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New cardiac project is first to tackle clinical and operational issues

Time commitment high for data collection, analysis

Any hospital with a cardiac program probably has been involved in a benchmarking project focused on clinical outcomes. But to date, no one has looked at both clinical as well as operational issues on any scale. Now the University Hospital Consortium (UHC) based in Oak Brook, IL, is about to do just that.

According to **Cathleen Krsek**, RN, MSN, assistant director of operations improvement, no one had looked at the processes of caring for patients before. "We had done projects in three areas — coronary artery bypass graft (CABG), percutaneous coronary intervention (PCI), and congestive heart failure (CHF). But we hadn't looked at how clinical and operational issues work together. We still wanted to see the issues from the patient level, but also the organizational level," she explains. "We wanted to see how the organizational end supports the clinical end."

While discussing the need to look at operational issues, many of the UHC's 84 members wanted to do projects on acute myocardial infarction (MI) and revisit the CABG issue in light of minimally invasive surgery techniques that had grown in popularity since the last study, Krsek says.

"There are a lot of accepted standards of care, like giving aspirin or beta blockers to patients. On the operational side, however, there aren't those kinds of standards. But we thought that if we could draw some conclusions, based on clinical outcomes, or if we could look at the facilities with the best outcomes

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and see what operational issues they have in common, then we could make some statements that will help our members and their patients," she adds.

Cindy Abel, RN, MSN, assistant director for clinical process improvement, adds that members wanted to find a way to link efficiency issues to positive outcomes. "We can't put a best performer in front of members whose costs are twice as much," she explains. "That just shoots us right out of the water."

Not all members are participating in the project. Right now, 43 hospitals are involved in the operational survey, and most of the members are participating in at least one or two of the clinical surveys, says Krsek. For each data point, the facilities involved are providing information on 40 cases. "It's not a huge number of cases per institution," says Abel. "What makes it so useful is that the data are so rich."

In the operational survey, there are some 90 questions divided into five sections, Krsek explains. The first section covers organizational structure, such as whether a hospital is organized along service lines. The facility must provide an organizational chart and information on reporting relationships, budget management, and who sees financial data.

The patient-flow section asks questions on how patients are managed, particularly in the emergency department. "We want to know when a consult is called, whether the hospital uses pathways, and if they use case management," says Krsek.

A section on the cardiac catheterization lab asks operational questions on the number of rooms and whether they are multipurpose; staffing ratios; and inventory control. The final section is short, Krsek says, asking about patient volumes and staffing numbers.

For the clinical questions, Abel says UHC used some of the ORYX core measures. For acute MI, questions include the rate of aspirin administration, door-to-needle rates for PCI and thrombolytics, rates of aspirin prescription at discharge, rates of beta-blocker administration within 24 hours, length of stay, mortality rates, and complication rates.

For the PCI survey, the questions are less well defined, but some are similar to those in the acute MI section, says Abel. They include door-to-reperfusion rates; administration of aspirin and prescription of aspirin at discharge; complications or rates of patients who have to go on to CABG;

and rates of glycoprotein 2b3a inhibitors. "That last one is new, so there is a lot of interest," Abel adds. "We are also looking at the number of patients who get stents vs. those who don't."

The CABG questions are still under discussion, but many will be similar to those asked in previous studies. Among the factors that will determine best performers are length of stay less than or equal to five days; less than a day spent in ICU; extubation in less than six hours; and lower morbidity and mortality rates, Abel says. "We will also analyze the number of units of blood transfused and the criteria used for transfusion."

Other data collected will likely include infection rates and the timing of antibiotic administration. "We also will probably measure OR time, pump time, whether patients get education on smoking cessation and diet if their lipids are high, and if statin drugs [were] prescribed for high cholesterol," she adds. Participants also will collect data on whether their facilities are doing any minimally invasive procedures to reduce recovery time.

The results from the CABG part of the study will have the added weight of four previous projects in this area, Abel adds. "That will make our comparative analysis really rich."

CHF will largely mimic the past studies, with the addition of core measures from ORYX, data on new pharmacology management, and facilities' outpatient strategies, says Abel.

More work, but worth it

One of the facilities that is participating in all the parts of this project is the University of California, Los Angeles (UCLA). **Gregg C. Fonarow**, MD, associate professor of medicine at the university and director of its cardiomyopathy center, says that with all the chances facilities have to participate in projects that can improve efficiency and quality, he has to be picky about which ones he opts to do.

"We have to choose issues that are of significant volume, significant risk to patients, or significant utilization," explains Fonarow. "Or we have to choose something where we need to improve outcomes."

