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APRIL 2001

VOL. 8, NO. 4 (pages 37-48)

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Rooting out health care discrimination: It's not just the right thing to do

Concrete actions to take to reduce discrimination

Delivering high-quality health care equally to all patients may be a matter of common decency, but unfortunately, it's not always common practice. Discrimination in health care can open organizations to serious legal problems and cause patient satisfaction scores to plummet.

It's hard to know exactly how widespread the problem is, but studies conducted in individual health care markets paint an alarming picture. Most recently, the Seattle and King County (WA) public health department released a study that showed fully one in 10 people of color reported discrimination in health care episodes. **(See related story, p. 40.)**

But you can take action — whether you know you have a problem or simply suspect you might. You can start by gathering what data you have:

• Make sure patient satisfaction surveys contain a component on discrimination and differential treatment. "I think it's hard for people to talk about their differential treatment," says **Michael Smyser**, MPH, an epidemiologist with the Seattle and King County public health department. "They want to move beyond it, and the reluctance increases if the environment isn't perceived as friendly." Special training for interviewers can help. But Smyser says that for many there will be a fear of retaliation. "They might worry that their care will be compromised further, and they will hold back."

• Check the racial and ethnic data you already maintain on your own computer systems, says

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Lisa Evans, JD, research analyst at the U.S. Department of Health and Human Services, Office for Civil Rights (OCR) in Washington, DC. Ethnic data also often are provided to the state by hospitals and health plans. You can use these data to determine where patients come from and what treatment they receive.

"I don't think very many hospitals collect these kind of data on their own," says Evans. "And if they do, it's more than likely that a disenfranchised group has approached them with concerns, and they are responding to that. But it can provide a wealth of information."

For instance, in New York state, hospital discharge data that include racial identification were instrumental in showing that certain minorities didn't go to certain hospitals for treatment. "They showed this graphically," Evans explains. "You could see clearly where they lived and where they went."

• Consider using the federal government as a resource. Evans says the OCR isn't just there to respond to complaints; it also can be used as an investigative tool if you are interested in looking at racial and ethnic data. "If you come to us and say we have a problem or we want to look at this, that is part of what we are charged with doing," she says. "We are charged with helping facilities obtain voluntary compliance, not terminating federal funding if you do something wrong."

Should you wait for data to take action? **Tom Lonner**, PhD, research manager at the Cross Cultural Health Care Program in Seattle, contends very little gets done in this area without some evidence proving you have a problem. "Advances are made in competition with other compelling choices," he says. "And the evidence for these investments must be sound and, often, specific to the institution or agency making the decision. More generic 'conditions of the world' will not move folks to action."

Evans disagrees. "Data are helpful because they focus your attention," she says. "But most of the time when action is taken, it isn't the result of complaints being filed but about people who are interested in getting together to address the perception and reality of differentiation in health care."

If you are moved to act immediately, there are some simple actions you can take:

• Make sure consumers know their rights and what actions they can take to make sure grievances are addressed, says Smyser. Publicize and post your policies.

Description of Discrimination Events

	Number of Events	Percent of Total Events
Event by Provider/Facility Type		
Hospital inpatient	20	25.6%
Doctor's office	14	17.9
Medical center outpatient	12	15.4
Community clinic	9	11.5
Emergency facility	7	9.0
Urgent care center	3	3.8
Other	9	11.5
Personnel involved in event		
Physician	46	59.0
Nurse	30	38.5
Front desk staff	18	23.1
Medical assistant	8	10.3
Dentist	5	6.4
Billing clerk	1	1.3
Dental assistant	1	1.3
Pharmacist	1	1.3
Lab technician	1	1.3
Emergency personnel	1	1.3
Security	1	1.3
Other	25	32.1
Type of perceived discrimination		
Differential treatment	50	64.1
Perceived negative attitude	36	46.2
Treated as dumb	22	28.2
Made to wait	13	16.7
Ignored	11	14.1
Pain ignored	11	14.1
Inflicted unnecessary pain	5	6.4
Racial slur	4	5.1
Harassed	3	3.8
Being watched	2	2.6
Exhibited fear	1	1.3
Other	32	41.0

Note: Multiple responses allowed in each category.

