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Trauma program bolsters case for better equipment with benchmarking study

Better performers use high-end equipment most

Gregory Jurkovich, MD, FACS, head of trauma at Harborview Medical Center in Seattle, contended that patients with severe head injuries did better when they had intercranial pressure (ICP) monitors.

But it is an expensive proposition that some might question. So it was gratifying to get support from national benchmarking data that the best trauma programs did just what his physicians did at Harborview, he says. The best performers in the University HealthSystem Consortium's (UHC) trauma benchmarking study had a high percentage of patients with severe head injuries on ICP monitors, and Harborview's use of them was at the top. **(For more on the characteristics of better performers, see chart, p. 15.)**

The results justify the expense

"We do this, and it's expensive, but we believe it's worth it," Jurkovich says. His next step is to prove that this high ICP monitor use, along with the use of daily CT scans on patients, has a positive impact on outcomes.

The data come from 57 hospitals within the Oak Brook, IL-based UHC and from outside the consortium.

Data were collected in three categories, says **Danielle Carrier**, program director for operations improvement: an operational look at the overall program, clinical information from penetrating

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Press, Ganey Associates acquires Parkside
Press, Ganey Associates recently announced it has acquired the health care satisfaction survey business of Parkside Associates from Advocate Health Care 24

NCQA launches new certification programs
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abdominal injuries, and head injuries with long bone fracture.

The operational data included basic information on the number of cases, the percentage of injuries that were penetrating vs. blunt, length of stay (LOS) in the emergency department (ED) prior to admission or transfer to the operating theater, and overall LOS.

UHC also asked for information on who is included in trauma teams, the number of full-time employees in the trauma program, and data on the call program for attending physicians.

Clinical indicators included information such as the time it took from door to femur fixation, the percentage of liver and spleen injuries that received operative vs. nonoperative treatment, and the use of ICP monitors.

The more patients, the better the service

In 1997, members were expressing interest in looking at improving trauma care while increasing efficiency, according to **Julie Cerese**, RN, MSN, director of clinical practice improvement for UHC.

Among the key findings of the study:

• Of the average 1,400 trauma cases per year in a responding institution, about a third spend time in the intensive care unit, 41% have at least one operative procedure, and a quarter come from another facility.

• Average LOS is 3.7 days, and mortality rate is 1% for those with an injury severity score of 0 to 8. For those with a score of 25 or above, average LOS is 14.5 days, with a 37% mortality rate.

• Time in the ED for patients directly admitted ranges from 3.3 to 3.9 hours, depending on the severity score. Those going to the operating room (OR) are in the ED for 1.8 to 2.5 hours.

• Femur fixation occurs within about 25 hours of arrival in the ED.

• A quarter of severe head injury patients have ICP monitors.

• 65% of lacerated liver patients are treated without surgery, as are 56% of adult patients with ruptured spleens.

• Hospitals with trauma or critical care fellowship programs get patients out of the hospital between half a day and one day sooner than other centers.

There were some surprises, says Cerese. For penetrating injuries, some institutions' patient

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Key Success Factors of Better Performers

Case Study Site	Areas of Outstanding Performance	Key Success Factors
University of Tennessee, Knoxville	Penetrating abdominal injury, overall trauma program	• Trauma nurse specialists ensure ongoing patient management • Use of protocols and practice guidelines to optimize resource utilization • Concurrent quality improvement data collection, with weekly review meetings • 24-hour in-house attending trauma surgeon coverage • Team approach to care delivery and collaborative relationship with other departments • Balanced scorecard concept for trauma program • Implementation of telemedicine program
University of New Mexico	Penetrating abdominal injury	• Trauma program one of three strategic business units • Hospital central dispatch activates trauma alert based on protocols • Trauma attending surgeons respond to all penetrating injury trauma cases • Active management of OR so room available for trauma cases • Implementation of penetrating injury practice guideline • Use of ED observation unit to evaluate stab wound injuries • Trauma coordinators provide case management and identify and follow up on system issues
Oregon Health Sciences University	Head injury with long bone fracture, overall trauma program	• Emphasis on faculty-driven care • Innovative trauma/neurosurgery ICU • Use of ED observation unit • Specialized neurotrauma physician • Addition of a critical response nurse • Empowered trauma case manager/nurse practitioner • Hospital administration supportive of trauma program

Source: University HealthSystem Consortium, Oak Brook, IL.

management protocols may bypass the ED and go directly to the OR to expedite the patient through the system, she says. "But this may not be the ideal strategy, particularly in cases of low-level stab wounds."