Working on issues where there are marked differences among institutions in procedures, lengths of stay, outcomes, rehospitalization rates, mortality rates, and medications used provide obvious opportunities for his facility, he adds. "What you often find is that those who provide the best care with lowest mortality and better clinical outcomes often provide that care with less utilization of resources. You can improve processes and still provide better care."

But just because UHC has come up with a good idea to work on doesn't make participation a slam-dunk, Fonarow says. "For some of these projects, you have to get involved in creating the data collection tool or in doing some of the data analysis. That means having the time to commit. Once the tool is created, you have to find an interested director or nurse practitioner who can do the chart abstractions. Usually, it's not a large number — maybe 30 patients."

But even if the idea is good and the work minimal, Fonarow explains that there are many other competing projects that have to be completed. There is an endless number of organizations out there that want information: the National Council on Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and the Health Care Financing Administration, as well as health maintenance organizations.

"The good news for us is that UHC has a solid strength in linking outcomes back to utilization of resources," Fonarow says. "That makes the data more detailed."

Having that data can help facilities develop best practices, he says. For instance, when UCLA did a CHF project six years ago, there were marked variations among participating hospitals in length of stay and their use of ACE inhibitors. Fonarow says it was shocking that months after studies came out indicating the benefits of ACE inhibitors, there were facilities whose ACE inhibitor use was as low as 30%. Others were as high as 85%.

Fonarow and a multidisciplinary team of nurses, physicians, pharmacists, and lab personnel reviewed the data and the processes of care. Frequently, CHF patients being admitted had volume overload, and diuretics were started at low dosages and gradually increased. ACE inhibitor use started later.

"We were able to come up with some preprinted orders and new procedures that helped. Just those small changes enabled us to initiate therapy earlier, adjust medications more toward what patients would use on discharge, and start the patient education earlier," he says. The upshot was turning CHF from a loss-making DRG to a profitable one.

And even if you are the best performer, he adds, your participation can help other facilities improve by giving them something to aim for.

Neither Abel or Krsek have any expectations

about what the data in the latest project will show. But they have been through enough projects that come May when the "knowledge transfer" is scheduled, there are bound to be surprises.

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Rapid-cycle feedback can work for multiple needs

Why wait for information if you can have it now?

For a dozen years, administrators at Delnor-Community Hospital in Geneva, IL, had seen patient satisfaction scores fluctuate between the 50th and 75th percentile. And for a dozen years, management felt that while that was "pretty good, we wished we could do better," says **Michael Kittoe**, MBA, the chief financial officer of the 118-bed facility.

"We had gone through all of the usual efforts we had heard other organizations do, like working on call-light response time, forming continuing process improvement teams, and having campaigns to get our staff to do things like use patient names." Despite those efforts, says Kittoe, results never changed much.

About two years ago, though, the hospital administration started a campaign to make customer service a real competitive differentiation for the hospital. "It was a top priority, and we started seeking out new education." One of the leaders in the field that Delnor sought out was Quint Studder, the president and CEO of Baptist Hospital in Pensacola, FL, at that time. He was the first to tell Kittoe about rapid-cycle feedback, and by November 1999, Delnor had shifted from quarterly patient satisfaction reports to weekly feedback from surveys.

The impact over the last year has been marked. Combined average patient satisfaction results have risen from the upper 60 percentiles to the most recent figure of the 87th percentile. Inpatient results, says Kittoe, are No. 1 in the state, and outpatient surgery ranks in the 99th percentile in the country. The emergency department at Delnor is in the 98th percentile nationwide.

Even better, the rapid feedback of data is expanding to other data areas at Delnor. "Right now, we are experimenting with rapid-cycle feedback on financial performance measures," he says. Productivity is being measured using a product that looks at time and attendance, labor productivity, and management. "We e-mail department managers daily on yesterday's productivity," explains Kittoe. Information on patient days, radiology procedures, or whatever is that department's unit of service, is included along with how many staff hours were worked, how that data compare to budget, targets, and actual for the time period to date. "That means that if something is amiss, you can correct it quickly," he says. "If 10 days into a pay period you know you are 10 hours over the target for that period, you can use the last four days to make corrections."

In the future, rapid-cycle feedback will be used in the clinical arena too, says Kittoe. "We'll provide physicians with feedback on their practice patterns in a more timely fashion."

How does it work?

While not "real-time" data, rapid-cycle feedback of data is just what it sounds like, says Kittoe. "It is quick and timely. You report survey results much faster than the traditional monthly or quarterly periods. We could do it daily if we thought it was appropriate and needed."