Source: Racial Discrimination in Health Care Interview Project, Public Health — Seattle & King County, WA.

• Provide interpreter services where needed. You can formally hire people, keep them on-call on a contract basis, use volunteers, or have an ad-hoc program that utilizes staff, patients' family members, or even strangers from the waiting room. But Evans warns that this should not be your only action.

• Recruit, hire, and retain a diverse work force, and make sure you maintain, enforce, and publicize a nondiscriminatory workplace policy that is known and understood by all staff.

According to a recent literature review on cultural competency,[1] having more minority staff can create a more welcoming environment to minorities. Among the programs a hospital can try are setting up minority residency or fellowship programs, having senior executives mentor minority employees, and tracking staff satisfaction by racial and ethnic groupings.

According to **Mike Carter**, Region II manager for the OCR, who you hire should largely mimic who you serve. "If your staff don't look like who you market to, you may have a problem."

• Provide cultural competency training. "This is something you have to continually work on," Smyser says. Although 90% of the discriminatory

events reported in the King County study were attributed to a physician, nurse, or other provider, all staff should be involved in cultural competency training. "And this has to be worked into a person's evaluation," he says. But note that a literature review found that shorter courses and didactic approaches are not as effective as other methods.[1]

• Coordinate with traditional healers. Native American healers, acupuncturists, holistic medicine providers, and others should be included in caring for patients who use them so there is a continuity of care. Patients whose providers exhibit knowledge and are nonjudgmental in questioning are more likely to give honest responses about herbal or other remedies they are using.

• Make use of community health workers to provide outreach and liaison services between patients and providers.

• Make your health promotion materials culturally competent. Take into account different beliefs among races about diseases, such as breast cancer, where minority women are much less likely to get mammograms and often present much later with breast cancer.

• Include family and community members where appropriate. In many cultures, the patient isn't the focus, but rather the family. Mexican-Americans and Korean-Americans are more likely to prefer that family members be involved in decision making, and such family members are crucial to ensuring compliance.

There are assessments you can do yourself to determine how culturally competent you are. Carter, who worked on the New York project that found disparities between where minority patients lived and where they went for health care, worked with New York health care providers and organizations to develop an assessment tool that anyone can use. **(For sample tool, see p. 42.)**

Alternatively, you can ask for assistance from your regional OCR office or one of the numerous private organizations that work in minority health care. **(For web sites to find additional information, see box, p. 44.)**

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Reference

1. Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review* 2000; 57:187-217. ■

Study reveals disturbing trends in care of minorities

Seattle study has implications nationwide

A 2000 survey of residents in the Seattle area shows that one in five adult residents believe they have experienced discrimination in health care. One-sixth of African-Americans interviewed and nearly a tenth of all people of color reported discrimination in medical care settings in the previous year.

"I think if it's happening here, it's happening everywhere," says **Michael Smyser**, MPH, an epidemiologist with the Seattle and King County (WA) public health department and one of the study's authors. "Other studies have shown that reports of differential treatment can't be ascribed to education or income but [are] clearly about a person's race. They are getting less rigorous treatment, treatment that isn't of the same quality."

Smyser cites several investigations and literature reviews by Robert Mayberry, MD, MPH, PhD, director of Morehouse Medical Treatment Effectiveness Center at Morehouse School of Medicine in Atlanta, that show differential practices. Smyser adds that it seems natural his study found perceptions matched practice. "We are seeing it on both ends."

The King County study was a random survey of more than 1,500 King County residents that dealt with a variety of issues, including health care. Smyser says the percentages of people of color reporting discriminatory practices in health

care settings were so disturbing that the public health department opted to look into it further. Fifty-one African-Americans were selected for in-depth interviews, and their reports have lessons for providers in clinics, private practices, and hospitals, he says.

The 51 people reported incidents at 30 facilities throughout King County, the 12th most populous county in the country with more than 1.5 million people. Among the findings:

• Many of the interviewees could cite more than one perceived incidence of discrimination.

• All felt the rude and/or differential treatment they received was racially motivated.