Carrier says some of the results confirmed suspicions. For example, facilities that do the most trauma work achieve better results. Hospitals that are part of a trauma system also have better outcome. The message, she says, is to market your system so you get the kinds of numbers that create stellar trauma programs.

Get ready to work

Jurkovich admits that there was a lot of hard work involved in getting the data together. "We have to go out of our way to do this," he says, but adds that at least some of the data can be used for other regulatory and accreditation processes. "But all of us by nature like to compare ourselves to others, and we want to know how we are doing compared to everyone else. Just having a sense of doing a good job isn't enough for us."

Maria Moore, MPH, coordinator of clinical projects at UHC, says having physician champions like Jurkovich helps get other doctors and staff on board. "They can help drive the project and help convey how useful the hard work will be in the end." It's rarely a problem to get members on board if they have participated in at least one project. "That gets them over the hurdle."

Already, Jurkovich is working with the data that came from the knowledge transfer meeting. "We have shared them with the community of physicians that deals with these kinds of patients," he says. "We know that there are areas in which we stood out, and we are looking at those areas. The numbers and kinds of tests we do are on the end of the spectrum, and we have to determine if what we are doing is the right thing."

Next time, not so specific

When UHC revisits the trauma study again, it will take a broader look, Cerese says. "The penetrating injury population is an urban group," she says. "That limits the number of institutions that can participate because they don't have the volume of patients." Only 26 hospitals could meet the volume necessary for penetrating abdominal injuries, she adds. "A lot of others just didn't have the volume."

For the blunt injury, UHC was pretty specific about the kind of injury and the long bone fracture needed, Cerese continues. "In the future, we will extend the population so we can see how head injury is managed. We wanted the complicated patient, which is why we chose head injury and long bone. There was a sense that would be a big number. What they really had was head with pelvic, or head and foot, and concussions. We wanted something with a higher level head injury."

The study doesn't just leave members with the data. It also includes recommendations and suggests opportunities for improvement. Among them:

- Develop a faculty- and attending-driven practice and a collaborative approach to delivery of care.
- Empower staff to avoid delays in delivery of care.
- Make use of practice guidelines to minimize care variations.
- Use protocols such as standard lab tests and response times to optimize resource utilization.
- Get patients out of the ED quickly.
- Use dedicated trauma nurses to actively manage care.
- Low-level penetrating injuries may not need surgery. Consider ED or 24-hour observations first.
- Start patients with penetrating abdominal injuries on antibiotics within two hours of incision.
- Use ICP monitors for patients with positive CT scans and patients with Glasgow Coma Scores of 8 to 12.
- Use dedicated ICUs to stabilize patients and ED observation units for low-risk trauma evaluations.

[For more information, contact:

- ***Danielle Carrier**, Program Director, Operations Improvement, University HealthSystem Consortium, 2001 Spring Road, Suite 700, Oak Brook, IL 60523-1890. Telephone: (630) 954-1700.*
- ***Julie Cerese**, RN, MSN, Director of Clinical Practice Improvement, University HealthSystem Consortium. Telephone: (630) 954-1700.*
- ***Maria Moore**, MPH, Coordinator, Clinical Project, University HealthSystem Consortium. Telephone: (630) 954-1700.*
- ***Gregory J. Jurkovich**, MD FACS, Head of Trauma, Harborview Medical Center, 325 Ninth Ave., Seattle, WA 98104. Telephone: (206) 731-8485.*

For more about the study, visit the UHC Web site: www.uhc.edu.] ■

Are you doing your best for women patients?