The faster you get the data to staff, he adds, the more meaningful they are. "It is hard to respond to something that happened two to five months ago," Kittoe says.

"It is easier to dispute or deny data at that point. With rapid-cycle feedback, people can relate to the data better, and it has the benefit of [being] a constant reminder of what is being measured and what is important," he says.

It wasn't an easy transition for Delnor to go from quarterly patient satisfaction reports to weekly. "The biggest hurdle was developing a process for collecting, recording, analyzing, and

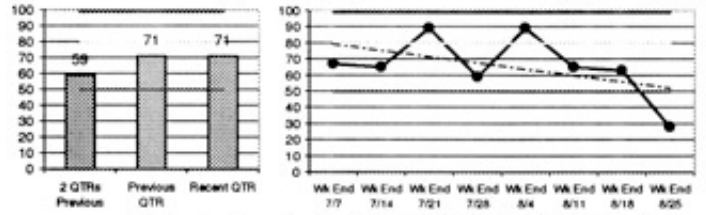
(Continued on page 6)

Delnor Community Hospital: Weekly Patient Satisfaction Report

INPATIENT SURVEY Percentile Rank by Question

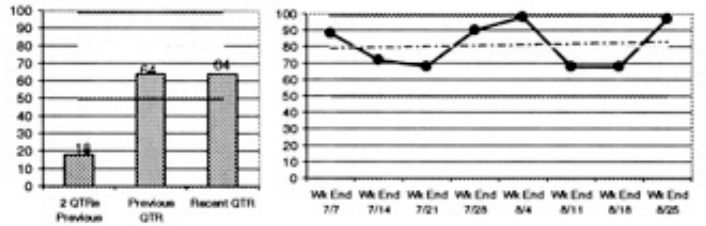
99th Percentile
80th Percentile
50th Percentile
Trendline

Question 1: Did the nursing staff call you by name?



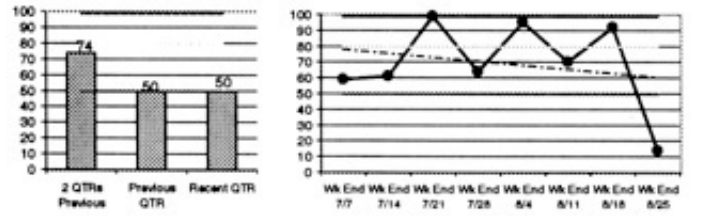
	2 QTRs Previous	Previous QTR	Recent QTR	Wk End 7/28	Wk End 8/4	Wk End 8/11	Wk End 8/18	**Wk End 8/25**
Responses (n)	281	496	865	36	27	60	70	**39**
Yes	85%	85%	85%	84%	89%	83%	89%	**77%**
To some extent	13%	13%	14%	14%	11%	17%	7%	**23%**
No	2%	2%	1%	2%	0%	0%	4%	**0%**
%ile Rank	59	71	71	59	89	65	63	**28**

Question 2: Did you receive your medications in a timely manner?



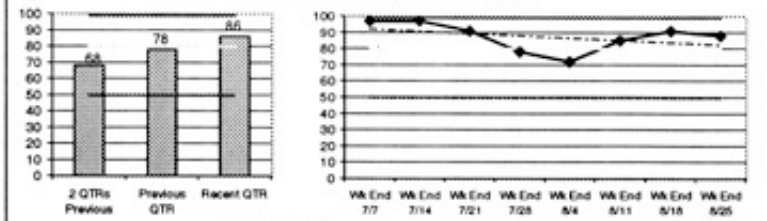
	2 QTRs Previous	Previous QTR	Recent QTR	Wk End 7/28	Wk End 8/4	Wk End 8/11	Wk End 8/18	**Wk End 8/25**
Responses (n)	262	502	823	50	27	55	69	**36**
Yes	84%	89%	88%	94%	96%	91%	86%	**94%**
To some extent	13%	8%	9%	2%	4%	4%	14%	**6%**
No	3%	3%	3%	4%	0%	5%	0%	**0%**
%ile Rank	18	64	64	90	98	68	68	**97**

Question 3: Did you feel that there was adequate comunication among your physicians and the nursing staff regarding your care?