• The events were recent; about half of the 92 reports were less than 10 months old, and most were within the last two years.

• Most reported changing their health-seeking behaviors as a result of the events. Many avoid the health care institutions or even delay seeking health care.

And lest providers and health care facilities think they are immune because they don't see a lot of indigent patients, Smyser says more than half of the interviewees had private medical insurance, and a similar number were college graduates or had some college education. "Interviewees who were college graduates and who had private insurance reported many of the more severe events," the study notes.

The findings are divided into several categories:

• **Receiving differential treatment.** Respondents said they were treated as if they didn't matter or differently than Caucasian patients. One respondent who had differential treatment on two successive visits took a 15-mile detour to obtain care at a different location.

• **Experiencing negative attitudes.** People interviewed reported being treated rudely, being treated as if the patient smelled, not being looked at, and being disregarded. The behavior was not seen as hostile but as uncaring. Many respondents used the term "belittled" in describing their experiences, or reported that the physicians weren't interested in what they were saying.

• **Being made to feel stupid.** Several patients reported that physicians described problems or treatments slowly, as if they were not intelligent or were unable to care for their children.

• **Being ignored.** Some respondents reported that in an emergency department setting, they were made to wait a long time or ignored when they asked for help.

• **Being accused of drug abuse.** Two patients said they were accused of using drugs. In neither case was the patient a drug user, and both were shocked by the accusations. In one instance, a nurse told a hospitalized respondent, "I know you shoot dope." The other reported a physician wanted to know if the patient always asked for specific drugs. "He treated me as if I were drug shopping."

• **Experiencing perceived racist remarks.** One respondent, a registered nurse, reported that she was told her daughter's condition, asthma, was "an African-American thing." One patient who asked for a sedative during a breast biopsy was refused pain medication and told "you people accepted pain as part of slavery because you tolerate pain so well." A nurse told one woman who had come in for a scheduled appointment at a major medical center that "you people never make appointments. You want to come in whenever

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More Data on Health Care Disparity Among Minorities

- ✔ **Heart disease.** African-Americans are 13% less likely to undergo coronary angioplasty and one-third less likely to undergo bypass surgery than are whites.
- ✔ **Asthma.** Among preschool children hospitalized for asthma, only 7% of black and 2% of Hispanic children are prescribed routine medications to prevent future asthma-related hospitalizations, compared to 21% of white children.
- ✔ **Breast cancer.** The length of time between an abnormal screening mammogram and the follow-up diagnostic test to determine whether a woman has breast cancer is more than twice as long for Asian-American, African-American, and Hispanic women as for white women.
- ✔ **HIV infection.** African-Americans with HIV infection are less likely to be on antiretroviral therapy, less likely to receive prophylaxis for pneumocystis pneumonia, and less likely to be receiving protease inhibitors than other persons with HIV.
- ✔ **Nursing home care.** Asian-American, Hispanic, and African-American residents of nursing homes are all far less likely than white residents to have sensory and communication aids, such as glasses and hearing aids.

Source: Agency for Healthcare Research and Quality, Rockville, MD.

Do You Discriminate? An Internal Self-Assessment Tool

The following self-assessment tool was developed by Mike Carter, regional manager at the Office of Civil Rights (OCR) in New York City, and a variety of health care professionals and organizations in the state. It is not a policy guide or enforcement document from the OCR.

He views it as "a road map that your agency or facility can use to determine how accessible you are to racial and ethnic minority patients." Not every question may apply to your particular case, and the ultimate goal should be for an institution to be able to determine why certain patient populations do not access a particular facility or service and how this situation can be remedied.

The tool is a work in progress. If you have suggestions for input or update, contact Carter at mcarter1@os.dhhs.gov.

Carter says the first step in doing the assessment is to appoint a coordinator and establish a self-assessment committee with a cross-section of staff representing the protected classes. The coordinator or committee chair should be an individual with sufficient authority within the organization to take the needed actions.