Report card data show failing grades for U.S.

When the National Women's Law Center (NWLC) in Washington, DC, released its premier issue of *Making the Grade on Women's Health: A National and State-by-State Report Card* in August, a lot of policy-makers and state health leaders took notice.

But now even health plans are taking a look at the data, says one of the authors of the report, **Michelle Berlin**, MD, MPH, assistant professor of obstetrics, gynecology, and epidemiology and co-director of FOCUS on Health and Leadership for Women at the University of Pennsylvania in Philadelphia.

"Right now the Blue Cross/Blue Shield organizations in Georgia have expressed a lot of interest," she says. "They are avidly looking at ways to incorporate this information into their plans and act on it."

The data included in the report give plans, hospitals, and even individual physicians plenty of areas on which to work. Of the 25 indicators for which benchmarks were available, only one — mammography for women over 50 — was met by every state and the District of Columbia, and all missed 10 of the benchmarks.

Those included women without health insurance, first trimester prenatal care, no leisure time physical activity, overweight, eating five fruits and vegetables a day, high blood pressure, diabetes, life expectancy, poverty, and the wage gap. Nine states received failing grades, with the other 41 states and Washington, DC, getting unsatisfactory ratings. None received a satisfactory mark.

Along with clinical benchmarks, the report card placed a strong focus on women's wellness. Berlin and her co-authors from the NWLC and the San Francisco consulting firm Lewin Group included health behaviors, social supports, economic independence, and safety and health conditions as critical indicators in assessing the status of women's health in each state and nationwide. The study also examined statutes, regulations, public policies, and government investment in resources that promote women's health.

"There are no commonly accepted sets of indicators for women's health," Berlin says. "I think this [issue] has been plaguing us for a while and prevented us from characterizing what is going on with women's health."

Berlin says her interest, as well as the law center's interest in forwarding policies that advance women's physical and social well-being led to the collaboration. "I wanted to put together something that academicians and public health officials would use."

The group decided not to do any primary data collection but rather concentrate on information that was already available. **(For a list of the indicators on which data was collected, see box p. 18.)**

"There are a huge number of topics we could have looked at," says Berlin, "but there is a limit to what we can do. The most common illness is the cold, but looking at that won't help anyone. Surveys of what people go to the doctor for find that the most common thing they suffer from is 'other.'

"We decided to look at what women suffer from, what they are sick with, what they die from. And we wanted to look at wellness issues, prevention, and a healthy environment," she explains.

Dismal results

In all, status and policy indicators were taken in four categories: access to health care services; wellness and prevention; key health conditions, diseases, and causes of death; and living in a healthy community.

The results aren't very promising.

• **Access to health care is compromised by inadequate health insurance.**

Nationally, about 14% of women are uninsured, and that number is growing, says the report. No state met the goal of having all people insured, and only eight came within 10% of it. Prescription drug coverage also is lacking, and only 19 states have significant support beyond what Medicaid covers.

Coverage of specific conditions is often excluded from general insurance. Only four states require mental health insurance parity, and just eight states require coverage for post-mastectomy hospital stays and reconstructive surgery after mastectomy.

Just two states require public and private insurance plans to provide contraceptive coverage, and only six states require coverage for hospital stays after childbirth deemed necessary by the women's physician.

Selected Indicators: States and Washington, DC

WOMEN WITHOUT HEALTH INSURANCE

✔ Hawaii	7.5%
✔ Texas	28%

WOMEN LIVING IN POVERTY

✔ Utah	8.2%
✔ New Mexico	21.4%
✔ Washington, DC	21.6%

WOMEN WHO SMOKE

✔ Utah	12.6%
✔ Kentucky	28.5%

WOMEN 50 AND OLDER WHO HAD A MAMMOGRAM IN THE PAST TWO YEARS

✔ Washington, DC	89.4%
✔ Massachusetts	84.2%
✔ Minnesota	64.9%

WOMEN WHO ARE OVERWEIGHT

✔ Arizona	21.9%
✔ Mississippi	38.4%

Source: National Women's Law Center, Washington, DC.