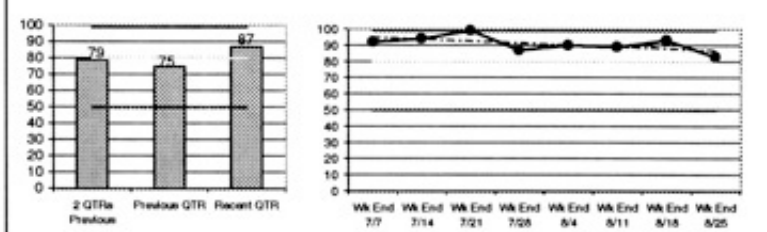
	2 QTRs Previous	Previous QTR	Recent QTR	Wk End 7/28	Wk End 8/4	Wk End 8/11	Wk End 8/18	**Wk End 8/25**
Responses (n)	270	481	844	51	26	60	69	**37**
Yes	84%	82%	81%	82%	92%	87%	88%	**78%**
To some extent	12%	14%	15%	16%	4%	8%	10%	**19%**
No	3%	4%	4%	2%	4%	5%	1%	**5%**
%ile Rank	74	50	50	64	95	70	92	**14**

Question 4: How would you rate the cleanliness of your room?



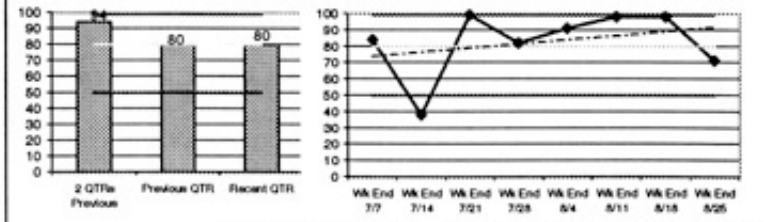
	2 QTRs Previous	Previous QTR	Recent QTR	Wk End 7/28	Wk End 8/4	Wk End 8/11	Wk End 8/18	**Wk End 8/25**
Responses (n)	280	502	875	55	27	60	70	**39**
Excellent	51%	54%	59%	53%	56%	58%	61%	**59%**
Good	43%	40%	34%	42%	33%	35%	34%	**36%**
Fair/Poor/V Poor	6%	6%	7%	5%	11%	7%	4%	**5%**
%ile Rank	68	78	86	78	72	85	91	**88**

Question 5: How would you rate the temperature of your food?



	2 QTRs Previous	Previous QTR	Recent QTR	Wk End 7/28	Wk End 8/4	Wk End 8/11	Wk End 8/18	**Wk End 8/25**
Responses (n)	266	470	827	54	25	57	66	**37**
Excellent	26%	25%	30%	20%	28%	30%	38%	**35%**
Good	54%	54%	54%	70%	56%	53%	44%	**38%**
Fair/Poor/V Poor	21%	21%	16%	9%	16%	18%	20%	**27%**
	79	75	87	87	90	89	93	**83**

Question 6: How would you rate the courtesy of the person who admitted you?



	2 QTRs Previous	Previous QTR	Recent QTR	Wk End 7/28	Wk End 8/4	Wk End 8/11	Wk End 8/18	**Wk End 8/25**
Responses (n)	269	473	826	54	26	59	64	**35**
Excellent	67%	66%	67%	61%	65%	73%	77%	**61%**
Good	31%	30%	29%	39%	35%	25%	20%	**36%**
Fair/Poor/V Poor	2%	4%	4%	0%	0%	2%	3%	**3%**
	94	80	80	82	91	98	98	**71**

Source: Delnor-Community Hospital, Geneva, IL.

reporting the data," recalls Kittoe. Most of the work was done in-house, but the hospital did make use of its satisfaction survey vendors, Parkside Associates, to help convert data into benchmark measurements in a faster time frame and put them into a report format.

Four or five questions from each survey are included in the weekly reports for each area: same-day surgery, inpatient, emergency department, and testing and therapy/outpatient. Delnor tallies up the results and submits them to Parkside by e-mail. Parkside looks up the percentile rankings for those questions and replies with the rankings for Delnor against past performance and against national norms. **(See sample weekly report, p. 5.)**

The questions are on only those key areas that administration feels need attention at the time. "It narrows what the focus now should be," he says. "So far, we have cycled through a couple different questions. We make the changes when we have two consecutive quarters of improvement in an area of focus."

Kittoe compares trying to effect change under the old quarterly format to "trying to eat an elephant. You just don't know where to start sometimes. So you zero in on the things that are really, really bad, like call light response times."

Because that's always an area needing improvement, Kittoe says there were several performance improvement projects undertaken to improve the issue at Delnor. "But with a quarterly measurement cycle, we weren't as successful in getting information back to line staff. They lost interest before we got the data back to them." Having the data available weekly, and data on specific questions that are of interest, helps to focus attention. "On the big survey, we didn't know how to pick the right questions that were actionable. We didn't have real success stories. With particular questions now, we have more success stories and more buy-in from staff."

