systems in the new HIPAA regulatory environment. On the surface, it would seem that the 'free' availability of radio frequency signal carrying private patient data would be too tempting for would-be hackers and information thieves. The signal itself is not the primary concern for clinicians and IT managers because encryption, authentication, and other data security measures are proving to be effective. Of more concern is securing the actual devices, staff education, the protocol, policies and procedures surrounding the use of wireless devices. The displayed data and its storage are more cause for concern. Consider a tablet personal computer (PC), a lightweight, manageable, yet powerful computing tool. It seems to be *(Continued on Page 2)*



*Renovation projects offer easy opportunities to reduce operating costs.*



## ENERGY SAVINGS CONTRIBUTE DIRECTLY TO THE BOTTOM LINE

Operating budgets are affected by tougher requirements in emergency management, infection control, patient safety, utility system testing and maintenance, and many other pressures. This cost pressure is not likely to become any lighter; if anything, it will continue to grow.

With these other pressures, it can be easy to overlook the energy and water conservation initiatives that marked the 1990s. And this is despite the fact that gas and electricity costs are now higher than they were then, with even greater risk of price volatility. For the healthcare facility looking to reduce its operating costs with a low-risk investment that pays competitive ROIs for the long term, there is help from a myriad of sources, including the Association of Energy Engineers, U.S. EPA's ENERGY STAR® program, engineering societies and others.

Funding energy conservation opportunities (ECOs) can be challenging, but don't try to rely on simple paybacks. Instead, justify ECOs with financial modeling that calculates the annual returns and projects the long-term savings over the life of the equipment. Trumpet the fact that **energy savings contribute directly to the bottom line.**

Healthcare facilities are ever-changing and renovation projects offer easy opportunities to reduce operating costs. Factoring energy management concepts into renovation project designs will lower the life cycle cost of the renovated area and contribute directly to the bottom line.

One should also not overlook routine preventive maintenance (PM) of heating and cooling equipment. *In tough budget times PM is an easy target for cuts.* However, a financial analysis of maintenance costs versus reduced system efficiency can demonstrate that such cuts can hurt, rather than help, the bottom line. Dirty filters and coils cost more because they reduce system efficiency.

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## HIPAA & Wireless Technology: Safety & Security

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the wireless device of choice for acute care clinicians. Using a stylus with a tablet PC, electronically-handwritten text can be included in the electronic medical record (EMR). As with other handhelds, the danger lies in the management of this device. Critical questions must be considered.

***Is it an application tool only, or does it have permissions and capacity to store personal health information (PHI)?***

If the assignment and tracking of the PC is not managed and administered, it could potentially fall into the wrong hands. An unattended tablet PC would certainly be an easier target than 'hacking' a wireless Ethernet signal. These are just a few considerations when applying wireless technology in today's regulatory environment. Healthcare facilities are beginning to rely on wireless technology to achieve the efficiency critical to success in today's market. Wireless can be successfully deployed when key issues are addressed: **protected access, device management, and staff education.** A win-win for all.

# Who Regulates Healthcare?

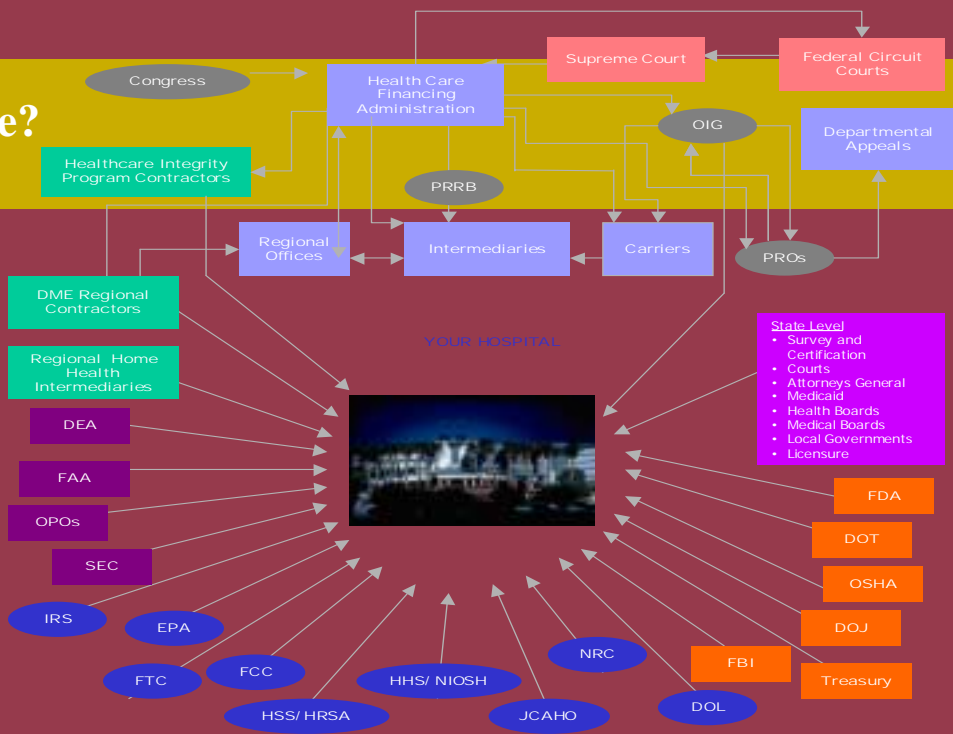


Chart Legend

DEA:	Drug Enforcement Administration	JCAHO:	Joint Commission on Accreditation of Healthcare Organizations
FAA:	Federal Aviation Administration	NRC:	Nuclear Regulatory Commission
OPO:	Organ Procurement Organizations	DOL:	Department of Labor
SEC:	Securities and Exchange Commission	FBI:	Federal Bureau of Investigation
IRS:	Internal Revenue Service	DOJ:	Department of Justice
EPA:	Environmental Protection Agency	OSHA:	Occupational Safety and Health Administration
FTC:	Federal Trade Commission	DOT:	Department of Transportation
FCC:	Federal Communications Commission	FDA:	Food and Drug Administration
HHS:	Health and Human Services	OIG:	Office of Inspector General
HRSA:	Health Resources and Services Administration	PRO:	Peer Review Organization
NIOSH:	National Institute for Occupational Safety & Health	PRRB:	Provider Reimbursement Review Board