Key health care services aren't being met, in part because nearly a 10th of the national population lives in a medically underserved area. In Louisiana, nearly a quarter of the population is underserved. No state met the benchmark of 90% of pregnant women getting prenatal care in the first trimester, although Maine was close with 89.9%.

• **Wellness and prevention programs still are lacking.**

No state has met national goals for increasing physical activity, reducing overweight, or improving diet. Only Utah met the national goal for reducing the percentage of adults who smoke, and 18 states met the national goal for reducing binge drinking.

• **States did better in screening for key diseases.**

All the states meet mammogram goals for women 50 and older, but some populations — those who are uninsured, some racial and ethnic groups, and older women — don't receive such screenings at the national rate.

Washington, DC, and 24 states met the goal for Pap smears, and the district and 19 states met the national goal for colorectal cancer screenings. But only two states require private insurers to cover the latter.

Thirty states met the goal for the number of women dying from heart disease, but only four met the goal for deaths from strokes, the third leading cause of death among women. Lung cancer, the second most common cause of death among women, is adequately targeted by 24 states and the District of Columbia, and 36 states met the goal for deaths from breast cancer.

Controlling high blood pressure can help prevent heart disease and stroke, but no state met the goal for reducing high blood pressure. Diabetes prevention also failed nationwide. Maternal health levels nationwide also show a need for improvement.

The World Health Organization ranks 20 countries ahead of the United States in maternal mortality levels, and the number of mothers who die is four times higher among African-Americans than for white women. Only three states met the national goal for maternal mortality.

• **Living in a healthy environment could help increase women's life expectancy**, which at just under 80 years lags behind 19 other countries.

Among the dangers women face are exposure to hazardous agents in the air, water, and soil; violence including gun violence; and discriminatory practices that prevent women from securing education, financial independence, or insurance.

Differences abound

Perhaps the biggest surprise in the study was the wide disparity among the states. For instance, in maternal death, New Hampshire had only 1.9 per 100,000 live births, while the District of Columbia had 22.8.

In life expectancy, Hawaii ranked No. 1 with 81.3 years, compared to Washington, DC, where women can expect to live 74.2 years. Minnesota, which may be a template for others, had just 65.4 deaths per 100,000 women from coronary heart disease, compared to Mississippi, where there were 141.2 such deaths per 100,000 women. **(For**

(Continued on page 20)

Report Card Health Status Indicators

1. Women's Access to Health Care Services

- Percentage of women who don't have health insurance
- Percentage of people living in a medically underserved area
- Percentage of women receiving prenatal care in the first trimester
- Percentage of women living in a county without an abortion provider

2. Wellness and Prevention

Screening:

- Percentage of women 18 and older who have had a Pap smear in the past three years
- Percentage of women 50 and older who have had a mammogram in the past two years
- Percentage of women 50 and older who have ever had a sigmoidoscopy

Prevention:

- Percentage of women who haven't engaged in leisure time physical activity in the last month
- Percentage of women who are overweight
- Percentage of women who eat five or more servings of fruit and vegetables per day
- Percentage of women who smoke
- Percentage of women who have had five or more drinks on at least one occasion during the past month

3. Key Health Conditions, Diseases, and Causes of Death

Causes of Death:

- Number of women who die from heart disease
- Number of women who die from strokes
- Number of women who die from lung cancer
- Number of women who die from breast cancer

Chronic Conditions:

- Percentage of women with high blood pressure
- Percentage of women with diabetes
- Number of women reported to have been diagnosed with AIDS
- Number of women with arthritis
- Number of women 50 and older with osteoporosis

Reproductive Health

- Percentage of women with chlamydia
- Percentage of pregnancies that are unintended
- Maternal mortality ratio

Mental Health

- Average number of mental health days during the past 30 that were "not good" for women

Violence Against Women

- Percentage of women who are victims of violence

4. Living in a Healthy Community

Overall Health

- Average life expectancy for women
- Average number of days in the past 30 days that women limited their activity
- Infant mortality rate

Economic Security and Education

- Percentage of women 18 and older living in poverty
- Wage gap between male and female wage earners in the state
- Percentage of women who graduate from high school

Source: National Women's Law Center, Washington, DC.

more on the disparities, see chart, p. 19.)