There are still hurdles. It takes education to help managers and supervisors understand how to read the new reports. And there is a tendency to overreact to the variations in weekly results, Kittoe says. "Because of smaller sample sizes with weekly reporting, there will be more statistical variation in the results. We will have a 99th percentile one week and the 4th the next on the exact same question. This was hard for our associates to understand at first. What we had to focus on was the fact that to become the 'Best of the Best' — the 99th percentile — we had to excel every day in every way. This helps us to look for opportunities for improvement all the time."

Change is never an easy thing, Kittoe admits. "We had the usual reactions to change: What is this? Why are we doing this? This won't work. But we stayed committed and stayed the course." And it wasn't just an attitudinal commitment that was needed. There were other resources required, too, including about 100 hours of staff planning time, and an additional eight hours a week of staff time to support the new process.

But so far so good, he says. By starting small and thinking big, Delnor-Community Hospital has made real progress in customer care, and if the expansion of rapid-cycle feedback continues, Kittoe thinks that progress will be mirrored in financial management and clinical areas, too.

"Pick a few questions from your survey that you know you can act upon," he advises. "Celebrate your small successes to keep the momentum going."

Kittoe says that with the increasing use of the Internet, external benchmarking companies will be better able to provide more timely data in the future. But for now, "you just have to do it for yourself."

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SIMPLE SOLUTIONS

Survey results spur spiritual care program

Simple ideas win national recognition

There have been plenty of studies in the last few years that indicate patients do better if their spiritual needs are being met. This is a message that Baxter Regional Medical Center in Mountain Home, AR, recently took to heart.

Under the leadership of **Sandy Rehak**, patient satisfaction coordinator, the 225-bed hospital formed a spiritual care committee, which effected changes that led to improved patient satisfaction scores and recognition from Press,

Volunteers need guidelines for prayer program

If you think the idea of volunteer "Prayer Warriors" to pray with patients might work at your hospital, take a page out of the book of Baxter Regional Medical Center in Mountain Home, AR, first and set up some rules that volunteers need to follow in order to participate, says **Sandy Rehak**, patient satisfaction coordinator at the hospital.

Here's a sample of the information Baxter Regional gives to volunteers before they can start; there's a place for the volunteer's and his or her supervisor's signatures and the date.

Thank you for your interest in being a Prayer Warrior. The goal of this program is to address the spiritual needs of our customers by matching employees with patients with an urgent need for a prayer partner. Being in the hospital often is associated with unknown procedures and unpredictable events, and sometimes a family member or minister is not available to offer reassurance to patients in need.

If a patient indicates to a nurse or other staff members that he or she would like to have someone pray with him or her, the charge nurse or care coordinators will locate an available employee from an established list of names.

In order for this program to be a success, we ask that you adhere to the following guidelines:

1. Use good judgment in regard to the length of your visit. It is anticipated that these visits will range from 5-15 minutes. Do not stay longer unless the patient requests it, and you get approval from your supervisor.
2. Be respectful of the patient's privacy and dignity. He or she may not want to discuss the details of his or her illness. Focus on the person, not on how he or she looks or what else may be going on in the room.
3. Consider everything you learn about patients, their family, and their illness to be strictly confidential. Do not divulge a patient's name or situation to other staff members (unless special intervention is needed) or people outside of the hospital.
4. Follow patients' lead in regard to how they want to pray, e.g. in silence, reading from the Bible, reciting standard prayers, ad lib prayers, etc. It is not appropriate to impose your preferred prayer style nor discuss your particular religious denomination with the patient.
5. Discuss your desire to be a Prayer Warrior with your supervisor in advance to ensure that you have permission to leave your work area when needed.

Thank you for generously volunteering your time to serve our patients in this unique manner.

_____

Signature of Volunteer/Date

_____

Signature of Supervisor/Date

Ganey Associates, a South Bend, IN-based customer satisfaction consulting agency, as a finalist in its annual *Client Success Stories* publication.

Rehak says the driving force for the committee came after Press, Ganey added a question on spiritual care to its survey in 1998. "We didn't do well there, and it was always up in the 'priority index' on our reports," Rehak says. "But no one ever did anything about this. We live in the Bible Belt. There are 79 churches in our immediate area, but we had no chaplain at the hospital. We didn't even have a ministerial alliance."