## JCAHO PERIODIC REVIEW - FRIEND OR FOE? (Editorial Comments)

Has JCAHO truly achieved its goals? JCAHO standards were designed to establish a foundation to monitor processes that provide quality patient care, affect safety, infection control, human resources and medical staff issues – to name a few. Yet, JCAHO accredited healthcare organizations still flounder.

Starting January 2004, JCAHO will revise its efforts and require that all accredited organizations participate in the *self-assessment* process titled **JCAHO Periodic Review**. The *periodic review* is a method to move hospitals away from the frantic preparation for survey process that typically occurs 6-12 months prior to the scheduled JCAHO triennial survey. It is designed to encourage organizations to establish an on-going process to look at the organization-wide compliance to JCAHO standards and intents. In 2006, the process of scheduling surveys will disappear for accredited organizations. *All* hospitals will need to be ready to demonstrate compliance at all times. Wow – what a change!

Representative Pete Stark (D, California) clearly thinks that the JCAHO periodic review process is bogus and worthless based on his January 15, 2003 letter to the

Office of the Attorney General. Is the premise good or is Representative Stark right? Will these new processes work? Is JCAHO establishing friendly but ineffective processes or is this a trick? Will the processes help or hurt while trying to encourage ongoing review of JCAHO standards, ensure quality patient care and patient safety? Will the development and implementation assure compliance with CMS and OSHA regulations making Medicaid patients safer?

Should hospitals start considering alternatives to JCAHO – alternatives that will help ensure compliance to a basic set of standards that incorporate CMS, DHS and OSHA regulations in one process? All are good questions for patients, healthcare providers, federal and state legislators and insurers.

Stay tuned to this column for further discussion, comments and answers to the questions posed and much, much more in future issues of the **Compliance News**. Send us email and voice your opinion regarding what you think will happen with the JCAHO new initiatives, Representative Pete Stark's concerns, or what you think will work to move the healthcare culture toward safer care.

## New CDC Guidelines Provide Prudent Infection Control Strategies

(Continued from Page 1)

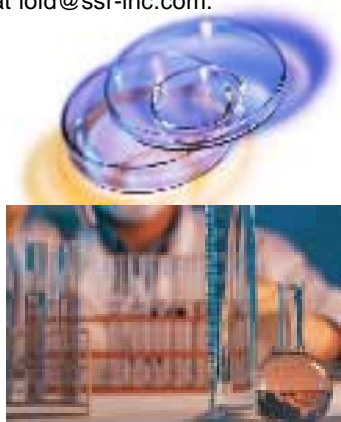
Additionally, costs may vary from \$600 for urinary tract infections to over \$50,000 for prolonged bloodstream infections. During her presidential address at the 30<sup>th</sup> Annual APIC (Association for Professionals in Infection Control and Epidemiology) Educational Conference (June 9, 2003), Barbara Soule, RN, MPA, CIC reported that the average confirmed nosocomial infection costs \$15,275 in patient care expenses.

To address infection control, one proactive tool hospitals can utilize is implementation of the new *Guidelines for Environmental Infection Control for Healthcare Facilities*, published June 6, 2003 by the CDC. The guidelines provide specific infection control measures regarding HVAC (heating, ventilation and air conditioning) systems, water systems, environmental services, environmental sampling, laundry and medical waste. The guidelines can be found at the website address: [www.cdc.gov/ncidod/hip/enviro/guide.htm](http://www.cdc.gov/ncidod/hip/enviro/guide.htm).

The CDC acknowledges that specific infection control strategies and engineering controls are effective in minimizing the occurrence of nosocomial infections. Hospitals should expect that regulatory and accrediting agencies will use the CDC guidelines as a resource when assessing infection control issues within facilities.

For more information on prudent infection control strategies, contact:

Leo Old, PE, CIH at [lold@ssr-inc.com](mailto:lold@ssr-inc.com).



## PUBLICATIONS & SEMINARS

### Look for these articles in publication

"Safety Training is Priority for OSHA Compliance," *Kentucky Society of Healthcare Engineers Newsletter*, July 2003.

"All Things Considered - An Emergency Power Management Program Has Many Variables," *Health Facilities Management Magazine*, June 2003.

"Managing Hospital Emergency Power Testing Programs," *ASHE Management Monograph*, April 2003.

"Joining Forces - Integrating Utility and Emergency Management for Better Patient Safety," *Health Facilities Management Magazine*, April 2003.

### Upcoming seminars in 2003

- Aug 6 Houston: "Infection Control Risk Assessments from Plan to Implementation"
- Aug 7 North Carolina Healthcare Engineers Association: "Mold Prevention in Healthcare Facilities"  
"A Quality Management Program for Infection Control in the Environment of Care"  
"A Quality Management Program for the Utility Management Plan"
- Aug 24 The Quality Colloquium Harvard University: "The Role of the Patient Safety Officer"
- Aug 29 University of Arkansas: "2000 International Building Code Implementation"
- Oct 15 Tennessee Hospital Engineers Association: "JCAHO Update"
- Nov 11 Indianapolis Midwest Healthcare Engineering Conference:  
"Effective Infection Control for Healthcare Construction"
- Nov 13 "Surgery HVAC Systems"

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