Data were limited, lacking, or nonexistent for several key areas, such as state level data on arthritis or osteoporosis, mental health status, or data on physical and sexual assault, and Berlin says that drilling down even more — to the county or city level — would have been impossible. "But this does offer a snapshot, and you can see where you stand." The lack of data was mentioned in the report, along with a call for more research on women's health, better enrollment of women in clinical trials, and more research on the racial, ethnic, and socioeconomic disparities in health conditions that affect women.

The project will become annual, so when the next issue comes out, there may be some better data, Berlin says, as well as a way to see how states are improving in various areas.

"I think the best use of this report is for organizations and states to plan what to do next," she says. "Take this into account when you look at what you will emphasize in the next few years. Make it a five-year plan. Ask your state legislators what they will do to help you fix some of these things. Incorporate this into what you do."

[For more information, contact:

*• **Michelle Berlin**, MD, MPH, assistant professor of obstetrics, gynecology, and epidemiology, co-director of FOCUS on Health & Leadership for Women, University of Pennsylvania, 915 Blockley, 423 Guardian Drive, Philadelphia, PA 19104-6021. Telephone: (215) 898-1539.*

To read the report in its entirety, visit these Web sites:

*• **NWLC** at http://www.nwlc.org.*

*• **University of Pennsylvania FOCUS center** at http://cceb.med.upenn.edu/focus.*

Information on ordering hard copies is also available from both organizations.] ■

Outsourcing satisfaction gives system a boost

Costs are higher, but impact is greater

As the author of a book about customer service in health care, one might expect **Kristin Baird**, RN, MHA, vice president of business development at the small health system Watertown (WI) Area Health Services, to know the value of measuring patient satisfaction.

That assumption is correct. And since the system and its hospital, five clinics, and two senior housing complexes already engage in external benchmarking of financial and quality indicators, you might expect that they did the same with patient satisfaction. But here, you'd be wrong.

Until mid-1999, the system used an internal tool to measure patient satisfaction. "I think the reason we didn't follow the same line for patient satisfaction was two-fold," says Baird.

"First, it was a lot to tackle all at once. In 1997, we were new to benchmarking and trying to get management buy-in for the quality and financial benchmarking that we were doing," she explains. "At the same time, we were launching a new patient satisfaction tool that we developed internally. People were comfortable with what we were doing, and the results were positive."

But Baird says she wondered, "compared to what and to whom? We knew we had to give our people an effective target. They have to know that raw scores of 92 aren't enough. You have to do more than say, 'Wow! We got an A-. Aren't we great?!'"

The success of the other benchmarking projects, however, spurred Baird on to bring external benchmarking to patient satisfaction. "It gave us legitimate targets and common goals to shoot for."

And the result has been positive. In the first year after Watertown Area Health Services started using the external comparisons for its hospital, scores increased from the 56th percentile for inpatient care to the 99th. They increased from the 43rd percentile to the 69th in the emergency department and from the 47th to the 73rd for outpatient rankings.

It could be worse, couldn't it?

There were bumps along the way, though. The first hurdle was getting middle management to buy into the idea. "I just had to put it in front of them all the time, give them a sense of ownership in the idea and how it will help us get and keep corporate executives."

The new hospital CEO came in after a 30-year stint by the man he replaced, and Baird says his emphasis on "paying attention to the outside world" helped to sway some people. "He believes in setting what he calls big hairy audacious goals. Among them are cost effectiveness, getting the

best people, high clinical quality, and stellar customer service. We had three of the four all set up, but had no goals for customer service. We had to have external benchmarking to give validity and teeth to that whole issue."