When Rehak asked her boss about hiring a chaplain, she was told there was no budget. But Rehak didn't let the idea go. She started doing her own research. Calling patients who had responded to surveys and scored that area low, Rehak asked what they would like to see in the area of spiritual care. "They wanted bibles in their rooms — something we were supposed to do anyway — and they wanted a chaplain."

Next, she surveyed local pastors, asking if they were interested in helping out and what they thought should be included in the spiritual care of patients. "I knew I had to have local pastors supporting the idea if I wanted to get administrative buy-in," says Rehak.

Through word of mouth, other hospital staff came on board, and the spiritual care committee was formed. Among the charter members was

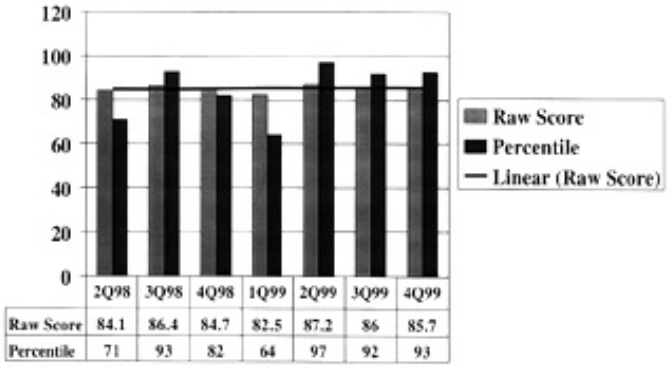
(Continued on page 9)

Volunteer Prayer Program Manual — Sample Pages

SPIRITUAL CARE COMMITTEE

- Self appointed Spiritual Care Committee
- Five members
- Goal for the committee - to convince our Administration that the hospital needed a full-time chaplain and other spiritual care modalities
- The committee researched the spiritual needs of our patients without the knowledge of our Administration
- Once the committee had the support of our patients, community pastors and documentation we presented our findings to our Administrative Staff

BRMC Spiritual Trend



	2Q98	3Q98	4Q98	1Q99	2Q99	3Q99	4Q99
Raw Score	84.1	86.4	84.7	82.5	87.2	86	85.7
Percentile	71	93	82	64	97	92	93

Ever get the feeling something's missing?

Source: Baxter Regional Medical Center, Mountain Home, AR.

Jan Ringler, RN, the cancer resource coordinator at the hospital. She coordinated a trip to a hospital in Fayetteville, where committee members talked to the chaplains and volunteers about their spiritual care program. It was the first of several field trips and conference calls to area hospitals to determine what works.

The committee came up with a list of the items it determined were key to improving the spiritual care of patients. These are:

• Arrange for local ministers to visit their church members. Just forging a relationship with the 79 area ministers helps to ensure the goal is met.

• Provide patients with an updated list of churches.

• Provide Bibles in all patient rooms. This was already hospital policy, but until the committee acted on it, many rooms were missing their Bibles.

• Obtain Bible cassettes for visually impaired patients. Each nursing unit now has a tape player and cassettes on hand.

• Improve directional signs to the chapel and refurbish that facility. That was achieved through volunteer time and local donations.

• Create and disseminate a spiritual brochure handout. **(See sample pages from brochure, p. 8.)**

• Start a volunteer "Prayer Warriors" — hospital employees who will go to a patient's room to pray with them when requested. **(See box on p. 7 for program guidelines.)**

• Form a pastor's advisory committee. Five area pastors now serve on that committee.

• Hire a full-time chaplain.

Most of these were easy and cheap to accomplish. The only big-ticket item was the full-time chaplain.

Around the same time the committee was putting its list together, a local pastor approached the hospital administrator and asked why there was no chaplain at the hospital. It was, Rehak says, serendipitous to say the least.

Along with all her initial research, Ringler was able to include some of the medical literature that supported the idea that spiritual care could have a positive impact on outcomes. After the meeting, the administration decided to budget for a chaplain. At press time, interviews were pending and Rehak anticipated that a chaplain would start at the beginning of the year.

"The idea isn't to push religion, but to meet spiritual needs," says Rehak. To make sure that everyone understood the difference, there were training sessions and written information reinforcing the idea. "Nothing will turn people off more than someone trying to jam religion down their throat," says Ringler. "And while we are mostly white and Christian down here, there are others. We have a lot of retirement communities and are a summer recreational area. There are increasing numbers of Asians, Hispanics, African-Americans, and Jews. We have to meet all the needs."