The committee should include persons who have responsibilities in admissions and intake, provision of services, personnel administration, and physical plant management, as well as specialists who work with disabled persons. The committee should ask the following questions:

GEOGRAPHIC AND DEMOGRAPHIC DATA

1. What is the actual geographic service area for your facility? Has your facility recently reviewed patient demographics? Do you know the current racial, gender, age, and geographic distribution of your patient population? Review patient discharge data that your facility gathers. This can help you determine exactly who you serve.
2. Do you have a breakdown of your facility's service area by race and/or national origin and age? You can check U.S. Census Bureau data, state and local population data, and statistical models to find this information.
3. Do you operate any satellite facilities? If so, where are these facilities located? What type of services do these facilities offer? What is the racial and/or ethnic breakdown of the patient population that uses these facilities. (Use most recent data available.)
4. Identify your patients/clients by race, ethnicity, age, disability, and primary source of payment.
5. List your facility's major referral sources. Do you have referral sources in minority communities? Consult minority community representatives to assure that these referral sources are adequate.
6. Does your facility's service area include one or more national origin minority groups (i.e., Hispanic, Chinese, Russian, Polish, Italian, etc.) with at least 100 persons of limited English proficiency (LEP)?
7. What are the most sophisticated medical services that your facility is known for? What is the racial and/or ethnic breakdown of the patients who have received these services during the last calendar year?
8. Does your facility offer emergency room services? If so, what is the racial and/or ethnic breakdown of the patient population treated in your emergency room during the last calendar year? How many of the patients seen in your emergency room were admitted to your facility? What is the racial and/or ethnic breakdown of this patient group?

POLICY SECTION

9. Does your facility have a nondiscrimination policy? If so, how do you train your staff in this policy? How is the policy updated? How are staff informed of updates? Is the policy reviewed regularly? Are your nondiscrimination policies posted in public areas? Are they printed in facility publications? Are those publications available in languages other than English? If so, what other languages? Do those languages correspond to the languages spoken in your facility's service area?
10. Have you notified participants, applicants, and employees that you do not discriminate on the basis of race, color, national origin, age, or disability?
11. Do your written materials include a notice of nondiscrimination on the basis of race, color, national origin, age, or disability?
12. Have you designated someone to coordinate your efforts to comply with Title VI of the Civil Rights Act of 1964? If so, what authority does that person have to correct situations that may violate Title VI? Does that person have the necessary resources to perform the job?

MARKETING AND COMMUNITY OUTREACH SECTION

13. What type of marketing of your facility is conducted by TV, radio, print, billboards, mailings, ethnic media, and community media? Where is it conducted? Which services (e.g. cardiac care, diabetes care) are marketed? Is any marketing aimed at non-English-speaking populations? If so, which populations and in what language?
14. Does your facility conduct any type of community outreach? If so, what type? To which communities?

(Continued)

STAFF SECTION

15. Identify the total number of patient contact staff by race, ethnicity, and position held? (e.g. RNs, LPNs, admission staff, etc.)
16. Identify the total number of physicians with staff privileges by specialty, race, ethnicity, and type of position held. If different from staff privileges, specify the total number of physicians with admitting privileges by specialty, race, ethnicity, and location of office. Do any of these physicians serve predominantly minority communities? What efforts does your facility have in place to recruit minority physicians, nurses, and other medical professionals? If your facility does actively seek minority health professionals, where and how are these individuals sought?
17. What is the racial and/or ethnic and gender composition of your board of directors? What role does your board play in community outreach decisions? Admitting and staffing privileges? Marketing decisions?

AFFILIATION SECTION

18. Does your facility have any particular affiliation with medical schools, nursing schools, etc.? If so, which schools?
19. Does your facility have any relationship with community-based organizations? If so, which organizations? What is the nature of the relationship?

TRAINING SECTION

20. Is there any type of racial and/or ethnic sensitivity training (e.g. cultural medical competence) for your staff or a particular element of your staff? If so, what type of training? How extensive is it? What percentage of your staff availed themselves of this training? Is the training conducted by a contractor or by in-house staff? If by a contractor, who is the contractor? If this training program exists, has it been evaluated? If so, by whom?

ACTION SECTION

21. In some racial and ethnic minority communities, there is an historical and/or cultural mistrust of the medical profession (especially within the African-American community in light of such things as the Tuskegee Study and segregated hospitals that are still remembered by older patients). This can cause patients to avoid medical checkups and even avoid medical help when ill. What does your facility do to try to overcome this problem? Is it successful? If not, what are you doing to address the situation?