Another potential setback was the initial shock of the first set of low rankings. "I was really disappointed because I thought we were doing well," Baird says. "I was glad to have the information, but I expected it to be much higher. It was truly humbling."

> *"I think we needed that shock. I believe in competition and the competitive spirit to keep people hungry. I think when staff saw these scores come in, and looked question by question to see where we compared in food, friendliness, call lights — well, it has an impact on them that just talking about something doesn't."*

It could have been worse, she notes. "At least our lowest scores weren't in the single digits like some others." The hospital CEO — whom Baird calls "forward-thinking and supportive" — also felt it was a good beginning, considering the hospital was just starting out. But staff also were disappointed.

"I think we needed that shock," she says. "I believe in competition and the competitive spirit to keep people hungry. I think when staff saw these scores come in, and looked question by question to see where we compared in food, friendliness, call lights — well, it has an impact on them that just talking about something doesn't."

'Punch Your Lights Out' big success

An example is the call-light issue, Baird says. "We started out in the 13th percentile on that issue. But staff came up with some ingenious programs to make it better." For instance, when making rounds, they manage patient expectations by telling them how long before they will return.

The hospital also created a new policy where anyone, whether it is the CEO or a maintenance worker, can answer a call light. "The vast majority of requests have little or nothing to do with nursing and more to do with connecting with people. Maybe they need their blinds adjusted or something fell," she says.

Training for the entire hospital staff ensued, so that everyone would feel comfortable with the new policy. There was also a contest to kick off the new policy, where everyone had a punch card. The "Punch Your Lights Out" contest rewarded those staff members who had the most punches in their card, with one punch received for every call-light response.

The result of those efforts was an improvement in the call-light response question from the dismal 13th percentile to 99th.

It's important not to get too complacent, though, says Baird. "We are really grappling with that. Whatever got their attention and created these big turnarounds isn't there anymore. Our outpatient scores are in the 89th percentile now after a steady climb. A lot of people were doing a lot of things. And maybe that will keep us from slipping. It isn't just one person preaching fire and brimstone from the pulpit, but creating a whole new mindset among staff. We are rewarding people for their good ideas, we are promoting the standards that we want to live by. We introduce them at orientation, post them on walls, and carry them on pocket-sized cards."

There also are weekly team meetings to work on specific issues that need addressing. "It's a lot of work and very labor intensive," says Baird.

Raising the bar

But there are other benefits, too. For instance, some of the fervor from improving customer service has bled into other "big hairy audacious goals." she says that by being clear about the values and expectations in an organization, you find that people who don't fit in leave.

"People on the edge may go one way or the other," she adds. "And those at the top are invigorated when you raise the bar. Our employee satisfaction has risen. The national benchmarks we measure against for overall satisfaction, trust, and whether they would recommend us as a place to work are all near 90%. The industry norm is in the 60s."

There also has been more employee input in cost-containment goals. Through the bright ideas program, people have recommended ways to cut costs and improve morale. One winning idea commented on the overuse of Styrofoam. "It was costly and nonrecyclable, so we bought everyone in the organization an insulated mug with our logo on it."

Another idea was to create a check sheet for

nurses to go through prior to a physician's rounds. "Nurses and physicians felt that the nurses weren't prepared for physician questions. There was a lot of time wasted in that. Now they have a sheet to make sure they are ready to answer the questions," she says.

Nurses also reformatted how they change shifts. Before, two shifts of nurses were on at the same time, but none were with patients at the bedside. Now they use written reports and electronic records so that time and money are saved. "And there is pride, too, because the nurses came up with the idea," says Baird. "It also improves patient satisfaction because the nurses spend more time with patients, and physician satisfaction because the patients are happier."