Along with an increase in patient satisfaction from the 71st to the 97th percentile, the new emphasis on spiritual care has created an increase in the use of the hospital chapel and increased calls for spiritual care from patients to their nursing units.

Key to the success, says Ringler, has been the willingness of area ministers to work with the hospital. "Without their support, this couldn't have happened. And we knew we had to have that support before we went to our administrator. One of his first questions was, 'What did the local pastors say?'"

[For more information, contact:

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GUEST COLUMN

Benchmarking: Beating the information explosion

By **Shelley Burns**
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What could possibly be more intriguing for health care professionals than access to comparative data, of all types, at their doorstep, for use at any time? The only fantasy more engaging would be having the data and actually being able to use them constructively. Many executives shudder at the idea of organizing and analyzing data. That reaction comes from the sheer volume of the data, their complexity, and often their complete irrelevance to their situations. Yet, it's widely known that when data are organized strategically,

such as with benchmarking analysis, they suddenly take on a sense of structure. It's the structure behind benchmarking that gives organizations the confidence to use their databases for making decisions and taking action.

One of the biggest challenges for health care organizations is interpreting their data. But data are gathered so those organizations can compare themselves to others in the same field, have a better understanding of their own operations, and have the data for use as a guide in the search for improvement priorities. With these data seem to come tremendous opportunity, but not without a caveat. Challenges often arise when organizations attempt to make sense out of massive amounts of information.

For starters, far too much is expected of these unanalyzed data, especially when department managers are the ones delegated to the job of analyzing them. The unique skills required for such extensive data analysis are greatly underestimated. The reality is that well-analyzed but imperfect data rate as far more valuable than a massive, insignificant database. What is needed is a method by which the data can be organized and structured — or the practice of benchmarking. It provides the means for an organization to identify the most important questions to ask as well as the confidence to act on them accordingly.

The basics of benchmarking

Stated simply, benchmarking ties all the numbers together in a way that uncovers best practices within an industry. "It's a guidepost," says **Sherry Kwater**, director of Case Management at St. Francis Medical Center in Peoria, IL. "It shows me my current opportunities, where my future opportunities may be, as well as where my organization can make a potential impact." Kwater believes strongly in the practice of benchmarking. Once she determines opportunity, she also uses benchmarking to find out where to focus her efforts. "If it says I have a $5 million dollar opportunity in my rehab department, first I do a check and balance with past rehab records, and then I move forward."

Kwater further emphasizes that the most important step in her process is contacting the organizations she aspires to emulate. "I'll ask them what their top five innovative developments are that have contributed the most to improved performance." From there, she analyzes how those might transfer to her organization.

"All benchmarking really tells us is someone is doing it better, so let's find out what they're doing," adds Kwater. In other words, health care organizations need to step back from the trenches created by what is called data denial. Without knowing it, an institution can be swallowed up in mounds of data, which ends up defeating its purpose.

Consider an example: A 243-bed hospital faces the prohibitive costs of maintaining a low-volume obstetrics service line. In 1999, the hospital had 396 obstetrics cases. After doing an analysis, it uncovered the following:

- Cost per case for the obstetrics service line was 131% greater than the benchmark target.
- The primary issue was a cost per patient day, which was 90% above the benchmark target.
- A functional cost review shed greater light on this problem, identifying nearly $800,000 in potential savings over the 65th percentile target in obstetrics nursing at the hospital.
- Management issues that were highlighted included: high cost per patient day ($992 vs. benchmark target of $318) and high labor hours per patient day (34 hours vs. benchmark target of 11 hours).

After performing a market analysis, the organization learned that the majority of births to mothers in its city (and surrounding communities) were performed at other hospitals in the area. While community hospitals typically overlook the unprofitable nature of obstetrics in order to build relationships within the community, the marketplace viewed obstetrics as a specialized service.

Consumers were choosing hospitals based on reputation and amenities instead of proximity and allegiance to their community. Rather than trying to find more ways to cut costs on an unpopular service line, the hospital determined the best way to impact profit margin would be to eliminate the obstetrics unit. In the end, it expects to reduce its budgeted loss by more than $1 million for 2001.

As with the prior example, benchmarking helps uncover what otherwise might take many years and many thousands of dollars to disclose. Using the following tips, organizations can save time, money, and reputation:

- Educate the entire team on the role being played by benchmarking analysis.
- Focus on data relevance vs. statistical significance.
- Utilize any well-analyzed, relevant data. Don't write off "older" data by waiting for a new

report. As long as they're relevant and strategic, they're useful.

• Focus on as few specific, strategic numbers as possible. The alternative will create massive reports with great detail but no focused direction.