LEP SECTION:

22. What are the procedures in place for assisting LEP patients or clients? Are LEP patients forced to wait an unreasonable amount of time for interpreter services? Do your frontline staff know what to do when LEP patients present themselves? How do they know what to do? Who maintains staff training standards on this issue? Is staff conduct in this context monitored? By whom?
23. Can you identify staff who are fluent in languages other than English? What role do these staff members play in providing interpreter services to LEP patients? Who monitors the quality of the interpretation? What standards are used to evaluate the interpretation?
24. Does your institution contract out for interpreter services? If so, with whom? What are the qualifications of those contractors? Are they trained or certified in medical interpreting? Who evaluates the work performed by the contractors?
25. Determine what signs, postings, and other printed materials are translated into languages spoken by LEP patients and clients who use your institution. Has everything that must be translated to allow for equal access been translated? Who provides the translation service? How do you determine if the translations are accurate?

Source: U.S. Department of Health and Human Services, Office of Civil Rights, Region II, New York City.

you want." Another respondent was told by an attending physician that, "being a typical black woman, I bet you haven't dieted in over 20 years."

In the most serious incident reported, a hospital refused to treat an unconscious patient. Family members overheard some racial comments during the event. They sued and won their case. The hospital admitted the treatment was denied based on race and fired the physician, a physician's assistant, and a nurse. The event, which occurred three years ago, still causes distress to the family.

The study authors admit that it is difficult to determine how many of the events were racially motivated, but all the interview subjects perceived the events that way. About 85% of them were shocked by the incident that occurred, indicating they weren't predisposed to expect discriminatory behavior.

Half the time, the patients made a complaint, although in only 9% of the cases was it a written complaint. In two-thirds of the cases, the perpetrators were providers.

"In a health care setting, people feel vulnerable and want good advice," says Smyser. "We like to take it for granted that we provide that. But we find a significant number of minority residents feel they are treated differently, discriminated against, or treated rudely. And it goes beyond all

Web Sites for Further Information

- The Department of Health & Human Services Office for Civil Rights (OCR): **www.dhhs.gov/ocr/**. Includes news, office newsletters, regulations, and contact information for every regional OCR office.
- The Cross Cultural Health Care Program: **www.xculture.org/**. Conducts cultural competency training. Web site includes a comprehensive list of on-line and hard-copy resources.
- The Center for Cross-Cultural Health: **www.crosshealth.com/**. A Minneapolis-based training and resource organization that also lists web links and other resources for visitors.
- The Agency for Healthcare Research & Quality: **www.ahrq.gov/**. The agency's web site has a minority health subindex that includes research findings and initiatives, as well as articles on the topic of racial disparity.

of our frustrations with managed care. We might want to blame it on limited time or say that everyone is ruder these days. But it is more than that. Patients see themselves treated one way and other people treated another. And the stories most frequently come from people of color."

Smyser says the interviews spawned several community forums that led to specific recommendations to improve the situation. **(For more on some remedial suggestions, see related cover story.)**

Tom Lonner, PhD, the research manager at the Cross Cultural Health Care Program in Seattle — the organization conducting the interviews for the public health department — says one of the toughest things about dealing with discriminatory behavior is that changing person-to-person interactions is more difficult than doing something concrete, such as hiring interpreters to ease interactions between those with limited English skills and their providers.

At the U.S. Department of Health and Human Services, Office for Civil Rights, research analyst **Lisa Evans**, JD, sees the same problem. "We can go in and look for documents in multiple languages, or look for signs posted in other languages," she says. "That's easy. But how do you find evidence that someone is culturally competent?"

Lonner says facilities need to make a commitment to address the problems throughout their organizations. For instance, Harborview Medical Center, a regional trauma center in Seattle, has several of its departments working on cultural competency, Lonner says. "And those parts are doing a great job, but the notion of cultural competency doesn't pervade the whole institution."