All this from outsourcing patient satisfaction surveys? You bet, says Baird. It isn't easy or cheap, "but unless people have a point of reference, you don't have a clear goal post in sight. You may be saying that you want to improve raw scores, but that's not enough. You want to compare yourself and be competitive with what others are doing out there."

[For more information, contact:

• ***Kristin Baird**, RN, MHA, vice president of business development, Watertown Area Health Services, 125 Hospital Drive, Watertown, WI, 53098. Telephone: (920) 262-4309.*

• *Baird's book,* **Customer Service in Health Care** *(published last year by Josey Bass and the American Hospital Association) is available for $34.95 on amazon.com.]* ■

New technology helps data management

Are the new Web-based, wireless systems for you?

The age of technology has many benefits for the health care industry. Information is easier to come by, easier to access. But how do you bring all the pieces together? Two new systems may help health care organizations manage their data and information better in the future.

The first, AVT CallXpress, links e-mail, voice mail, and faxes. According to **Laura Johnson**, vice president of product marketing for AVT, based in Kirkland, WA, the system provides users with a single point of access to receive and manage all three message types — voice, fax and e-mail — through their wireless device, telephone, the Internet, or their familiar e-mail inbox.

All three types of messages appear in the e-mail inbox. Outside the office, users can check e-mail, voice mail, or faxes from another computer, or even a regular telephone. Text-to-voice technology allows users to listen to written messages, and then reply to them using his or her voice. The reply is transcribed into an e-mail message.

There are other similar systems. Johnson says she sees Lucent, Nortel, and Siemens as her main competition. "They are all PBX vendors, though, and they sell a solution that integrates with their PBX. But we integrate with more than 150 circuit and IT-based PBX switches.

"They also only operate in an exchange environment, while we allow you to access messages via e-mail on either Microsoft Outlook or Lotus Notes. That's 80% of the market." Johnson says her product also allows for greater size, with up to 10,000 users being served.

Another distinction, says Johnson, is the fax component of the product. The competition can't integrate all three components — fax, voice, and e-mail — with e-mail access to all.

While she wouldn't discuss the pricing structure, Johnson says an organization using her system could do away with its answering services. "A physician could be notified on a cell phone, pager, or home phone that there is an urgent message, regardless of where he or she is. If you are out of the office, just dial the system and pick up your messages."

Custom applications available

There are also custom applications that AVT can create, Johnson says. For instance, an appointment wizard could let patients set appointments over the phone. Classified communications like test results could be provided through a secure mailbox.

"A lot of calls to physicians are asking the same kinds of questions," she says. "During a greeting, you can prompt patients to press one for directions, enter a fax number and they will be automatically faxed, or press one to have them given by voice. All that can be automated. That's a real timesaver."

One of the biggest customers for the company is the Louisiana State Senate in Baton Rouge. According to **Mike Baer**, secretary of the senate, The Louisiana State Senate was able to eliminate

numerous fax machines and telecommunications management costs of $25 per month per employee.

Time savings are also considerable. So far, employees think this "is the greatest thing since sliced bread," says Baer.

Among the health care customers is Sutter Health of Sacramento, CA.

Another new system will allow physicians to receive transcribed reports and patient chart information over the Web or even through wireless telephones. MDinTouch Inc., based in Miami, and MODCOMP of Ft. Lauderdale, FL, have linked up to give physicians access to data that had been locked away in old style computer systems. By creating a bridge between palm computers and old mainframe systems, MDinTouch will allow physicians to take notes using new technology, have it transcribed, and sent back in a secure Internet connection. Physicians can access, sign, amend, and send on the reports using the new system.

Currently, a women's clinic in Miami, Femwell Diagnostic Center, is piloting the system, which also can be accessed using two different models of Erikson cellular telephones.

In the future, other phones will be able to access the system, too, says MDinTouch's chief technical officer **Kent Wreder**.

The system allows immediate access to data that might be hard to get in the middle of the night, on weekends, or simply when the physician is not in the office, Wreder says. They can have instantaneous access to medical data, he adds.