• Benchmark data by comparing them with peer performance.

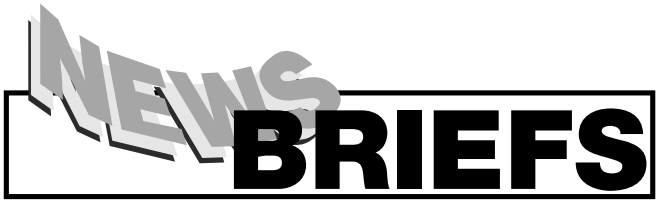
• Compare the data to other organizations that are also committed to sharing practices.

• Encourage integration of information from multiple sources. That includes internal trends, external comparisons, anecdotal knowledge, and industry trends.

Somewhere in an organization's reams of data are the sources of their biggest operating challenges and the clues to their greatest opportunities. But why search for the right questions to ask about company performance when benchmarking can lead directly to them? One of the biggest challenges for organizations is to be able to interpret data so the best decisions can be made accordingly. By strategically analyzing significant information, health care institutions can jump far ahead in understanding what performance improvement opportunities are available. Only then can they plan for and establish their own best practices.

[Shelley Burns heads the Knowledge Management team at The Healthcare Management Council Inc., located in Needham, MA, a benchmarking and consulting firm. For further information, call (781) 449-5287 or visit the company Web site at www.HMC-benchmarks.com.

If you have an idea for a guest column, contact Healthcare Benchmark's editor Lisa Hubbell at thehubbells@earthlink.net.] ■



AAAHC gets accreditation status in California

The Accreditation Association for Ambulatory Health Care (AAAHC) of Wilmette, IL, has been awarded recognition as an approved accreditation agency for outpatient surgery centers in the state of California. It is one of four accrediting organizations recognized under a new California law, which establishes regulations for surgeries being performed in certain outpatient settings.

"Through the accreditation process, outpatient surgical facilities are answering the demand for oversight in this environment and receiving an objective, independent review of their scope of practice and quality of care," says **William Beeson**, MD, president of the association.

"Accreditation not only demonstrates professional achievement but also provides tangible

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evidence of a commitment to high-quality patient care," he adds.

Organizations seeking AAAHC accreditation must undergo a rigorous review and demonstrate compliance with standards addressing training and credentialing of physicians and other staff, safety of the facility, the administration of anesthesia, and other items related to patient safety.

The AAAHC is a private, not-for-profit organization that has helped ambulatory health care organizations to improve their quality of care since 1979. The AAAHC has accredited more than 1,200 organizations nationally, ranging from ambulatory health care clinics and surgery centers to large managed care organizations.

For more information on the accreditation program in California or other association programs, contact the AAAHC at (847) 853-9028, or visit the Web site at www.aaahc.org. ▼

JCAHO joins the electronic age

The Joint Commission on Accreditation of Healthcare Organizations is jumping on the electronic mail bandwagon and now offers an e-mail service for newsletters, accreditation information, and news releases.

An unlimited number of people from a health care organization can sign up for the service, which was created after a recent Joint Commission survey in which nearly 90% of respondents wanted to receive information by electronic mail.

Among the items offered to participants:

• *The Inside Perspective*, the Joint Commission's official monthly newsletter;

• *Home Care Bulletin*, a bimonthly newsletter that keeps home care organizations up-to-date on the latest trends and accreditation information;

• *Sentinel Event Alert*, a periodic publication that focuses on health care errors;

• news releases.

Subscribers also may ask for information about any of the commission's accreditation programs, including notices about standards, field reviews, publications, and upcoming education programs.

For more information, contact the Joint Commission through its Web site at www.jcaho.org. ▼

Conference targets cost, quality for case managers

Experts will share their proven ideas for successful case management at The 6th Annual Hospital Case Management Conference: Blueprint for Case Management Success: Information, Accountability and Collaboration, to be held March 25-27 in Orlando, FL. The conference is sponsored by American Health Consultants, publisher of *Healthcare Benchmarks.*

Topics offer something for every hospital-based case manager or quality professional including:

• Values, ethics, and legal parameters in case management

• An interdisciplinary practice model for acute-care case management

• Measuring the impact of case management interventions

Each session sets aside time for you and your peers to ask the experts your most burning questions. Nineteen contact hours of continuing education will be offered.

The conference fee includes a cocktail party to network with speakers and other registrants, continental breakfasts, lunches, a course manual, and a form exchange for attendees. For more information, contact American Health Consultants, Customer Service, P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. ■