It will take a social movement to solve the problem, says Lonner. "Right now, we are talking to one organization at a time. There just isn't a critical mass." ■

Purchasers' group 'leapfrogs' to quality

Group wants to spark changes in health care

What happens when big health care purchasers such as AT&T, Boeing, Caterpillar, Delta Airlines, Eli Lilly, Ford, General Motors, and IBM get together and voice an opinion about the quality of health care? Hospitals listen. At least that's the theory behind the Leapfrog Group, an organization sponsored by the Business Roundtable and including some 70 companies with the goal of improving safety in health care by alerting patients to key features of hospitals around the country.

Together, the private and public-sector purchasers represent more than 20 million Americans and $40 billion in health care expenditures, says Leapfrog's executive director, **Suzanne Delblanco**, PhD. The group contends that by leveraging its collective might, it can get health plans and hospitals to adhere to three specific safety initiatives and in the process save an estimated 58,000 lives and prevent more than 500,000 medication errors.

"After the Institute of Medicine report [on medication errors] came out, we felt that we had some real areas of common ground and a chance to get consumers interested in health information," explains Delblanco. "Quality is hard to relate to, and consumers don't usually think about health plans but about physicians and hospitals. We felt that if we come up with a common set of purchasing principles, we could help patients."

Those principles are to educate and inform enrollees about medical errors; let patients know what systems and processes can help protect them; and use incentives, recognition, and rewards for those providers and hospitals who put practices in place that will save lives.

The group asked "safety gurus" and systems experts to come up with lists of what might help

improve patient safety. "We also looked at published information," she adds. The goal was to identify actions or methods that would serve as concrete evidence that a facility was working on patient safety.

Eventually, three initiatives were chosen:

1. Use of computerized physician order entry. Using such a system eliminates the problem of illegible physician handwriting and allows for automatic checks for drug interactions, allergies, and appropriate doses. "Hospitals that have these in place can prevent up to 88% of serious medication errors," says Delblanco.

2. Specialist-managed intensive care units (ICUs). "Really sick people need special care," says Delblanco. Ensuring ICUs are managed by physicians with special training can reduce mortality by 10%. Yet these physicians, called intensivists, are in place in only 10% of ICUs. "You aren't usually in a situation where you can choose an ICU," she admits. "But if you are going to a hospital for a procedure that may lead to a critical situation, choose one that is intensivist-managed."

3. Referral of special patients to specialized hospitals. Certain high-risk surgeries have better outcomes if they occur at specialized hospitals, says Delblanco. Leapfrog established seven specific conditions, "for which there is a rock-solid relationship between volume and outcome," she notes. The conditions and related volume are:

- coronary artery bypass graft — 500 or more per year;
- coronary angioplasty — 400 or more per year;
- abdominal aortic aneurysm repair — 30 or more per year;
- carotid endarterectomy — 100 or more per year;
- esophageal cancer surgery — seven or more per year;
- delivery with expected birth weight less than 1,500 g or gestational age less than 32 weeks — regional neonatal ICU with average daily census greater than or equal to 15;
- delivery with prenatal diagnosis of major congenital anomalies — regional neonatal ICU with average daily census greater than or equal to 15.

During the coming year, Leapfrog will launch a web site that will collect data from hospitals to determine if they meet standards. There will be interim measures, too, for facilities that are working on issues but haven't completed their work.

For instance, says Delblanco, a hospital might be researching computer order entry before implementing it. "That means we can highlight them as working toward our standards."

Delblanco expects the data eventually will show more admissions to hospitals that meet the Leapfrog standards. "We'll be analyzing the data to see if the admissions change at all."

She says she hopes the data collection will start in May for pilot tests before the standards are initiated in a variety of large markets. Currently, Detroit; Seattle; California; Knoxville, TN; St. Louis; and Atlanta are scheduled, but the list will expand over time.

"We think this is a great opportunity for hospitals to be recognized and rewarded for meeting standards that we know will improve safety," says Delblanco. "Having these data available for everyone to see will let us use market forces to effect change."