It makes use of XML, the up-and-coming Internet computer language, says Wreder, which allows the system to talk to systems which using other languages it could not.

So convinced are at least two physicians of the importance of both wireless technology and XML to the health care industry that they started a company, ChartWare, based in Rohnert Park, CA. The company makes medical record-keeping software that can be used on palm and other handheld electronic devices and uses the XML language.

According to ChartWare president **David Tully-Smith**, MD, getting rid of paper-based charts not only eliminates errors due to misfiling or illegible writing, but it also gives physicians access to their patient data on the spot. "They become a permanent, legible, and immediately accessible part of the patient record."

[For more information, contact:

*• **Mike Baer**, Secretary of the Louisiana State Senate, Baton Rouge, LA. Telephone: (225) 342-0629.*

*• **Laura Johnson**, Vice President of Product Marketing, AVT Corp., 11410 N.E. 122nd Way, Kirkland, WA 98034. Telephone: (425) 820-6000.*

*• **Kent Wreder**, Chief Technical Officer, MDinTouch, 7428 S.W. 48 St. Miami, FL 33155. Telephone: (786) 268-1161.*

*• **David Tully-Smith**, MD, President, ChartWare, 101 Golf Course Drive, Rohnert Park, CA. 94928. Telephone: (800) 642-4278.]* ■

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Editor: **Lisa Hubbell**, (425) 739-4625.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Russell Underwood**, (404) 262-5521, (russ.underwood@ahcpub.com).
Production Editor: **Ann Duncan**.

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Editorial Questions

For questions or comments, call **Lisa Hubbell** at (425) 739-4625.

NEWS BRIEFS

Press, Ganey Associates acquires Parkside

Press, Ganey Associates recently announced it has acquired the health care satisfaction survey business of Parkside Associates from Advocate Health Care. More than 2,500 health care organizations, including nearly 1,100 hospitals, are currently clients of Press, Ganey and Parkside.

The combined businesses will process more than 7 million patient surveys annually and will be based in South Bend with offices in Park Ridge, IL.

In other news, Press, Ganey and its partner, Market Strategies, have been recertified by the National Committee for Quality Assurance to conduct the HEDIS/CAHPS 2.0H commercial, Medicaid, and Management of Menopause surveys. The surveys provide consumers, purchasers, and health plans with information about a broad range of key consumer issues such as overall satisfaction, average wait times, physician availability, obstacles to receiving care, and parents' impressions of their children's care. ▼

NCQA launches new certification programs

Utilization management and credentialing are up for review with National Committee for Quality Assurance (NCQA)'s new certification programs. Already, three organizations — Private Healthcare Systems, Beech Street Corp., and the Detroit Medical Center have agreed to have their programs reviewed.

The certification programs adapt standards included in the credentialing and utilization management sections of NCQA's PPO (preferred provider organization) Plan Accreditation program, which was introduced last August. The standards have been adapted to allow PPO networks and other organizations performing these functions to participate.

"Giving organizations other than HMOs a chance to prove themselves through NCQA Certification will drive improvement across the industry," says **Spencer Falcon**, MD, executive vice president of medical management at Private Healthcare Systems, a Waltham, MA, company that covers more than 6 million lives. "We're pleased to be among the first PPO networks to take part in this program."

NCQA believes that employers and PPOs that contract with organizations for utilization management or provider networks will seek out certified organizations to meet their needs.

According to NCQA officials, while many participants in the program will be PPO networks, certification is open to any organization that performs the specified functions and is not eligible for NCQA's accreditation programs for managed care organizations and managed behavioral health care organizations. Physician organizations (PO) certified under the 2000 standards for NCQA's PO Certification program will be deemed to be certified under the new programs.

NCQA currently is accepting survey applications from organizations interested in pursuing certification and is holding two conferences to bring organizations up to speed. The first will be March 19-20 in Houston, and the second will be in Orlando, FL, in early October. For more information on the conferences or the program, visit the NCQA web site at www.ncqa.org, or contact the NCQA at (202) 955-5697. ■