[For more information, contact:

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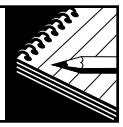
GUEST COLUMN



How to spring clean your organization's data

By **Connie L. Van Fleet**
Senior Vice President for Information Services
Chief Information Officer
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It's time for a thorough spring-cleaning of your company's data. Corporate data are a lot like someone's closet: packed to the point of bursting; filled with items that are similar but not quite identical; archiving things that haven't been worn in years; sprinkled with a few items that were trendy but aren't useful over the long term; holding other gems that are worn all the time because they're good quality, they work well together, and they fit your lifestyle; and storing the indispensable favorite pair of bluejeans.

Look around your work area and your company. There probably are stacks of paper or piles of reports sitting there. Some of them may be yellowed and dusty. Or if you're the "paperless" company, ask your CIO how much data he's

archiving that never get recalled. Think about what that costs.

If your organization is like most companies, you're drowning in data and starved for information. Just like my closet; stuffed to the max and yet I have nothing to wear. The road between a sea of data and high-value information has three rest stops: vision, a pragmatic approach, and a commitment to quality investments. Oh yes, there's a lot of hard work.

Rest stop one: Vision

Vision is the magnetic north. If I'm cleaning out my closet, or cleaning out my company's array of data, I'm only going to be successful if I have a vision of what I want the final product to look like. If I don't, I'm just going to keep repeating my prior experience. And here's where many companies really struggle: They can't achieve a common vision. People come and go. People are reactive to the current crisis. People solve only part of the problem and then forget the rest of the work. But vision implies a view of things as they should be in the most perfect world. Vision also implies something that you keep rechecking, just as we orient ourselves from that northern indicator on the compass when we're lost.

My own company embarked on a vision for analytical reporting a number of years ago. The principles of that vision included building a single repository of data, integrating all the source transaction systems into a common view, and delivering the data through self-service distributed reporting. The vision was to get the data close to business users, and then they could create meaningful information.

Rest stop two: A pragmatic approach

Taking inventory and knowing what you have is the starting point. Doing the inventory is not so hard, but knowing what the data really are might be. Ever had a blouse that looked white in some light, but ivory in others? Or a pair of pants or socks that could be dark navy, but also might be black? You get a rude awakening in the middle of the day when you realize that you have one black sock and one navy sock on. But that same experience happens frequently in business. That report you thought contained the complete medical expense for a product line isn't complete. Why? Because you might have said you wanted the claims expense for the product line, and the analyst interpreted that literally, excluding capitation costs or fees paid for care management programs. You have data. You don't have useful information because you didn't get what you thought you asked for.

Ever had the experience of attending a meeting, and two departments have analyzed the same business question and provide two completely different conclusions? They're both coming at the task with their own understanding of the data, and most likely their own separate sources.

So taking inventory and knowing exactly what you have is crucial. If you understand the vision and you understand what you have, then you have a chance to architect your data into useful business information. But what's missing?

Rest stop three: Quality

Quality is the anchor of your vision. It's the bedrock, and if you don't have it, you will eventually drift into danger. You'll be back out in the sea of data.

I mentioned that my own company started with a vision for an enterprise-architected data warehouse as the solution to business analytic and ad hoc reporting. We built it, they came once or twice, but didn't come again. Why? Because the quality was inconsistent. Business users got burned basing critical business decisions on the data because we couldn't guarantee the quality.

So we invested in a process for measuring and ensuring a level of quality in our analytical data. We developed the key data element (KDE) measurement process. First, we partnered with business units to identify the critical data elements that drive the majority of business decisions for pricing, product design, reimbursement methods, and other corporate expenses. Then we developed a set of statistical measures to evaluate every month's data load against a set of predefined minimum tolerance levels to determine whether the data are up to standards. If not, teams work on correcting the problems at the source systems if possible. This process has provided better end-to-end cooperation between those teams accountable for transaction processing and those teams accountable for analytical reporting. And it puts a consistent product at the fingertips of my business partners.

Sometimes in your quest for quality information, you need to revisit all the rest stops. Recently, my company modified its vision to add another element. We found we'd been fairly successful in the distributed reporting aspects, especially since we improved the quality aspects. But that still left various departments either information-rich or

information-starved. It overlooked the needs of some of the senior executives. It also caused duplication of efforts among different departments with slightly different outcomes for similar efforts. Remember all those things in your closet that are fairly similar, but not identical?

We've modified our vision to include developing a standard set of metrics and reporting capabilities focused around key levers that drive the pricing of our products and targeted to senior executives.

Yes, there's the natural desire to ask for everything during this project. But we're winnowing things down by asking the question "So what?" — meaning what are the actions we'd be able to take if we had that information. If it doesn't result in an actionable step related to our key business drivers, we drop it from the project scope. We'd just be filling up our closet again with useless stuff.

If you're like me, every time I clean out my closet, there are some things that always stay. Usually, those are the clothes that I really thought about before I bought them. They're the ones that were high-quality and not just trendy. They're the ones that match most closely to my lifestyle needs. And they're the ones that provide the most value to me year after year.

Your company's closet of data is not much different. It needs a good spring-cleaning, too. Look

Healthcare Benchmarks™ (ISSN# 1091-6768) is published monthly by American Health Consultants®, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Healthcare Benchmarks**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30-6:00 Monday-Thursday; 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $399 per year; 10 to 20 additional copies, $299 per year. For more than 20 copies, call customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $83 each. (GST registration number R128870672.)

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for the quality stuff, and don't forget to keep the bluejeans too. Everything else can go.

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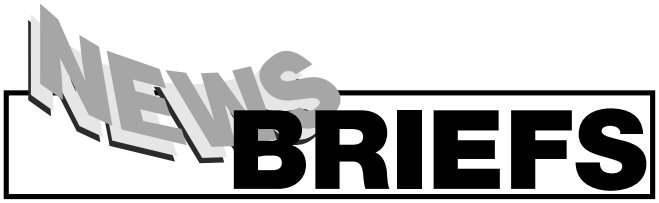

Managed care quality focus of AAAHC guide

With quality of care in the managed care arena coming under intense scrutiny, the Accreditation Association for Ambulatory Health Care Inc. (AAAHC) has published a guide to assist those seeking accreditation in reviewing its standards.

The *AAAHC Guide to Reviewing a Managed Care Organization* encompasses AAAHC's core and adjunct standards, breaking them down so readers will learn exactly how they are applicable to a managed care organization. In addition, each section of the guide outlines exactly what AAAHC site surveyors look for in reviewing a managed care organization for compliance with the standards. AAAHC surveyors will use the guide during their on-site review of managed care organizations.

In other AAAHC news, the association is holding conferences to assist ambulatory health care organizations that are interested in association accreditation. The conferences are April 27-28 in Cleveland, and June 8-9 in New Orleans. The June event will also coincide with the AAAHC Institute for Quality Improvement's (IQI) first National Quality Forum for Ambulatory health care.

Cost of the conferences is $515 for the first person from a non-AAAHC accredited organization; $475 for the first person from an AAAHC-accredited organization. Each additional person from the same organization can attend for a fee of $425. Combined pricing for participants of the AAAHC "Achieving Accreditation" education conference who would like to attend the IQI National Quality Forum is also available. The guide is available for $95.

For more information, contact the AAAHC at (847) 853-6060. Web site: www.aaahc.org. ▼

Learn strategies to cut medical errors

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), is holding a series of one-day seminars for health care professionals to examine the risk for medical errors and develop practical strategies to improve patient safety.

The Executive Briefings on the Patient Safety Standards: Designing Safer Health Care Systems will be held at these locations:

- St. Louis — April 26;
- Fort Lauderdale, FL — May 4;
- Oklahoma City — May 11;
- Princeton, NJ — June 12;
- Louisville, KY — Sept. 21;
- Indianapolis — Nov. 2.

Participants will learn to identify characteristics inherent to health care that lead to errors and sentinel events. The courses will also focus on identifying specific high-risk activities, developing strategies to minimize risks for the most common types of medical errors, and using a variety of sources to establish organization-specific error prevention programs.

The seminar fee varies from $475 to $490, depending upon the location. To register, or for more information, call JCAHO at (630) 792-5800 between 8 a.m. and 5 p.m., central time, or contact the commission via e-mail at customerservice@jcaho.org. ■